Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

Table of Contents
(Rev, 263, 07-30-04)

10 - General Inpatient Requirements

(Rev. 1, 10-01-03)

HO-400, HO-400.G, HO-403, HO-412

The hospital may bill only for services provided. If the provider billing system initiates billing based on services ordered, the provider must confirm that the service has been provided before billing either the carrier or intermediary (FI).

The provider agreement to participate in the program requires the provider to submit all information necessary to support claims for services. Failure to submit such information in an individual case will result in denial of the entire claim, the charging of utilization in inpatient cases to the beneficiary record, and a prohibition against the provider billing or collecting from the beneficiary or other person for any services on the claim. A provider with a common practice of failing to submit necessary information in connection with its claims subjects itself to possible termination of its participation in the program. (See Chapter 1.)

State agencies will find that a significant deficiency exists in complying with the conditions of participation if the hospital repeatedly fails to transfer appropriate medical information when patients are transferred to other health facilities. Appropriate medical information includes the discharge summary, the physician's medical orders, and a summary of departmental medical records. The hospital must obtain the patient's consent for the release of medical information as soon as the decision to transfer is made, unless a blanket authorization was obtained at admission.

10.1 - Forms

(Rev. 1, 10-01-03)

HO-400.A, HH-401

Form CMS-1450 (UB-92 data set), Inpatient and/or Outpatient Billing, or the electronic equivalent, is used for all provider billing, except for the professional component of physicians services. (See Chapter 25 for instructions for hospital services and Chapter 26 for instructions for physician services.)

Providers are responsible for purchasing their own forms. They can be bought as a regular stock item from many printers as a snap-out set or as a continuous pin-feed form (either glued on the side or not) and are available as carbonless or with carbon paper. Medicare accepts them all. The standard form set contains four copies, one page of which is designed to bill the patient.

Special orders can be made for fewer copies, e.g., one-part for a Medicare hospice election, three-part excluding patient copy.

A - Form CMS-1490S Patient's Request for Medicare Payment

Only beneficiaries (or their representatives) who complete and file their own claims use this. Providers have no need for this form.

B - Form CMS-1500 Health Insurance Claim Form

HH-424

This is the prescribed form for claims prepared by physicians or suppliers whether or not the claims are assigned. Institutional providers may use the Form CMS-1500 to bill the Part B carrier for the professional component of physicians' services where applicable.

Form CMS-1450, is processed by the provider's FI.

10.2 - Focused Medical Review (FMR)

(Rev. 1, 10-01-03)

HO-419, HH-450, HH-452, HH-462.1

This section has been moved to the Program Integrity Manual, which can be found at the following Internet address http://www.cms.hhs.gov/manuals/cmsindex.asp.

10.3 - Spell of Illness

(Rev. 1, 10-01-03)

A3-3622

The FI makes spell of illness determinations in accordance with the Medicare Benefit Policy Manual, Chapter 3, and these special instructions.

A - Beginning a Spell of Illness in Nonparticipating Provider

The noncovered services furnished by a nonparticipating provider can begin a spell of illness only if the provider is a qualified provider. A qualified provider is a hospital (including a psychiatric hospital) or an SNF that meets all requirements in the definition of such an institution even though it may not be participating.

It is most unlikely that a nonparticipating hospital that is not accredited by JCAHO or a nonparticipating SNF satisfies the conditions of participation, particularly with regard to utilization review. Therefore, for spell of illness purposes, the FI assumes that nonparticipating providers are not qualified providers in the absence of evidence to the contrary. Situations that might constitute such contrary evidence include cases where the provider recently dropped out of the program or, after a survey by the State agency, decided not to participate even though the conditions of participation were met. Hospitals accredited by JCAHO are deemed to meet all requirements except utilization

review. For such a hospital, the FI determines through the RO whether the hospital has a utilization review plan in effect.

B - Continuing a Spell of Illness

1 - Hospital Services

For purposes of continuing a spell of illness in a hospital, the hospital in which the stay occurs need not meet all requirements that are necessary for starting a spell of illness. If there has been a stay in a hospital that might continue the spell of illness and the FI cannot ascertain its status, the FI contacts the RO, which maintains a list of all medical facilities and their status.

2 - SNF Services

For purposes of continuing a spell of illness in a SNF the spell of illness ends when the beneficiary no longer needs or receives a Medicare covered level of care.

The FI uses the following seven presumptions to determine whether the skilled level of care standards were met during a prior SNF stay. If the information upon which to base a presumption is not readily available, the FI may, at its discretion, review the beneficiary's medical records to determine whether the beneficiary was an inpatient of an SNF for purposes of ending a spell of illness.

These special rules for determining whether a beneficiary in a SNF is an inpatient for benefit period purposes is applicable in all cases where a prior SNF stay affects benefit period status, not only when a beneficiary is seeking to continue a benefit period, but also where it results in the beneficiary starting a new benefit period. If the applicable skilled level of care standards were met during a prior SNF stay, the spell of illness is continued with current utilization available to the beneficiary. If the applicable skilled level of care standards were not met during a prior SNF stay, the spell of illness is not continued. A new spell of illness restores full utilization and imposes a cash deductible.

Presumptions

Presumption 1: A beneficiary's care in a SNF met the skilled level of care standards if a Medicare SNF claim was paid for the care, unless such payment was made under limitation of liability rules.

Presumption 2: A beneficiary's care in a SNF met the skilled level of care standards if a SNF claim was paid for the services provided in the SNF under the special Medicare limitation on liability rules pursuant to placement in a noncertified bed. See Chapter 30.

Presumption 3: A beneficiary's care in a SNF did not meet the skilled level of care standards if a claim was paid for the services provided in the SNF pursuant to the general Medicare limitation on liability rules in Chapter 30. (This presumption does not apply to

placement in a noncertified bed. For claims paid under these special provisions, see Presumption 2.)

Presumption 4: A beneficiary's care in a Medicaid nursing facility (NF) did not meet the skilled level of care standards if a Medicaid claim for the services provided in the NF was denied on the grounds that the services received were not at the NF level of care (even if paid under applicable Medicaid administratively necessary days provisions which result in payment for care not meeting the NF level of care requirements).

Presumption 5: A beneficiary's care in an SNF met the skilled level of care standards if a Medicare SNF claim for the services provided in the SNF was denied on grounds other than that the services were not at the skilled level of care.

Presumption 6: A beneficiary's care in an SNF did not meet the skilled level of care standards if a Medicare claim for the services provided in the SNF was denied on the grounds that the services were not at the skilled level of care and no limitation of liability payment was made.

Presumption 7: A beneficiary's care in a SNF did not meet the skilled level of care standards if no Medicare or Medicaid claim was submitted by the SNF.

Rebuttal of Presumptions

Presumptions 1 through 4 cannot be rebutted. Thus, prior Medicare and Medicaid claim determinations that necessarily required a level of care determination for the time period under consideration are binding for purposes of a later benefit period calculation. Although Presumptions 1 through 4 are not in themselves rebuttable, a beneficiary may seek to reverse a benefit period determination that was dictated by one of these presumptions by timely appealing the prior Medicare or Medicaid claim determination which triggered the presumption.

Presumptions 5 through 7 can be rebutted by beneficiary showings that the level of care needed or received is other than that which the presumption dictates. Rebuttal showings are permitted at both FI determination levels under 42 CFR 405, Subpart G (i.e., a rebuttal showing regarding the status of a prior SNF stay is made at the time that an inpatient claim is submitted and/or at the reconsideration level). Evaluate rebuttal documentation even if the presumption being rebutted was triggered by a Medicaid denial. Decisions under presumptions 5 through 7 require the FI to send a notice to advise the beneficiary of the basis for the determination and the right to present evidence to rebut the determination on reconsideration.

Presumption 6 can be rebutted because the Medicare skilled level of care definition for coverage purposes is broader than the skilled level of care definition used here for benefit period determinations. For example, prior hospital care related to the SNF care is included in the Medicare SNF coverage requirements but is not included in the standard for benefit period determinations. Therefore, Medicare payment could have been denied for an SNF stay because of noncompliance with that requirement, even though skilled level of care requirements for benefit period determinations were in fact met by the SNF

stay. Consequently, when Medicare SNF payment is denied, the beneficiary must be given the opportunity to demonstrate that he/she still needed and received a skilled level of care for purposes of benefit period determinations to extend a benefit period if this would be to the beneficiary's advantage.

NOTE: Effective October 1, 1990, the levels of care that were previously covered separately under the Medicaid SNF and intermediate care facility (ICF) benefits are combined in a single Medicaid nursing facility (NF) benefit. Thus, the Medicaid NF benefit includes essentially the same type of skilled care covered by Medicare's SNF benefit, but it includes less intensive care as well. This means that when a person is found not to require at least a Medicaid NF level of care (as under Presumption 4), it can be presumed that he or she also does not meet the Medicare skilled level of care standards. However, since the NF benefit can include care that is less intensive than Medicare SNF care, merely establishing that a person does require NF level care does not necessarily mean that he or she also meets the Medicare skilled level of care standards. Determining whether an individual who requires NF level care also meets the Medicare skilled level of care standards requires an actual examination of the medical evidence and cannot be accomplished through the simple use of a presumption.

Medicare no payment bills submitted by an SNF result in Medicare program payment determinations (i.e., denials). Therefore, such no payment bills trigger the appropriate presumptions. This also applies in any State where the Medicaid program utilizes no payment bills which lead to Medicaid program payment determinations. If an SNF erroneously fails to submit a Medicare claim (albeit a no-pay claim) when Medicare rules require such submission, request compliance. Once the no-pay bill is submitted and denied, the applicable presumption (other than presumption 7) is triggered. If a patient is moving from a SNF level of care to a non-SNF level of care in a facility certified to provide SNF care, occurrence code 22 (date active care ended) is used to signify the beginning of the no-pay period on the bill and trigger the appropriate presumptions.

Some of the presumptions require knowledge of Medicaid's claims processing involvement with the prior claim. The FI uses current bill data, accompanying documentation, bill history files, and telephone contacts with the prior stay facility and/or the Medicaid agency to develop the Medicaid aspects. It does not continue Medicaid development beyond a telephone contact. It concludes its consideration of the presumption at this point based upon the Medicaid information available.

10.4 - Payment of Nonphysician Services for Inpatients

(Rev. 1, 10-01-03)

HO-407

All items and nonphysician services furnished to inpatients must be furnished directly by the hospital or billed through the hospital under arrangements. This provision applies to all hospitals, regardless of whether they are subject to PPS.

A - Other Medical Items, Supplies, and Services

The following medical items, supplies, and services furnished to inpatients are covered under Part A. Consequently, they are covered by the prospective payment rate or reimbursed as reasonable costs under Part A to hospitals excluded from PPS.

- Laboratory services (excluding anatomic pathology services and certain clinical pathology services);
- Pacemakers and other prosthetic devices including lenses, and artificial limbs, knees, and hips;
- Radiology services including computed tomography (CT) scans furnished to inpatients by a physician's office, other hospital, or radiology clinic;
- Total parenteral nutrition (TPN) services; and
- Transportation, including transportation by ambulance, to and from another hospital or freestanding facility to receive specialized diagnostic or therapeutic services not available at the facility where the patient is an inpatient.

The hospital must include the cost of these services in the appropriate ancillary service cost center, i.e., in the cost of the diagnostic or therapeutic service. It must not show them separately under revenue code 0540.

EXCEPTIONS

- Pneumococcal Vaccine - is payable under Part B only and is billed by the hospital on the Form CMS-1450.
- Ambulance Service - For purposes of this section "hospital inpatient" means a beneficiary who has been formally admitted it does not include a beneficiary who is in the process of being transferred from one hospital to another. Where the patient is transferred from one hospital to another, and is admitted as an inpatient to the second, the ambulance service is payable under only Part B. If transportation is by a hospital owned and operated ambulance, the hospital bills separately on Form CMS-1450 as appropriate. Similarly, if the hospital arranges for the ambulance transportation with an ambulance operator, including paying the ambulance operator, it bills separately. However, if the hospital does not assume any financial responsibility, the billing is to the carrier by the ambulance operator or beneficiary, as appropriate, if an ambulance is used for the transportation of a hospital inpatient to another facility for diagnostic tests or special treatment the ambulance trip is considered part of the DRG, and not separately billable, if the resident hospital is under PPS.
- Part B Inpatient Services - Where Part A benefits are not payable, payment may be made to the hospital under Part B for certain medical and other health services. See Chapter 4 for a description of Part B inpatient services

- Anesthetist Services "Incident to" Physician Services - If a physician's practice was to employ anesthetists and to bill on a reasonable charge basis for these services and that practice was in effect as of the last day of the hospital's most recent 12-month cost reporting period ending before September 30, 1983, the physician may continue that practice through cost reporting periods beginning October 1, 1984. However, if the physician chooses to continue this practice, the hospital may not add costs of the anesthetist's service to its base period costs for purposes of its transition payment rates. If it is the existing or new practice of the physician to employ certified registered nurse anesthetists (CRNAs) and other qualified anesthetists and include charges for their services in the physician bills for anesthesiology services for the hospital's cost report periods beginning on or after October 1, 1984, and before October 1, 1987, the physician may continue to do so.

B - Exceptions/Waivers

These provisions were waived before cost reporting periods beginning on or after October 1, 1986, under certain circumstances. The basic criteria for waiver was that services furnished by outside suppliers are so extensive that a sudden change in billing practices would threaten the stability of patient care. Specific criteria for waiver and processing procedures are in §2804 of the Provider Reimbursement Manual (CMS Pub. 15-1).

20 - Payment Under Prospective Payment System (PPS) Diagnosis Related Groups (DRGs)

(Rev. 156, 04-30-04)

A3-3610, HO-415

A - General

The Social Security Amendments of 1983 (P.L. 98-21) provided for establishment of a prospective payment system (PPS) for Medicare payment of inpatient hospital services. (See §20.4 for corresponding information for PPS capital payments and computation of capital and operating outliers for FY 1992.) Under PPS, hospitals are paid a predetermined rate per discharge for inpatient hospital services furnished to Medicare beneficiaries. Each type of Medicare discharge is classified according to a list of DRGs. These amounts are, with certain exceptions, payment in full to the hospital for inpatient operating costs. Beneficiary cost-sharing is limited to statutory deductibles, coinsurance, and payment for noncovered items and services. Section 4003 of OBRA of 1990 (P.L. 101-508) expands the definition of inpatient operating costs to include certain preadmission services. (See §40.3.)

The statute excludes children's hospitals and cancer hospitals, hospitals located outside the 50 States~~, the District of Columbia, and Puerto Rico are also excluded.~~ In addition to these categorical exclusions, the statute provides other special exclusions, such as

hospitals that are covered under State reimbursement control systems. These excluded hospitals and units are paid on the basis of reasonable costs subject to the target rate of increase limits.

In accordance with Section 1814 (b) (3) of the Act, services provided by hospitals in Maryland subject to the Health Services Cost Review Commission (provider numbers 21000-21099) are paid according to the terms of the waiver, that is 94% of submitted charges subject to any unmet Part B deductible and coinsurance.

For discharges occurring on or after April 1, 1988, separate standardized payment amounts are established for large urban areas and rural areas. Large urban areas are urban areas with populations of more than 1,000,000 as determined by the Secretary of HHS on the basis of the most recent census population data. In addition, any New England County Metropolitan Area (NECMA) with a population of more than 970,000 is a large urban area.

OBRA 1987 required payment of capital costs under PPS effective with cost reporting periods that began October 1, 1991, or later. A 10-year transition period was provided to protect hospitals that had incurred capital obligations in excess of the standardized national rate from major disruption. High capital cost hospitals are known as "hold harmless" hospitals. The transition period also provides for phase-in of the national Federal capital payment rate for hospitals with capital obligations that are less than the national rate. New hospitals that open during the transition period are exempt from capital PPS payment for their first two years of operation. Hospitals and hospital distinct part units that are excluded from PPS for operating costs are also excluded from PPS for capital costs.

Capital payments are based on the same DRG designations and weights, outlier guidelines, geographic classifications, wage indexes, and disproportionate share percentages that apply to operating payments under PPS. 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 that have historically been applied to operating payments also apply to capital payments under PPS.

B - Hospitals and Units Excluded

The following hospitals and distinct part hospital units (DPU) are excluded from PPS and are paid on a reasonable cost or other basis:

- Pediatric hospitals whose inpatients are predominately under the age of 18. Provider numbers are in the 3300-3399 range.
- Hospitals located outside the 50 States. ~~and the District of Columbia.~~
- Hospitals participating in a CMS-approved demonstration project or State payment control system.
- Nonparticipating hospitals furnishing emergency services have not been affected by the PPS statute (P.L. 97-21). They are paid under their existing basis.

When benefits are exhausted and the hospital bills ancillary services that are rendered in a DPU, it must show the S, T, U, V, W, or Y in the third position of its provider number.

The following illustrate billing where services are provided under PPS and in a DPU:

EXAMPLE 1

A beneficiary is admitted to provider number 00-0001 (a swing-bed hospital) on January 1, and on January 6 begins to receive SNF level services and is discharged on January 12. There are two admission dates and two discharge dates as follows:

- From 00-0001 with an admission date of 01/01, a from date of 01/01, and a discharge date of 01/06.

- From 00-U001 with an admission date of 01/06, a from date of 01/06, and a discharge date of 01/12.

EXAMPLE 2

A beneficiary is admitted to a hospital January l and on January 6 is transferred to the psychiatric unit, and discharged on January 12. There are two admission dates and two discharge dates as follows:

- From 00-0001 with an admission date of 01/01, a from date of 01/01, and a discharge date of 01/06.

- From 00-S001 with an admission date of 01/06, a from date of 01/06, and a discharge date of 01/l2.

(Handle a change from 00-0001 to 00-T001 as in Example #2.)

C - Situations Requiring Special Handling

1 - Sole Community Hospitals are paid in accordance with the methods used to establish the operating prospective rates for the first year of the PPS transition for operating costs. The appropriate percentage of hospital-specific rate and the Federal regional rate is applied by the Pricer program in accordance with the current values for the appropriate fiscal year.

2 - Hospitals have the option to continue to be reimbursed on a reasonable cost basis subject to the target ceiling rate or to be reimbursed under PPS if the following are met:

- Recognized as of April 20, 1983, by the National Cancer Institute as Comprehensive Cancer Centers or Clinical Research Centers;

- Demonstrating that the entire facility is organized primarily for treatment of, and research on, cancer; and

- Having a patient population that is at least 50 percent of the hospital's total discharges with a principal diagnosis of neoplastic disease.

The hospital makes this decision at the beginning of its fiscal year. The choice continues until the hospital requests a change. If it selects reasonable cost subject to the target ceiling, it can later request PPS. No further option is allowed.

3 - Regional and national referral centers within short-term acute care hospital complexes. Rural hospitals that meet the criteria have their prospective rate determined on the basis of the urban, rather than the rural, adjusted standardized amounts, as adjusted by the applicable DRG weighting factor and the hospital's area wage index.

4 - Hospitals in Alaska and Hawaii have the nonlabor related portion of the wage index adjusted by their appropriate cost-of-living factor. These calculations are made by the Pricer program and are included in the Federal portion of the rate.

5 - Kidney, heart, and liver acquisition costs incurred by approved Transplant Centers are treated as an adjustment to the hospital's payments. These payments are adjusted in each cost reporting period to compensate for the reasonable expenses of the acquisition and are not included in determining prospective payment.

6 - Religious Nonmedical Health Care Institutions are paid on the basis of a predetermined fixed amount per discharge. Payment is based on the historical inpatient operating costs per discharge and is not calculated by "Pricer."

7 - Transferring hospitals with discharges assigned to DRG 385 (Neonates, Died or Transferred) or DRG 504-511 (burns, transferred to another acute care facility) have their payments calculated by the Pricer program on the same basis as those receiving the full prospective payment. They are also eligible for cost outliers.

8 - Nonparticipating hospitals furnishing emergency services are not included in PPS.

9 - Veterans Administration (VA) Hospitals are generally excluded from participation. Where payments are made for Medicare patients, the payments are determined in accordance with 38 U.S.C. 5053(d).

10 - A hospital that loses its urban area status as a result of the Executive Office of Management and Budget redesignation occurring after April 20, 1983 may qualify for special consideration by having its rural Federal rate phased-in over a 2-year period. The hospital will receive, in addition to its rural Federal rate in the first cost reporting period, two-thirds of the difference between its rural Federal rate and the urban Federal rate that would have been paid had it retained its urban status. In the second reporting period, one-third of the difference is applied. The adjustment is applied for two successive cost reporting periods beginning with the cost-reporting period in which CMS recognizes the reclassification.

11 - The payment per discharge under the PPS for hospitals in Puerto Rico is the sum of:

- 50 percent of the Puerto Rico discharge weighted urban or rural standardized rate.

- 50 percent of the national discharge weighted standardized rate.

(The special treatment of referral centers and sole community hospitals does not apply to prospective payment hospitals in Puerto Rico.)

There are special criteria that facilities must meet in order to obtain approval for payment for heart transplants and special processing procedures for these bills. (See §90.2.) Facilities that wish to obtain coverage of heart transplants for their Medicare patients must submit an application and documentation showing their initial and ongoing compliance with the criteria. For facilities that are approved, Medicare covers under Part A all medically reasonable and necessary inpatient services.

12 - Hospitals with high percentage of ESRD discharges may qualify for additional payment. These payments are handled as adjustments to cost reports.

13 - Exception payments are provided for hospitals with inordinately high levels of capital obligations. They will expire at the end of the 10-year transition period. Exception payments ensure that for FY 1992 and FY 1993:

- Sole community hospitals receive 90 percent of Medicare inpatient capital costs:

- Urban hospitals with 100 or more beds and a disproportionate share patient percentage of at least 20.2 percent receive 80 percent of their Medicare inpatient capital costs; and

- All other hospitals receive 70 percent of their Medicare inpatient capital costs.

A limited capital exception payment is also provided during the 10-year capital transition period for hospitals that experience extraordinary circumstances that require an unanticipated major capital expenditure. Events such as a tornado, earthquake, catastrophic fire, or a hurricane are examples of extraordinary circumstances. The capital project must cost at least $5 million to qualify for this exception.

D - DRG Classification

The DRGs are a patient classification system which provides a means of relating types of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. Payment for inpatient hospital services is made on the basis of a rate per discharge that varies according to the DRG to which a beneficiary's stay is assigned. All inpatient transfer/discharge bills from both PPS and non-PPS facilities, including those from

waiver States, long-term care facilities, and excluded units are classified by the Grouper software program into one of 489 diagnosis related groups (DRGs).

The following DRGs receive special attention:

- **DRG No. 468** - Represents a discharge with valid data but where the surgical procedure is unrelated to the principal diagnosis. This DRG has a weight assigned and will be paid. The hospital must review the record on each DRG in the remittance record and where either the principle diagnosis or surgical procedure was reported incorrectly, prepare an adjustment bill. The FI may elect to avoid the adjustment bill by returning the bill to the hospital prior to payment. Further, Quality Improvement Organizations (QIOs) will review all DRG 468 cases.

- **DRG No. 469** - Represents a discharge with a valid diagnosis in the principle diagnosis field, but one not acceptable as a principal diagnosis. Examples include a diagnosis of diabetes mellitus or an infection of the genitourinary tract during pregnancy, both unspecified as to episode of care. These diagnoses may be valid, but they are not sufficient to determine the principal diagnosis for DRG assignment purposes. FIs will return the claims. The hospital must enter the corrected principal diagnosis for proper DRG assignment and resubmit the claim.

- **DRG No. 470** - Represents a discharge with invalid data. FIs return the claims for correction of data elements affecting proper DRG assignment. The hospital resubmits the corrected claim.

When the bills are processed in conjunction with the MCE (see §20.2.1) coding inconsistencies in the information and data are identified.

The MCE must be run before Grouper to identify inconsistencies before the bills are processed through the Grouper.

E - Difference in Age/Admission Versus Discharge

HO-415.4

When a beneficiary's age changes between the date of admission and date of discharge, the DRG and related payment amount are determined from the patient's age at admission.

20.1 – Hospital Operating Payments Under PPS

(Rev. 70, 01-23-04)

Section 1886(d) of the Social Security Act (the Act) sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates. Under the PPS, Medicare payment for hospital inpatient operating costs is made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (DRGs).

The base payment rate is comprised of a standardized amount that is divided into a labor-related share and a nonlabor-related share. The labor-related share is adjusted by the wage index applicable to the area where the hospital is located; and if the hospital is located in Alaska or Hawaii, the nonlabor-related share is adjusted by a cost-of-living adjustment factor. This base payment rate is multiplied by the DRG relative weight.

If the hospital treats a high percentage of low-income patients, it receives a percentage add-on payment applied to the DRG-adjusted base payment rate. This add-on payment, known as the disproportionate share hospital (DSH) adjustment, provides for a percentage increase in Medicare payments to hospitals that qualify under either of two statutory formulas designed to identify hospitals that serve a disproportionate share of low-income patients. For qualifying hospitals, the amount of this adjustment may vary based on the outcome of the statutory calculations.

If the hospital is an approved teaching hospital, it receives a percentage add-on payment for each case paid under the PPS (known as the indirect medical education (IME) adjustment). This percentage varies, depending on the ratio of residents to beds.

Additional payments may be made for cases that involve new technologies that have been approved for special add-on payments. To qualify, a new technology must demonstrate that it is a substantial clinical improvement over technologies otherwise available, and that, absent an add-on payment, it would be inadequately paid under the regular DRG payment.

The costs incurred by the hospital for a case are evaluated to determine whether the hospital is eligible for an additional payment as an outlier case. This additional payment is designed to protect the hospital from large financial losses due to unusually expensive cases. Any outlier payment due is added to the DRG-adjusted base payment rate, plus any DSH, IME, and new technology add-on adjustments.

Although payments to most hospitals under the PPS are made on the basis of the standardized amounts, some categories of hospitals are paid the higher of a hospital-specific rate based on their costs in a base year (the higher of FY 1982, FY 1987, or FY 1996) or the PPS rate based on the standardized amount. For example, sole community hospitals (SCHs) are the sole source of care in their areas, and small rural Medicare-dependent hospitals (MDHs) are a major source of care for Medicare beneficiaries in their areas. Both of these categories of hospitals are afforded this special payment protection in order to maintain access to services for beneficiaries (although MDHs receive only 50 percent of the difference between the PPS rate and their hospital-specific rates if the hospital-specific rate is higher than the PPS rate).

The existing regulations governing payments to hospitals under the PPS are located in 42 CFR Part 412, Subparts A through M.

20.1.1 – Hospital Wage Index

(Rev. 70, 01-23-04)

Section 1886(d)(3)(E) of the Act requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. CMS defines hospital geographic areas (labor market areas) based on the definitions of urban (e.g., Metropolitan Statistical Areas (MSAs)) and rural areas issued by the Office of Management and Budget.

The Act further requires the wage index to be updated annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. These data are collected on Worksheet S-3, Parts II and III of the Medicare Cost Report (Form CMS-2552). To ensure the accuracy of the wage index, fiscal intermediaries are required to perform annual desk reviews of hospitals' wage data. CMS also publishes the wage data, and allows hospitals an opportunity to review and request corrections to the data, before the wage index is finalized.

In computing the wage index, CMS derives an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals surveyed in the nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. If a labor market area's average hourly wage is greater than the national average, the area's wage index value will be greater than 1.0000. If an area's average hourly wage is less than the national average, the area's wage index value will be less than 1.0000. The wage index adjustment factor is applied only to the labor portion of the standardized amounts.

Section 4410 of Public Law 105-33 provides that, for discharges on or after October 1, 1997, the area wage index value applicable to any hospital that is located in an urban area may not be less than the area wage index value applicable to hospitals located in rural areas in that State. Furthermore, this wage index floor is to be implemented in such a manner as to ensure that aggregate prospective payment system payments are not greater or less than those that would have been made in the year if this section did not apply.

20.1.2 - Outliers

(Rev. 70, 01-23-04)

A3-3610.7, HO-415.10

In addition to the basic prospective payment rates, payments are made for discharges involving day (eliminated October 1, 1997) and cost outliers. "Outliers" are cases which although classifiable into a specific DRG, have an unusually long length of stay or exceptionally high cost; the first category is considered a "day" (day outliers were discontinued at the end of FY 1997) and the latter a "cost" outlier. Section 1886(d)(5)(ii-iii) of the Act provides that outlier payments may not be less than five percent nor more than six percent of total payments projected to be made based upon the prospective payment rates in any year. (See §20.4.8 for computation of day and cost outlier payments for discharges that occur during cost report years that begin on or after October 1, 1991.) The FI will make outlier determinations and pay the entire bill. If the QIO determines the claim should be partially or completely denied, it informs the FI, which will prepare an adjustment bill.

The FI will pay any outlier amount indicated by its Pricer program unless the hospital indicates a condition code 66. Outlier payments apply only to the Federal portion of a capital PPS payment.

Outliers are not applicable to non-PPS hospitals. The Pricer program makes all outlier determinations except for the medical review determination. (See §20.2.3.) Outliers are usually reviewed by the QIO on a post-payment sample basis. If the QIO determines the claim should be partially or completely denied, it will inform the FI. Prepare an adjustment bill. (See §50.)

PPS standardized amounts are reduced separately for hospitals located in urban and rural areas. Adjustments are based upon the estimated proportion of total DRG payments attributable to outlier payments. Consequently, instead of a uniform percent reduction factor applying to all standardized amounts, the reduction varies, depending upon whether the hospital is classified as rural or urban.

See §20.4 for computation rules that apply to capital outliers during cost report years which began on or after October 1, 1991.

A - Day Outliers

Day Outliers Were Discontinued at the End of FY 1997

Day outlier cases (eliminated October 1, 1997) were long stay cases that received payment in addition to standard payment for the DRG when the length of stay exceeded a threshold.

CMS determined the threshold and included it in the Pricer program. The Quality Improvement Organization (QIO) determined whether the claim was medically necessary on a post-payment sample basis.

If the hospital stay included covered days of care in excess of the applicable threshold criteria, the FI made an additional payment on either, a per diem basis for those days, including covered days for beneficiaries requiring a SNF-level of care, if a SNF bed was not available, or on a cost basis for the entire stay.

The payment for each outlier day was equal to the Federal per diem rate for the DRG based on the arithmetic mean length of stay multiplied by a percentage determined by CMS and included in the Pricer program. We have phased-out the proportion of outlier payments paid under the day outlier methodology from FY 1995 - FY 1997.

Day outlier status was based upon the total length of stay and day outlier payment was based upon covered days. The amount was updated annually in the "Federal Register."

B-Cost Outliers

The FI, using Pricer, determines an appropriate additional payment for inpatient services where hospital charges for covered services furnished to the beneficiary, adjusted for cost, are inordinately high. CMS annually determines, and includes in Pricer, the threshold beyond which a cost outlier is paid. The additional payment amount is the difference between the hospital's cost for the discharge and the threshold criteria established for the applicable DRG multiplied by a percentage or marginal cost factor. Additional payment for cost outliers is determined by multiplying the difference between the hospital's adjusted costs for the discharge and the threshold amount by 80 percent. CMS includes the marginal cost factor in Pricer.

For transfers on or after October 1, 1984, the transferring hospital may be paid a cost outlier, but may not be paid a day outlier payment unless DRGs 385 or 456 apply. In these cases only, a cost outlier may be paid regardless of the day outlier criteria. For transfers prior to October 1, 1984, neither day nor cost outliers are payable to transferring hospitals.

When the hospital provides the Quality Improvement Organization (QIO) with medical records for cost outlier review, the hospital indicates the precise revenue code for each charge billed. In case adjustments are needed, revenue codes are necessary to ensure proper accounting for cost report purposes. It is not acceptable for the hospital to merely provide listings of revenue codes expecting the QIO to assign the charges to the

appropriate code. If the correct revenue codes are not provided, the QIO will deny the bill.

C - Special Outlier Payments for Burn Cases

Special payments are provided for cost outlier cases classified in DRGs relating to burns. Cost outliers in burn DRGs receive 90 percent of the cost of care above the cost outlier threshold.

The six DRGs relating specifically to burn cases are:

DRG	Name
456	Burns, transferred to another acute care facility
457	Extensive burns w/o O.R. procedure
458	Nonextensive burns with skin graft
459	Nonextensive burns with wound debridement or other O.R. procedure
460	Nonextensive burns w/o O.R. procedure
472	Extensive burns with O.R. procedure

D - Adjustments Where the Quality Improvement Organization (QIO) Denies Cost

Where a QIO's decision changes previously processed bills, an adjustment bill is prepared to correct the bill.

E - Pricer Coding for Outlier Cases

The FI follows these guidelines for using the Pricer program to determine outlier status and payment amount:

- Send to Pricer, with a review code of 00, any bills that do not meet the criteria listed below for review codes 03, 06, 07 or 08;
- Send to Pricer, with a review code of 03, any transfer bill that does not have a DRG of 385 or 456 and/or does not meet the criteria listed below for review code 06. Transfer bills with DRG 385 or 456 receive the full DRG payment and must be sent to Pricer with review code 00 or 01, as appropriate;
- Send to Pricer, with a review code of 06, any transfer bill that does not have a DRG of 385 or 456 and contains condition code 66;
- Send to Pricer, with a review code of 07, any nontransfer bill that contains condition code 66 (the provider refuses cost outlier payment for this bill); or

Send to Pricer, with a review code of 08, any bill that is for an approved liver transplant (grouped to DRG 191 or 192) that should be paid at the DRG 480 weight, and that has a discharge date of March 8, 1990, through September 30, 1990.

20.2 - Computer Programs Used to Support Prospective Payment System

(Rev. 1, 10-01-03)

A3-3656, HO-417

Medicare Code Editor

The Medicare Code Editor (MCE) edits claims to detect incorrect billing data. The MCE addresses three basic types of edits which will support the DRG assignment. They include code coverage, and clinical edits.

Grouper Program

The Grouper program determines the DRG from data elements the hospital reported. It is used on all inpatient discharge/transfer bills received from both PPS and non-PPS facilities, including those from waiver States, long-term care hospitals, and excluded units.

Built into the Grouper program are edits which reject incomplete or impossible codes. Claims submitted with valid diagnoses and valid diagnoses-surgical procedure combinations but are incorrect in that they do not represent the actual diagnosis or procedure, cannot be detected. The responsibility for accuracy rests with the hospital. However, a post claim approval review is conducted by the QIO using medical records and the approved claim.

Pricer Program

The Pricer program determines the amount to pay under prospective payment.

The Pricer program applies the DRG relative weights, hospital urban or rural and census division location, hospital specific data, and beneficiary hospital data from the bill to determine the amount payable for each PPS discharge bill.

Most hospitals should not need a Pricer program because only one rate per DRG applies unless the claim results in a cost outlier for a beneficiary who's benefits are exhausted during the stay. For those claims, the provider must identify the outlier threshold to properly bill covered days on an inpatient claim. See §20.7.4 below. Hospitals and hospital claims in multiple geographic areas may obtain a Pricer from

National Technical Institute
U.S. Department of Commerce
NTIS
Springfield, VA 22161.

Hospitals may also download a PC Pricer that will process one record at the time from the CMS Web site at: http://www.cms.hhs.gov/providers/pricer/default.asp.

20.2.1 - Medicare Code Editor (MCE)

(Rev. 73, 01-23-04)

A3-3656.1, HO-417.1

A - General

The MCE edits claims to detect incorrect billing data. In determining the appropriate DRG for a Medicare patient, the age, sex, discharge status, principal diagnosis, secondary diagnosis, and procedures performed must be reported accurately to the Grouper program. The logic of the Grouper software assumes that this information is accurate and the Grouper does not make any attempt to edit the data for accuracy. Only where extreme inconsistencies occur in the patient information will a patient not be assigned to a DRG. Therefore, the MCE is used to improve the quality of information given to Grouper.

The MCE addresses three basic types of edits which will support the DRG assignment:

Code Edits - Examines a record for the correct use of ICD-9-CM codes that describe a patient's diagnoses and procedures. They include basic consistency checks on the interrelationship among a patient's age, sex, and diagnoses and procedures.

Coverage Edits - Examines the type of patient and procedures performed to determine if the services where covered.

Clinical Edits - Examines the clinical consistency of the diagnostic and procedural information on the medical claim to determine if they are clinically reasonable and, therefore, should be paid.

B - Implementation Requirements

The FI processes all inpatient Part A discharge/transfer bills for both PPS and non-PPS facilities (including waiver States, long-term care hospitals, and excluded units) through the MCE. It processes claims that have been reviewed by the QIO prior to billing through the MCE only for edit types 1, 2, 3, 4, 7, and 12. It does not process the following kinds of bills through the MCE include:

- Where no Medicare payment is due (amounts reported by value codes 12, 13, 14, 15, or 16 equal or exceed charges).

- Where no Medicare payment is being made. Where partial payment is made, editing is required.

- Where QIO reviewed prior to billing (code C1 or C3 in FL 24-30). It may process these exceptions through the program and ignore development codes or bypass the program.

The MCE software contains multiple versions. The version of the MCE accessed by the program depends upon the patient discharge date entered on the claim.

C - Bill System/MCE Interface

The FI installs the MCE online, if possible, so that prepayment edit requirements identified in subsection C can be directed to hospitals without clerical handling.

The MCE needs the following data elements to analyze the bill:

- Age;

- Sex;

- Discharge status;

- Diagnosis (5 maximum);

- Procedures (3 maximum); and

- Discharge date.

MCE provides the FI an analysis of "errors" on the bill as described in subsection D. The FI develops its own interface program to provide data to MCE and receive data from it.

The MCE Installation Manual describes the installation and operation of the program, including data base formats and locations.

D - Processing Requirements

The hospital must follow the procedure described below for each error code. For bills returned to the provider, the FI considers the bill improperly completed for control and processing time purposes. (See Chapter 1.)

1 - Invalid Diagnosis or Procedure Code

The MCE checks each diagnosis code, including the admitting diagnosis, and each procedure code against a table of valid ICD-9-CM codes. An admitting diagnosis, a principle diagnosis, and up to eight additional diagnoses may be reported. A principle

procedure code and up to five other procedure codes may be reported on an inpatient claim. If the recorded code is not in this table, the code is invalid, and the FI returns the bill to the provider.

For a list of all valid ICD-9-CM codes see "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), January 1979, Volume I (Diseases)" and "Volume 3 (Procedures)," and the "Addendum/Errata" and new codes furnished by the FI. The hospital must review the medical record and/or face sheet and enter the correct diagnosis/procedure before returning the bill.

2 - Invalid Fourth or Fifth Digit

The MCE identifies any diagnosis code, including the admitting diagnosis or any procedure that requires a fourth or fifth digit, which is either missing or not valid for the code in question.

For a list of all valid fourth and fifth digit ICD-9-CM codes see "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), January 1979, Volume 1 (Diseases)" and "Volume 3 (Procedures)," and the "Addendum/Errata" and new codes furnished by the FI. The FI returns claims edited for this reason to the hospital. The hospital must review the medical record and/or face sheet and enter the correct diagnosis/procedure before returning the bill.

3 - E-Code as Principal Diagnosis

E-codes describe the circumstances that caused an injury, not the nature of the injury, and therefore are not principal diagnoses. E-codes are all ICD-9-CM diagnosis codes that begin with the letter E. For a list of all E-codes, see "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), January 1979, Volume l (Diseases)." The hospital must review the medical record and/or face sheet and enter the correct diagnosis before returning the bill.

4 - Duplicate of PDX

Any secondary diagnosis that is the same code as the principal diagnosis is identified as a duplicate of the principal diagnoses, because the secondary diagnosis may cause assignment to a complication/co-morbidity DRG in error. Hospitals may not repeat a diagnosis. The FI will delete the duplicate secondary diagnosis and process the bill.

5 - Age Conflict

The MCE detects inconsistencies between a patient's age and any diagnosis on the patient's record. Examples are:

- A 5-year-old patient with benign prostatic hypertrophy.
- A 78-year-old delivery.

In the above cases, the diagnosis is clinically impossible in a patient of the stated age. Therefore, either the diagnosis or age is presumed to be incorrect. Four age code categories are described below.

- A subset of diagnoses is intended only for newborns and neonates. These are "Newborn" diagnoses. For "Newborn" diagnoses, the patient's age must be 0 years.

- Certain diagnoses are considered reasonable only for children between the ages of 0 and 17. These are "Pediatric" diagnoses.

- Diagnoses identified as "Maternity" are coded only for patients between the ages of l2 and 55 years.

- A subset of diagnoses is considered valid only for patients over the age of 14. These are "Adult" diagnoses. For "Adult" diagnoses the age range is 15 through 124.

The diagnoses described in Addendum E, pages E-2-17 are acceptable only for the age categories shown. If the FI edits online, it will return such bills for a proper diagnosis or correction of age as applicable. If the FI edits in batch operations after receipt of the admission query response, it uses the age based on CMS records and returns bills that fail this edit. The hospital must review the medical record and/or face sheet and enter the proper diagnosis before returning the bill.

6 - Sex Conflict

The MCE detects inconsistencies between a patient's sex and a diagnosis or procedure on the patient's record. Examples are:

- Male patient with cervical cancer (diagnosis).

- Male patient with a hysterectomy (procedure).

In both instances, the indicated diagnosis or the procedure conflicts with the stated sex of the patient. Therefore, either the patient's diagnosis, procedure or sex is incorrect.

Addendum E, pages E-18-38 contain listings of male and female related ICD-9-CM diagnosis and procedure codes and the corresponding English descriptions. The hospital should review the medical record and/or face sheet and enter the proper sex, diagnosis, and procedure before returning the bill.

7 - Manifestation Code As Principal Diagnosis

A manifestation code describes the manifestation of an underlying disease, not the disease itself, and therefore, cannot be a principal diagnosis. Addendum E, pages E-39-41 contain listings of ICD-9-CM diagnoses identified as manifestation codes. The

hospital should review the medical record and/or face sheet and enter the proper diagnosis before returning the bill.

8 - Nonspecific Principal Diagnosis

A set of diagnosis codes, particularly those described as "not otherwise specified," are identified by the MCE as nonspecific diagnoses. While these codes are valid according to the ICD-9-CM coding scheme, more precise codes must be used for the principal diagnosis.

The edit is performed only if the patient was discharged alive. Deceased patients often do not receive a complete diagnostic workup, thus, the specification of precise principal diagnosis may not be possible.

Addendum E, pages E-42-50 contain listings of ICD-9-CM diagnosis codes identified as "nonspecific" when used as principal diagnosis.

If the hospital's coding can be processed by the Grouper program, its FI processes the bill. If not, the claim is returned for the hospital to provide a specific principal diagnoses.

If over 10 percent of a hospital's bills result in the MCE error type, its FI will contact it about improving it’s coding.

9 - Questionable Admission

There are some diagnoses, which are not usually sufficient justification for admission to an acute care hospital. For example, if a patient is given a principal diagnosis of:

4011 - Benign Hypertension

then this patient would have a questionable admission, since benign hypertension is not normally sufficient justification for admission.

Addendum E, page E-51 contains a listing of ICD-9-CM diagnosis codes identified as "Questionable Admission" when used as principal diagnosis.

QIOs review on a post-payment basis all questionable admission cases. Where the QIO determines the denial rate is sufficiently high to warrant, it requests the FI to refer claims for review before payment.

FIs will not interrupt processing based upon MCE identification of questionable admission.

10 - Unacceptable Principal Diagnosis

There are selected codes that describe a circumstance which influences an individual's health status but is not a current illness or injury; therefore, they are unacceptable as a

principal diagnosis. For example, Vl73 (Family History of Ischemic Heart Disease) is an unacceptable principal diagnosis.

In a few cases, there are codes that are acceptable if a secondary diagnosis is coded. If no secondary diagnosis is present for them, MCE returns the message "requires secondary dx." Codes that follow this rule are indicated with an asterisk (*) in Addendum E, pages E-52-57.

The QIO reviews claims with diagnosis V571, V572, V573, V5789, and V579 and a secondary diagnosis.

If these codes are identified without a secondary diagnosis, the FI returns the bill to the hospital and requests a secondary diagnosis that describes the origin of the impairment. Also, bills containing other "unacceptable principal diagnosis" codes are returned.

The hospital reviews the medical record and/or face sheet and enters the principal diagnosis that describes the illness or injury before returning the bill.

11 - Nonspecific O.R. Procedures

A set of O.R. procedure codes, particularly those described as "not otherwise specified" are identified by the MCE as nonspecific. While these codes are valid according to the ICD-9-CM coding scheme, the hospital must use more precise codes for Medicare. For example, 8020 (Arthroscopy NOS) is identified as a nonspecific O.R. procedure because the site is not specified by the code. Codes 8021-8029 specify the precise site.

MCE reports the nonspecific O.R. procedure condition only if all the O.R. procedures performed have been coded as nonspecific.

If the hospital's coding can be processed by the Grouper program, the FI processes the bill. If not, the FI returns the bill for the hospital to provide a specific O.R. procedure code.

The FI counts monthly by provider for this exception. If over 10 percent of a hospital's bills result in the MCE error type, it contacts the hospital about improving it’s coding.

12 - Noncovered O.R. Procedures

There are some O.R. procedures for which Medicare does not provide payment.

The FI will return the bill requesting either:

- A no pay bill, or
- A correction in the procedure code.
- A bill indicating the covered and noncovered procedures.

If the hospital indicates that there are covered and noncovered procedures, the FI refers the bill to the QIO for prepayment review. Upon receipt of the QIOs response, it either deletes the noncovered procedures and charges or requires the hospital to delete them. It does not process the noncovered procedures through Grouper or the noncovered charges through Pricer.

13 - Open Biopsy Check

Biopsies can be performed as open (i.e., a body cavity is entered surgically), or percutaneously or endoscopically. The DRG definitions assign a patient to different DRGs depending upon whether or not the biopsy was open. In general, for most organ systems, open biopsies are performed infrequently.

Effective October 1, 1987, there are revised biopsy codes that distinguish between open and closed biopsies. To make sure that hospitals are using ICD-9-CM codes correctly, the FI requests O.R. reports on a sample of 10 percent of claims with open biopsy procedures for review on a postpayment basis.

If the O.R. report reveals that the biopsy was closed (performed percutaneounsly, endoscopically, etc.) the FI changes the procedure code on the bill to the closed biopsy code and processes an adjustment bill. Some biopsy codes (3328 and 5634) have two related closed biopsy codes, one for closed endoscopic and for closed percutaneous biopsies. The FI assigns the appropriate closed biopsy code after reviewing the medical information.

14 - Medicare as Secondary Payer - MSP Alert

The MCE identifies situations that may involve automobile medical, no-fault or liability insurance. The hospital must develop other insurance coverage as provided in the Medicare Secondary Payer Manuals, before billing Medicare.

15 - Bilateral Procedure

There are codes that do not accurately reflect performed procedures in one admission on two or more different bilateral joints of the lower extremities. A combination of these codes show a bilateral procedure when, in fact, they could be single joint procedures (i.e., duplicate procedures).

If two more of these procedures are coded, and the principal diagnosis is in MDC 8, the claim is flagged for post-pay development. The FI processes the bill as coded but requests an O.R. report. If the report substantiates bilateral surgery, no further action is necessary. If the O.R. report does not substantiate bilateral surgery, an adjustment bill is processed.

If the error rate for any provider is sufficiently high, the FI may develop claims prior to payment on a provider-specific basis.

16 - Invalid Age

If the hospital reports an age over l24, the FI requests the hospital to determine if it made a bill preparation error. If the beneficiary's age is established at over l24, the hospital enters 123.

17 - Invalid Sex

A patient's sex is sometimes necessary for appropriate DRG determination. Usually the FI can resolve the issue without hospital assistance. The sex code reported must be either 1 (male) or 2 (female).

18 - Invalid Discharge Status

A patient's discharge status is sometimes necessary for appropriate DRG determination. Discharge status must be coded according to the Form CMS-1450 conventions. See Chapter 25.

19 - Invalid Discharge Date

An invalid discharge date is a discharge date that does not fall into the acceptable range of numbers to represent, either the month, day or year (e.g., 13/03/01, 12/32/01). If no discharge date is entered, it is also invalid. MCE reports when an invalid discharge date is entered.

20 – Limited Coverage

(Rev. 73, 01-23-04)

Effective October 1, 2003, for certain procedures whose medical complexity and serious nature incur extraordinary associated costs, Medicare limits coverage. The edit message indicates the type of limited coverage (e.g., LVRS, heart transplant, etc). The procedures receiving limited coverage edits previously were listed as non-covered procedures, but were covered under Medicare in certain circumstances. The FIs will handle these procedures as they had previously.

20.2.2 - DRG GROUPER Program

(Rev. 1, 10-01-03)

A3-3656.2

The FI pays for inpatient hospital services on the basis of a rate per discharge that varies according to the DRG to which a beneficiary's stay is assigned. Each DRG represents the average resources required to care for a case in that particular DRG relative to the national average of resources consumed per case. The DRG weights used to calculate payment are in the Pricer DRGX file.

The FI uses the GROUPER program to assign the DRG number. GROUPER determines the DRG from data elements reported by the hospital. This applies to all inpatient discharge/transfer bills received from both PPS and non-PPS facilities, including those from waiver States, long-term care hospitals, and excluded units.

The Pricer (PPSMAIN) driver program calls the correct fiscal year GROUPER based upon the discharge date. If the FI or shared system writes its own driver program, it must access the GROUPER for the correct FY based on discharge date. GROUPER does not determine the DRG price. GROUPER input/output are specified below. The FI determines the best place in its total system to place the GROUPER program.

Grouper requires the following items:

1 - Principal and up to eight other ICD-9-CM diagnoses

2 - Principal and up to five additional ICD-9-CM procedures

3 - Age at last birthday at admission

4 - Sex (1=male and 2=female)

5 - Discharge destination (patient status code from the claim)

UB-92 sex coding is M for male and F for female while GROUPER is l for male and 2 for female. Discharge destination codes are similar to UB 92 definitions for patient status except codes 20-29 are summarized as 20. The FI calculates age at admission. GROUPER needs age rather than date of birth.

Grouper responds with the following information:

1 - Major diagnostic category

2 - DRG number

3 - Grouper return code (a one position code indicating the action taken by the program)

4 - Procedure code used in determining the DRG

5 - Diagnosis code used in determining the DRG

6 - Secondary diagnosis code used in determining the DRG, if applicable

20.2.3 - PPS Pricer Program

(Rev. 1, 10-01-03)

A3-3615.3, A3-3656.3

CMS provides a Pricer program to determine the price upon which to base payment under prospective payment. A separate Pricer installation guide is provided. The FI uses the Pricer appropriate for the date of discharge.

After GROUPER determines the DRG, the FI's system calls the Pricer program. Pricer determines the price to pay and prepares a report.

Four data files are included. CMS maintains three:

- DRGX file - contains DRG weights, average length of stay and outlier cutoff points.
- MSAX file - contains urban and rural wage indexes used in calculating payment. CMS may request that the FI make interim changes to this file when index changes are issued for individual hospitals after issuance of Pricer for the period.
- RATE file - contains census division values and updating amounts used in calculating payment.

The FI maintains the provider-specific file, (PROV file). This contains information about the facts specific to the provider that affect computations, e.g., effective dates for PPS, type of provider (for application of special computation rules), census division, MSA, adjusted cost per discharge, disproportionate share adjustment percentage, and capital data.

Pricer also calculates the disproportionate share adjustment and adds it to the DRG payment. Correct calculation depends upon the accuracy of related information the FI includes in the PRICER PROV file.

The Pricer program applies the DRG relative weights, hospital urban or rural and census division location, provider-specific data, and beneficiary hospital data from the bill to determine the amount payable for each PPS discharge bill.

Pricer uses the Intern-to-Bed ratio in calculating the indirect teaching adjustment for operating costs for the FI to accumulate and use in related payments. Pricer uses the intern-to-average daily census ratio to calculate the indirect teaching adjustment for capital costs. The FI ensures that these ratios are available for Pricer to compute payment for teaching hospitals. It includes the ratios in its PROV file to ensure that cost outliers are not overpaid to its teaching hospitals.

Pricer does not calculate utilization days required for the PS&R, CWF, or cost report. It does not determine the amount to pay after deduction for deductible, coinsurance, or the

primary payment where Medicare is secondary. The FI must calculate the price and make adjustments to the price furnished before making payment.

FIs use the Pricer implementation guide for information concerning Pricer processing reports, input parameters and data requirements.

20.2.3.1 - Provider-Specific File

(Rev. 152, 04-30-04)

A3-3850 Transmittal 1863A3

The PROV file contains needed information about each provider to enable the pricing software to calculate the payment amount. The FI maintains the accuracy of the data in accordance with the following criteria.

Whenever the status of any element changes, the FI prepares an additional record showing the effective date. For example, when a hospital's FY beginning date changes as a result of a change in ownership or other "good cause," the FI makes an additional record showing the effective date of the change.

The format and data required by the Pricer program and by the provider-specific file is found in Addendum A.

FIs submit a file of provider-specific payment data to CMS CO every three months for PPS and non-PPS hospitals, inpatient rehabilitation hospitals or units (referred to as IRFs), long term care hospitals (LTCHs), SNF's, and hospices, including those in Maryland. Regional home health FIs (RHHIs) submit a file of provider specific data for all home health agencies. FIs serving as the audit FI for hospital based HHAs do not submit a file of provider specific data for HHAs.

FIs create a new record any time a change occurs for a provider. Data must be reported for the following periods: October 2 - January 1, January 2 - April 1, April 2 - July 1, and July 2 - October 1. This file must be received in CO within seven business days after the end of the period being reported.

NOTE: FIs submit the latest available provider-specific data for the entire reporting period to CO by the seven business day deadline. If CO fails to issue applicable instructions concerning changes or additions to the file fields by 10 calendar days before the end of the reporting period, the FI may delay reporting of data related to the CO instructions until the next file due date. For example, if CO instructions changing a file field are issued on or after September 21 with an effective date of October 1, the FI may exclude the October 1 CO-required changes from the file submitted by October 9. The FI includes the October 1 CO-required changes, and all subsequent changes through January 1 in the file submitted in January.

A - PPS Hospitals

FIs submit all records (past and current) for all PPS providers every three months. Duplicate the provider file used in the "PRICER" module of the claims processing system.

B - Non-PPS Hospitals and Exempt Units

FIs create a provider specific history file using the listed data elements for each non-PPS hospital and exempt hospital unit. Submit the current and the preceding fiscal years every three months. Code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file.

C - Hospice

FIs create a provider specific history file using the following data elements for each hospice. Submit the current and the preceding fiscal years every three months. Data elements 3, 4, 5, 6, 9, 10, 13, and 17 are required. All other data elements are optional for this provider type.

D - Skilled Nursing Facility (SNF)

FIs create a provider specific history file using the following data elements for each SNF beginning with their first cost reporting period that starts on or after July 1, 1998. FIs submit the current and the preceding fiscal years every three months. For PPS-exempt providers, code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file. Data elements 3, 4, 5, 6, 9, 10, 13, 19, and 21 are required. All other data elements are optional for this provider type.

E - Home Health Agency (HHA)

FIs create a provider specific history file using the following data elements for each HHA. Regional Home Health FIs (RHHIs) submit the current and the preceding fiscal years every three months. Data elements 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, and 19 are required. All other data elements are optional for this provider type. All fields must be zero filled if not completed. Update the effective date in data element 4 annually. Ensure that the current census division in data element 11 is not zero. Ensure that the waiver indicator in data element 8 is N. Ensure that the MSA code reported in data element 13 is a valid MSA code.

F - Inpatient Rehabilitation Facilities (IRFs)

FIs create a provider specific history file using the following data elements for each IRF beginning with their first cost reporting period that starts on or after January 1, 2002. FIs submit the current and the preceding fiscal years every three months. For PPS-exempt providers, code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file. Data elements 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 19, 21, 25, 27, 28, and 42 are required. All other data elements are optional for this provider type

G – Long Term Care Hospital (LTCH)

FIs create a provider specific history file using the following data elements for each LTCH beginning with their first cost reporting period that starts on or after October 1, 2002. FIs submit the current and the preceding fiscal years every three months. For PPS-exempt providers, code Y in position 49 (waiver code) to maintain the record in the PRICER PROV file. Data elements 3, 4, 5, 6, 7, 8, 9, 10, 12, 13, 14, 19, 21, 22, and 25 are the minimum required fields for entering a provider under LTCH PPS.

Note: All data elements, whether required or optional, must have a default value of "0" (zero) if numerical, or a blank value if alpha-numerical.

The provider specific file (PSF) should be transferred to CO using the Network Data Mover (NDM) system, COPY TO and RUN JOB statements, which will notify CO of PSF file transfer. FIs must set up an NDM transfer from the FI's system for which it is responsible. It is critical that the provider specific data is copied to the CMS Data Center using the following input data set names ("99999" should be changed to the FI's 5-digit number):

Data set Name ---COPY TO: --MU00.@FPA2175.intermediary99999

DCB=(HCFA1.MODEL,BLKSIZE=2400,LRECL=2400,RECFM=FB)

Data set Name ---RUN JOB: --MU00.@FPA2175.CLIST(intermediary99999)

See Addendum A for the Provider Specific File record layout and description.

20.3 - Additional Payment Amounts for Hospitals with Disproportionate Share of Low-Income Patients

(Rev. 1, 10-01-03)

A3-3610.15, A-03-067

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, (Public Law: 99-272), provides for an additional payment to an urban hospital of 100 or more beds that serves a disproportionate share of low-income patients.

Adjustments are made in the Federal portion of the operating cost DRG payment to increase payments to hospitals serving a disproportionate share of low-income patients. The additional payment equals the Federal portion of the operating cost DRG payment and outlier payments, but excludes any additional payments for the costs of indirect medical education multiplied by an adjustment percentage.

If a hospital meets the disproportionate share hospital (DSH) definition, an additional operating cost payment will be made for discharges occurring on or after May 1, 1986. The DSH adjustment is applied only to the Federal portion of the operating cost DRG payment (including outlier payments). It is basically a year-end lump sum adjustment. However, the FI will identify hospitals that are eligible to receive the DSH adjustment and make interim payments subject to a year-end settlement based upon the hospital's DSH percentage for the cost reporting period. The DRG payment a hospital receives includes the interim operating cost DSH payment and an interim operating indirect medical education adjustment.

For services on or after October 1, 1997, the DSH percentage is not applied to outlier payments.

The Supplemental Security Income (SSI)/Medicare Beneficiary Data for FY 2002 for IPPS hospitals is located at the following CMS web address:

http://www.cms.hhs.gov/providers/hipps/dsh.asp

The data is used for settlement purposes for hospitals with cost reporting periods beginning during FY 2002 (cost reporting periods beginning on or after October 1, 2001, and before October 1, 2002.

For years after FY 2002, CMS will issue Temporary Instructions to provide the FIs with the updated information.

A - Regular Calculation of DSH Percentage

The operating DSH percentage is the sum of:

- The percentage of the hospital's total Medicare Part A patient days attributable to Medicare patients who are also SSI recipients (this percentage will be supplied to the FI by CMS). Since the SSI/Medicare percentages are determined by CMS on a fiscal year basis, hospitals will be afforded the option (for settlement purposes) of determining their SSI/Medicare percentage based upon data from their own cost reporting period. If a hospital avails itself of this option, it must furnish its FI, in a manner and format prescribed by CMS, data on its Medicare patients for the cost reporting period. CMS will match these data to data supplied by SSA to determine the patients dually entitled to Medicare Part A and SSI for the hospital's cost reporting period. The hospital bears the full cost of this process, including the cost of verification by SSA.

- The percentage of total patient days attributable to patients entitled to Medicaid, but not to Medicare Part A. (Medicaid days and total days are available on the cost report.)

For operating DSH payments:

For discharges between May 1, 1986, and March 31, 1990, a hospital qualifies for an operating cost DSH adjustment if it has a DSH percentage of:

- At least 15 percent for an urban hospital with 100 or more beds;

- At least 40 percent for an urban hospital with less than 100 beds; or

- At least 45 percent for a rural hospital, with fewer than 500 beds.

For discharges on and after October 1, 1986, the hospital qualifies for an operating cost DSH adjustment if it has a DSH percentage of at least 15 percent, is located in a rural area, and has 500 or more beds.

For discharges between April 1, 1990 and December 31, 1995, a hospital qualifies for an operating DSH adjustment if it has a DSH percentage of:

- At least 15 percent for an urban hospital with 100 or more beds, or a rural hospital with 500 or more beds;

- At least 40 percent for an urban hospital with fewer than 100 beds;

- At least 45 percent for a rural hospital with 100 beds or fewer, if it is not also classified as a sole community hospital; or

- At least 30 percent for a rural hospital with more than 100 beds which is classified as a sole community hospital.

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 DSH percentage greater than 0.

For the DSH determination, the number of beds in a hospital is determined by counting the number of inpatient care bed days available during the cost reporting period, excluding beds assigned to newborns, custodial care, and PPS excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period. Inpatient care bed days available should be the same as Indirect Medical Education (IME) bed days. Available beds may not match the number of licensed beds.

B - Determination of Operating DSH Adjustment Percentage

Hospitals that meet the DSH percentage criteria are entitled to adjustments to the Federal portion of their operating cost DRG payments (including the Federal portion of outlier payments) as follows. For hospitals that qualify for DSH payment, Pricer calculates the DSH adjustment percentage. (See §20.2.3.) The following procedures are used to calculate the DSH adjustment.

For the period May 1, 1986 - September 30, 1988:

Urban hospitals with 100 or more beds and rural hospitals with 500 or more beds - The lesser of 15 percent or the percentage determined by using the following formula:

(DSH % - 15)(.5) + 2.5

EXAMPLES

Hospital A is an urban hospital with 200 beds and has a DSH percentage of 21. Its DSH payment factor is computed:

(21 - 15)(.5) + 2.5 = 5.5%

DSH adjustment factor = 5.5% (.0550)

Hospital B is an urban hospital with 250 beds and has a DSH percentage of 45. Its DSH payment adjustment factor is computed:

(45 - 15)(.5) + 2.5 = 17.5%

DSH adjustment factor = 15% (.1500) (the maximum adjustment under the law)

- Urban hospitals with fewer than 100 beds - 5 percent.
- Rural hospitals with fewer than 500 beds - 4 percent.

For the period October 1, 1988 - March 31, 1990:

- Urban hospitals with 100 or more beds and rural hospitals with 500 or more beds - the following formula is used:

  (DSH % - 15) (.5) + 2.5

EXAMPLES

Hospital A is an urban hospital with 200 beds and has a DSH percentage of 21 percent. Its DSH payment factor is computed:

(21-15)(.5) + 2.5 = 5.5%

DSH adjustment factor = 5.5% (.0550)

Hospital B is an urban hospital with 250 beds and has a DSH percentage of 45 percent. Its DSH payment adjustment factor is computed:

(45-15) (.5) + 2.5 = 17.5%

DSH adjustment factor = 17.5% (.1750, the limit was removed effective 10/1/88)

- Urban hospitals with fewer than 100 beds - 5 percent.
- Rural hospitals with fewer than 500 beds - 4 percent.

For the period April 1, 1990 - December 31, 1995:

- Urban hospitals with 100 or more beds and rural hospitals with 500 or more beds whose DSH percentage is greater than 20.2 - the following formula is used:

  Through December 31, 1990 - (DSH % - 20.2) (.65) + 5.62

  January 1, 1991, and later - (DSH % - 20.2) (.7) + 5.62

EXAMPLES

Hospital A is an urban hospital with 200 beds and has a DSH percentage of 21 percent. Its December 1990 DSH payment factor is computed:

(21 - 20.2) (.65) + 5.62 = 6.14%

DSH adjustment factor = 6.14% (.0614)

Hospital B is an urban hospital with 250 beds and has a DSH percentage of 45 percent. Its December 1990 DSH payment adjustment factor is computed:

(45 - 20.2) (.65) + 5.62% = 21.74%

DSH adjustment factor = 21.74% (.2174)

Urban hospitals with 100 or more beds and rural hospitals with 500 or more beds whose DSH percentage is equal to or less than 20.2 - the following formula is used:

(DSH % - 15) (.6) + 2.5

- Urban hospitals with fewer than 100 beds - 5 percent.

- Rural hospitals that are RRCs and sole community hospitals - the greater of 10 percent or the percentage determined using the following formula:

  (DSH % - 30) (.6) + 4.0

EXAMPLES

Hospital C is a rural hospital that is an RRC and a sole community hospital, and has a DSH percentage of 35 percent. Its DSH payment factor is computed:

(35 - 30) (.6) + 4.0 = 7%

DSH adjustment factor = 10% (.1000)

Hospital D is a rural hospital which is a RRC and a sole community hospital. It has a DSH percentage of 45 percent. Its DSH payment factor is computed:

(45 - 30) (.6) + 4.0 = 13%

DSH adjustment factor is 13% (.1300)

- Rural hospitals that are RRCs, but are not sole community hospitals-the following formula is used:

  (DSH % - 30) (.6) + 4.0

- Rural hospitals that are sole community hospitals, but are not RRCs - 10 percent.

- Rural hospitals not described above with 100 beds or less - 4 percent if DSH percentage is 45 percent or more.

- Rural hospitals not described above with more than 100 beds but fewer than 500 beds - 4 percent if DSH percentage is 30 percent or more.

- Urban hospitals with 100 or more beds whose DSH percentage is less than or equal to 20.2 - the following formula is used:

  (DSH % - 15) (.6) + 2.5

For the period October 1, 1993, through September 30, 1994:

- Urban hospitals with 100 or more beds whose DSH percentage is greater than 20.2-the following formula is used:

  (DSH % - 20.2) (.8) + 5.88

- Urban hospitals with 100 or more beds whose DSH percentage is less than or equal to 20.2 - the following formula is used:

  (DSH % - 15) (.6) + 2.5

- Rural hospitals that are RRCs and sole community hospitals - the greater of 10 percent or the percentage determined using the following formula:

  (DSH % - 30) (.6) + 4.0

EXAMPLES

Hospital C is a rural hospital that is a RRC and a sole community hospital. It has a DSH percentage of 35 percent. The DSH payment factor is computed:

(35 - 30) (.6) + 4.0 = 7%

DSH adjustment factor = 10% (.1000), the greater payment

Hospital D is a rural hospital that is a RRC and a sole community hospital. It has a DSH percentage of 45 percent. Its DSH payment factor is computed:

(45 - 30) (.6) + 4.0 = 13%

DSH adjustment factor = 13% (.1300)

Rural hospitals that are RRCs and are not sole community hospitals - the percentage is determined using the following formula:

(DSH % - 30) (.6) + 4.0

- Rural hospitals that are sole community hospitals and are not RRCs - 10 percent.

- Rural hospitals not described above - 4 percent.

For discharges after September 30, 1994:

- Urban hospitals with 100 or more beds and rural hospitals with 500 or more beds whose DSH percentage is greater than 20.2 - the percentage is determined using the following formula:

  (DSH % - 20.2) (.825) + 5.88

- Urban hospitals with 100 or more beds whose DSH percentage is less than or equal to 20.2 - the following formula is used:

  (DSH % - 15) (.65) + 2.5

- Rural hospitals that are RRCs and sole community hospitals - the greater of 10 percent or the percentage determined with the following formula:

  (DSH % - 30) (.6) + 4.0

EXAMPLES

Hospital C is a rural hospital that is an RRC and a sole community hospital. It has a DSH percentage of 35 percent. Its October 1994 DSH payment factor is computed:

(35 - 30) (.6) + 4.0 = 7%

DSH adjustment factor = 10% (.1000), the greater rate

Hospital D is a rural hospital that is an RRC and a sole community hospital. It has a DSH percentage of 45 percent. Its October 1994 DSH payment factor is computed:

(45 - 30) (.6) + 4.0 = 13%

DSH adjustment factor = 13% (.1300)

- Rural hospitals that are RRCs, but not sole community hospitals - Use the following formula:

  (DSH % - 30) (.6) + 4.0

- Rural hospitals that are sole community hospitals and are not RRCs - 10 percent.

- Rural hospitals not described above - 4 percent.

The amount of the operating cost DSH adjustment is computed by multiplying the Federal portion of the hospital's operating cost DRG revenues by the appropriate DSH adjustment factor.

EXAMPLE

Hospital A's DSH payment adjustment factor is 5.5 percent (.0550). The Federal portion of its DRG revenues including appropriate outlier payments, but excluding any payments for indirect medical education costs, equals $100,000.

Federal DRG revenues x DSH adjustment factor = DSH adjustment amount $100,000 x .055 = $5,500

The FI will accumulate a record of the DSH amount paid, the Federal portion of the operating cost DRG and any outlier amount for hospital discharges after April 30, 1986, to use at cost settlement.

C - Computation of DSH Adjustment

Compute the amount of the DSH adjustment by multiplying the Federal portion of the hospital's DRG revenues by the appropriate DSH adjustment factor.

EXAMPLE

Hospital A's DSH payment adjustment factor is 5.5 percent (or .0550). The Federal portion of its DRG revenues (including appropriate outlier payments, but excluding any payments for indirect medical education costs) equals $100,000.

Federal DRG revenues x DSH adjustment factor = DSH adjustment amount $100,000 x .055 = $5,500

D - DSH Exception

The law contains a provision whereby a hospital can qualify for an operating cost DSH adjustment of:

- 15 percent for discharges prior to October 1, 1988;
- 25 percent for discharges between October 1, 1988, and April 1, 1990;
- 30 percent for discharges from April 1, 1990, through September 31, 1991;
- 35 percent for discharges on or after October 1, 1991, if:
    - It is located in an urban area and has 100 or more beds; and
    - It demonstrates that, during its cost reporting period, more than 30 percent of its total inpatient care revenues were derived from State and local government payments for indigent care furnished to patients not covered by Medicare or Medicaid.

It is incumbent upon the hospital to demonstrate that more than 30 percent of its total inpatient care revenues are from State and local government sources and that they are specifically earmarked for the care of indigents (that is, none of the money may be used for any purpose other than indigent care). The following are the types of care that are not included as indigent care:

- Free care furnished to satisfy a hospitals Hill-Burton obligation.
- Free care or care a hospital furnished at reduced rates to its employees or by a government hospital to any category of public employee.
- Funds furnished to a hospital to cover general operating deficits.
- The adjustment is not automatic from year to year but must be applied for on an annual basis.

Documentation to support the application includes the hospital's complete audited financial statements and their accompanying notes. The hospital must provide detailed schedules related to State and local revenue appropriations and outline their purpose.

Unless the appropriations are specifically earmarked for indigent patient care, the FI will assume that a portion of the funds was intended to cover the costs of other uncompensated care, such as bad debts for non-indigent patients, free care to employees, etc., as well as to cover general operating deficits. The FI will calculate the percentage of charity care included in all uncompensated care and apply the percentage to the appropriate funds to determine the amount appropriated for charity care.

Hospitals must submit documentation to support amounts claimed as indigent patient care. This includes a copy of their procedures for determining indigence, steps used to verify a patient's financial information, and methods used to distinguish bad debts from indigence.

The FI is responsible for reviewing the documentation submitted in support of the provider's request for a disproportionate share adjustment under 42 CFR 412.106(c)(2) of the regulations. This review can be accomplished in conjunction with the audit/settlement of the cost report for the period subject to the adjustment. At a minimum, the FI must:

- Verify total inpatient revenues;
- Verify that State and local government appropriations on the financial statements are consistent with amounts contained in governmental appropriations bills;
- Review, on the basis of a sample of cases, the provider's implementation of procedures for identifying indigent patients. Ensure that amounts for "indigent" patients do not include charges associated with:
    - Titles XIX and XVIII patient care;
    - Hill-Burton care;
    - Free care to employees; and
    - Bad debts for patients who are not indigent.

E - Reporting for PS&R and CWF

The FI's PPS Pricer identifies the amount of the DSH adjustment on each bill. The FI reports this amount with value code 18 to its PS&R, and to CWF.

20.3.1 - Clarification of Allowable Medicaid Days in the Medicare Disproportionate Share Hospital (DSH) Adjustment Calculation

(Rev. 1, 10-01-03)

20.3.1.1 - Clarification for Cost Reporting Periods Beginning On or After January 1, 2000

(Rev. 1, 10-01-03)

PM A-01-03

Under §1886(d)(5)(F) of the Social Security Act (the Act), the Medicare disproportionate share patient percentage is made up of two computations. The first computation includes patient days that were furnished to patients who, during a given month, were entitled to both Medicare Part A and Supplemental Security Income (SSI) (excluding State supplementation). This number is divided by the number of covered patient days utilized by patients under Medicare Part A for that same period. The second computation includes patient days associated with beneficiaries who were eligible for medical assistance (Medicaid) under a State plan approved under Title XIX but who were not entitled to Medicare Part A. (See 42 CFR 412.106(b)(4).) This number is divided by the total number of patient days for that same period.

Included Days

In calculating the number of Medicaid days, the hospital must determine whether the patient was eligible for Medicaid under a State plan approved under Title XIX on the day of service. If the patient was so eligible, the day counts in the Medicare disproportionate share adjustment calculation. The statutory formula for "Medicaid days" reflects several key concepts. First, the focus is on the patient's eligibility for Medicaid benefits as determined by the State, not the hospital's "eligibility" for some form of Medicaid payment. Second, the focus is on the patient's eligibility for medical assistance under an approved Title XIX State plan, not the patient's eligibility for general assistance under a State-only program. Third, the focus is on eligibility for medical assistance under an approved Title XIX State plan, not medical assistance under a State-only program or other program. Thus, for a day to be counted, the patient must be eligible on that day for medical assistance benefits under the Federal-State cooperative program known as Medicaid (under an approved Title XIX State plan). In other words, for purposes of the Medicare disproportionate share adjustment calculation, the term "Medicaid days" refers to days on which the patient is eligible for medical assistance benefits under an approved Title XIX State plan. The term "Medicaid days" does not refer to all days that have some relation to the Medicaid program, through a matching payment or otherwise; if a patient is not eligible for medical assistance benefits under an approved Title XIX State plan, the patient day cannot become a "Medicaid day" simply by virtue of some other association with the Medicaid program.

Medicaid days, for purposes of the Medicare disproportionate share adjustment calculation, include all days during which a patient is eligible, under a State plan approved under Title XIX, for Medicaid benefits, even if Medicaid did not make payment for any services. Thus, Medicaid days include, but are not limited to, days that are determined to be medically necessary but for which payment is denied by Medicaid because the provider did not bill timely, days that are beyond the number of days for which a State will pay, days that are utilized by a Medicaid beneficiary prior to an admission approval but for which a valid enrollment is determined within the prescribed period, and days for which payment is made by a third party. In addition, we recognize in the calculation days that are utilized by a Medicaid beneficiary who is eligible for Medicaid under a State plan approved under Title XIX through a managed care organization (MCO) or health maintenance organization (HMO). However, in accordance with 42 CFR 412.106(b)(4), a day does not count in the Medicare disproportionate share adjustment calculation if the patient was entitled to both Medicare Part A and Medicaid on that day. Therefore, once the eligibility of the patient for Medicaid under a State plan approved under Title XIX has been verified, the FI must determine whether any of the days are dual entitlement days and, to the extent that they are, subtract them from the other days in the calculation.

Excluded Days

Many States operate programs that include both State-only and Federal-State eligibility groups in an integrated program. For example, some States provide medical assistance to beneficiaries of State-funded income support programs. These beneficiaries, however, are not eligible for Medicaid under a State plan approved under Title XIX, and, therefore, days utilized by these beneficiaries do not count in the Medicare disproportionate share adjustment calculation. If a hospital is unable to distinguish between Medicaid beneficiaries and other medical assistance beneficiaries, then it must contact the State for assistance in doing so.

In addition, if a given patient day affects the level of Medicaid DSH payments to the hospital but the patient is not eligible for Medicaid under a State plan approved under Title XIX on that day, the day is not included in the Medicare DSH calculation.

It should be noted that the types of days discussed above are not necessarily the only types of excluded days. Please see the chart in 140.2.4.1, which summarizes some, but not necessarily all, of the types of days to be excluded from (or included in) the Medicare DSH adjustment calculation.

To provide consistency in both components of the calculation, any days that are added to the Medicaid day count must also be added to the total day count, to the extent that they have not been previously so added.

Regardless of the type of allowable Medicaid day, the hospital bears the burden of proof and must verify with the State that the patient was eligible under one of the allowable categories during each day of the patient's stay. The hospital is responsible for and must provide adequate documentation to substantiate the number of Medicaid days claimed.

Days for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid as described in this memorandum cannot be counted.

20.3.1.2 - Hold Harmless for Cost Reporting Periods Beginning Before January 1, 2000

(Rev. 1, 10-01-03)

In accordance with the hold harmless position communicated by CMS on October 15, 1999, for cost reporting periods beginning before January 1, 2000, hospitals are not to disallow, within the parameters discussed below, the portion of Medicare DSH adjustment payments previously made to hospitals attributable to the erroneous inclusion of general assistance or other State-only health program, charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days in the Medicaid days factor used in the Medicare DSH formula. This is consistent with CMS' determination that hospitals and FIs relied, for the most part, on Medicaid days data obtained from State Medicaid agencies to compute Medicare DSH payments and that some of those agencies commingled the types of otherwise ineligible days listed above with Medicaid Title XIX days in the data transmitted to hospitals and/or FIs. Although CMS has decided to allow the hospitals to be held harmless for receiving additional payments resulting from the erroneous inclusion of these types of otherwise ineligible days, this decision is not intended to hold hospitals harmless for any other aspect of the calculation of Medicare DSH payments or any other Medicare payments.

Hospitals That Received Payments Reflecting the Erroneous Inclusion of Days at Issue

In practical terms this means that the FI is not to reopen any cost reports for cost reporting periods beginning before January 1, 2000, to disallow the portions of Medicare DSH payments attributable to the erroneous inclusion of general assistance or other State-only health program charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days if the hospital received payments for those days based on those cost reports. If, prior to the issuance of this Program Memorandum, a hospital reopened a settled cost report to disallow the portion of Medicare DSH payment attributable to the inclusion of these types of days, reopen that cost report again and refund the amounts (including interest) collected. Do not, however, pay the hospitals interest on the amounts previously recouped as result of the disallowance. Furthermore, on or after October 15, 1999, the FI is not to accept reopening requests for previously settled cost reports or amendments to previously submitted cost reports pertaining to the inclusion of these types of days in the Medicare DSH formula.

For cost reporting periods beginning before January 1, 2000, hospitals are to continue to allow these types of days in the Medicare DSH calculation for all open cost reports only in accordance with the practice followed for the hospital at issue before October 15, 1999, (i.e., for open cost reports, the FI allows only those types of otherwise ineligible days that the hospital received payment for in previous cost reporting periods settled before October 15, 1999). For example, if, for a given hospital, a portion of Medicare

DSH payment was attributable to the erroneous inclusion of general assistance days for only the out-of-State or HMO population in cost reports settled before October 15, 1999, the FI is to include the ineligible waiver days for only that population when settling open cost reports for cost reporting periods beginning before January 1, 2000. However, the actual number of general assistance and other State-only health program, charity care, Medicaid DSH, and/or ineligible waiver or demonstration days, as well as Medicaid Title XIX days, that the FI allows for the open cost reports must be supported by auditable documentation provided by the hospital.

Hospitals That Did Not Receive Payments Reflecting the Erroneous Inclusion of Days at Issue

If a hospital did not receive any payment based on the erroneous inclusion of general assistance or other State-only health program, charity care, Medicaid DSH, and/or waiver or demonstration population days for cost reports that were settled before October 15, 1999, and the hospital never filed a jurisdictionally proper appeal to the Provider Reimbursement Review Board (PRRB) on this issue, the FI is not to pay the hospital based on the inclusion of these types of days for any open cost reports for cost reporting periods beginning before January 1, 2000. Furthermore, on or after October 15, 1999, the FI is not to accept reopening requests for previously settled cost reports or amendments to previously submitted cost reports pertaining to the inclusion of these types of days in the Medicare DSH formula.

If, for cost reporting periods beginning before January 1, 2000, a hospital that did not receive payments reflecting the erroneous inclusion of otherwise ineligible days filed a jurisdictionally proper appeal to the PRRB on the issue of the exclusion of these types of days from the Medicare DSH formula before October 15, 1999, the FI will reopen the cost report at issue and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days. If there are any questions or concerns regarding the qualifications for a "jurisdictionally proper appeal," the FI submits them in writing before rendering a decision in a specific case to:

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Office of Financial Management
Financial Services Group
Location C3-14-16
Baltimore, Maryland 21244-1850.

Where, for cost reporting periods beginning before January 1, 2000, a hospital filed a jurisdictionally proper appeal to the PRRB on the issue of the exclusion of these types of days from the Medicare DSH formula on or after October 15, 1999, reopen the settled cost report at issue and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days, but only if the hospital appealed, before October 15, 1999, the denial of payment for the days in question in previous cost reporting periods. The actual number of these types of days that are used in this revision must be properly supported by adequate documentation provided by the hospital. Do not reopen a cost report and revise the Medicare DSH payment to reflect the inclusion of these types of

days as Medicaid days if, on or after October 15, 1999, a hospital added the issue of the exclusion of these types of days to a jurisdictionally proper appeal already pending before PRRB on other Medicare DSH issues or other unrelated issues.

Continue to pay the Medicare DSH adjustment reflecting the inclusion of general assistance or other State-only health program, charity care, Medicaid DSH, and/or waiver or demonstration population days for all open cost reports for cost reporting periods beginning before January 1, 2000, to any hospital that, before October 15, 1999, filed a jurisdictionally proper appeal to the PRRB specifically for this issue on previously settled cost reports.

Finally, if a hospital has filed a jurisdictionally proper appeal with respect to the CMS 97-2 ruling and the hospital has otherwise received payment for the portion of Medicare DSH adjustment attributable to the inclusion of general assistance or other State-only health programs, charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days based on its paid Medicaid days, include these types of unpaid days in the Medicare DSH formula when revising the cost reports affected by the CMS 97-2 appeal.

TYPE OF DAY	DESCRIPTION	ELIGIBLE TITLE XIX DAY
General Assistance Patient Days	Days for patients covered under a State-only (or county-only) general assistance program (whether or not any payment is available for health care services under the program). These patients are not Medicaid-eligible under the State plan.	No.
Other State-Only Health Program Patient Days	Days for patients covered under a State-only health program. These patients are not Medicaid-eligible under the State plan.	No.
Charity Care Patient Days	Days for patients not eligible for Medicaid or any other third-party payer, and claimed as uncompensated care by a hospital. These patients are not Medicaid-eligible under the State plan.	No.
Actual 1902(r)(2) and 1931(b) Days	Days for patients eligible under a State plan based on a 1902(r)(2) or 1931(b) election. These patients are Medicaid-eligible under the Title XIX State plan under the authority of these provisions, which is exercised by the State in the context of the approved State plan.	Yes.

TYPE OF DAY	DESCRIPTION	ELIGIBLE TITLE XIX DAY
Medicaid Optional Targeted Low-Income Children (CHIP-related) Days	Days for patients who are Title XIX-eligible and who meet the definition of "optional targeted low-income children" under §1905(u)(2). The difference between these children and other Title XIX children is the enhanced FMAP rate available to the State. These children are fully Medicaid-eligible under the State plan.	Yes.
Separate CHIP Days	Days for patients who are eligible for benefits under a non-Medicaid State program furnishing child health assistance to targeted low-income children. These children are, by definition, not Medicaid-eligible under a State plan.	No.
§1915(c) Eligible Patient (the "217" group) Days	Days for patients in the eligibility group under the State plan for individuals under a Home and Community Based Services waiver. This group includes individuals who would be Medicaid-eligible if they were in a medical institution. Under this special eligibility group, they are Medicaid-eligible under the State plan.	Yes.
Retroactive Eligible Days	Days for patients not enrolled in the Medicaid program at the time of service, but found retroactively eligible for Medicaid benefits for the days at issue. These patients are Medicaid-eligible under the State plan.	Yes.
Medicaid Managed Care Organization Days	Days for patients who are eligible for Medicaid under a State plan when the payment to the hospital is made by an MCO for the service. An MCO is the financing mechanism for Medicaid benefits, and payment for the service through the MCO does not affect eligibility.	Yes.
Medicaid DSH Days	Days for patients who are not eligible for Medicaid benefits, but are considered in the calculation of Medicaid DSH payments by the State. These patients are not Medicaid-eligible. Sometimes Medicaid State plans specify that Medicaid DSH payments are based upon a hospital's amount of charity care or general assistance days. This, however, is not "payment" for those days, and does not mean that the patient is eligible for Medicaid benefits or can be counted as such in the Medicare formula.	No.

20.3.2 - Updates to the Federal Fiscal Year (FY) 2001

(Rev. 1, 10-01-03)

PM A-01-47

20.3.2.1 - Inpatient Hospital Payments and Disproportionate Share Hospital (DSH) Thresholds and Adjustments

(Rev. 1, 10-01-03)

The new FY 2001 operating standardized amounts are effective April 1, 2001, as required by §301 of BIPA 2000 (P.L. 106-554), and the new DSH thresholds and adjustments are required by §211 of BIPA 2000. In conjunction with the new standardized amount, the new capital rates and outlier adjustment factor thresholds are effective April 1, 2001.

The following standardized amounts effective for discharges occurring on or after April 1, 2001, and before October 1, 2001, are:

Final FY 2001 Operating Rates

	Large Urban Areas		Other Areas	
	Labor-Related	Nonlabor-Related	Labor-Related	Nonlabor-Related
+National	$2,925.82	$1,189.26	$2,879.51	$1,170.43
National PR	$2,900.64	$1,179.02	$2,900.64	$1,179.02
Puerto Rico	$1,402.79	$564.66	$1,380.58	$555.72
SCHs	$2,895.02	$1,176.74	$2,849.20	$ 1,158.11

Final FY 2001 Capital Rates

National	$380.85
Puerto Rico	$184.61

Due to the changes to the standardized amounts, CMS recalculated the fixed loss cost outlier threshold applicable for discharges on or after April 1, 2001, and before October 1, 2001. The new thresholds are equal to the prospective payment rate for the DRG plus the IME and DSH payments plus $16,350 ($14,940 for hospitals that have not yet entered the prospective payment system for capital-related costs).

In addition, §211 of BIPA 2000 revised the thresholds by which certain classes of hospitals qualify for the disproportionate share adjustment, effective for discharges occurring on or after April 1, 2001. Section 211 also revised the adjustment computations for these hospitals.

The specific changes are identified below.

Urban Hospitals	Qualifying DSH Percent	Adjustment Computation
0-99 Beds	≥15%, <19.3% ≥19.3%	2.5% + [.65 x (DSH pct.-15)] 5.25%
100+ Beds (No Change in Law)	≥15%,<20.2% ≥20.2%	2.5% + [.65 x (DSH pct.-15%)] 5.88% + [.825 x (DSH pct.-20.2%)]
Rural Hospitals		
Sole Community Hospitals (SCH)	≥15%, <19.3% ≥19.3%,<30% ≥30%	2.5% + [.65 x (DSH pct.-15%)] 5.25% 10%
Rural Referral Centers (RRC)	≥15%,<19.3% ≥19.3%,<30% ≥30%	2.5% + [.65 x (DSH pct.-15%)] 5.25% 5.25% + [.6 x (DSH pct.-30%)]
Both SCH and RRC	≥15%	higher of SCH or RRC adjustment
Other Rural Hospitals		
0-499Beds	≥15%,<19.3% ≥19.3%	2.5% + [.65 x (DSH pct.-15%)] 5.25%
500+ Beds (No Change in Law)	≥15%,<20.2% ≥20.2%	2.5% + [.65 x (DSH pct.-15%)] 5.88% + [.825 x (DSH pct. -20.2%)]

These new rates as well as changes to the DSH adjustments are incorporated into Pricer 01.2. The formulas are spelled out in the statute.

20.3.3 – Prospective Payment Changes for Fiscal Year (FY) 2003

(Rev. 1, 10-01-03)

A-02-084

The PPS changes for FY2003 were published in the Federal Register on August 1, 2002. All changes are effective for hospital discharges occurring on or after October 1, 2002, unless otherwise noted.

ICD-9-CM coding changes are effective October 1, 2002. The new ICD-9-CM codes are listed, along with their diagnosis-related group (DRG) classifications in Tables 6a and 6b in the final rule for PPS changes for FY 2003. The ICD-9-CM codes that have been replaced by expanded codes or other codes, or have been deleted are included in Tables 6c and 6d. The revised code titles are in Tables 6e and 6f of the same final rule. GROUPER 20.0 assigns each case into a DRG on the basis of the diagnosis and procedure codes and demographic information (that is age, sex, and discharge status) and is effective with discharges occurring on or after October 1, 2002. Medicare Code Editor (MCE) 19.0 and Outpatient Code Editor (OCE) versions 18.0 and 3.20 use the new ICD-9-CM codes to validate coding for discharges and outpatient services effective October 1, 2002.

Additional changes for FY 2003 are:

- The standardized amount update factor is 2.95 percent for all hospitals.
- The hospital specific update factor is 2.95 percent for all hospitals.
- The common fixed loss cost outlier threshold in FY 2003 is equal to the PPS rate for the DRG, Indirect Medical Education (IME), and Disproportionate Share Hospital (DSH) plus $33,560.
- The marginal cost factor for cost outliers remains 80 percent.
- The 2003 Federal capital rate is $407.01 and the Puerto Rico capital rate is $198.29.
- The FY 2003 outlier adjustment factor is 0.948999 for the operating standardized amount.
- The FY 2003 outlier adjustment factor for Puerto Rico is 0.981651 for the operating standardized amount. Also new for FY 03, there is an outlier adjustment factor of 0.965325 for operating national/Puerto Rican blend.
- Payments under the DSH provision are not reduced in FY 2003.
- The IME formula is 1.35*[(1+ resident-to-bed ratio)**. 405-1] for FY 2003.
- The revised hospital wage indexes and geographic adjustment factors are contained in Tables 4a (urban areas), 4b (rural areas) and 4c (redesignated hospitals) of section VI of the addendum to the PPS final rule.
- Grouper 20.0 and MCE 19.0 for discharges occurring on or after October 1, 2002 replace earlier versions of the software.

See Addendum: Hospital Reclassifications and Redesignations by Individual Hospital – FY2003

20.3.4 – Prospective Payment Changes for Fiscal Year (FY) 2004 and Beyond

(Rev. 73, 01-23-04)

The IPPS changes for FY 2004 were published in the Federal Register on August 1, 2003. All changes are effective for hospital discharges occurring on or after October 1, 2003. Additional changes were listed in a Correction Notice to the Federal Register on October 6, 2003, and a One Time Notification (Pub. 100-20, Transmittal 16, published on October 31, 2003).

Changes to the inpatient prospective payment system occur every October. Specific instructions will be published shortly after the publication of the IPPS Final Rule each year.

20.4 - Hospital Capital Payments Under PPS

(Rev. 1, 10-01-03)

A3-3611

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 §§40, 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.

20.4.1 - Federal Rate

(Rev. 1, 10-01-03)

A3-3611.1

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. The FI calculates 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 CMS 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.) It reviews the hospital's records and makes any needed changes in the count at the end of the cost reporting period. It enters the indirect medical education adjustment ratio in positions 184-188 of the provider-specific file for use by Pricer.

20.4.2 - Hold Harmless Payments

(Rev. 1, 10-01-03)

A3-3611.2

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 §20.4.5 for the definitions of old and new capital); or

- The hold harmless - 100 percent Federal rate.

The FI adjusts the hospital-specific rate in the cost report for the period ending in FY 1990 for case mix. It updates 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 §20.2.3.)

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 the FI 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.

The FI does 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.

The FI converts 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
- A hospital does not maintain adequate records to identify its old capital related costs.

The FI enters the payment methodology change in the provider-specific file.

An adjustment is also provided to the Federal rate for indirect costs of medical education of interns and residents. The FI calculates 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 CMS 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). It reviews the hospital's records and makes any needed changes in the count at the end of the cost reporting period. It enters the indirect medical education adjustment ratio in positions 184-188 of the provider-specific file for use by Pricer.

20.4.3 - Blended Payments

(Rev. 1, 10-01-03)

A3-3611.3

Hospitals with a FY 1990 hospital-specific rate for capital below the Federal rate are paid a fully prospective capital rate based on a blend of their hospital-specific rate and the Federal rate. The payment for discharges occurring during a cost-reporting period that began in FY 1992 is based on a blend of 90 percent of the hospital-specific rate and 10 percent of the Federal rate. The payment for discharges occurring during a cost-reporting period that began in FY 1993 is based on a blend of 80 percent of the hospital-specific rate and 20 percent of the Federal rate. The Federal portion of the payment increases by 10 percent each year and the hospital-specific portions decreases by 10 percent each year, culminating in payment at 100 percent of the Federal rate in the tenth year.

20.4.4 - Capital Payments in Puerto Rico

(Rev. 1, 10-01-03)

A3-3611.4

A special standard rate applies to Puerto Rico. It is a combination of 50 percent of the Federal capital amount and 50 percent of the Puerto Rican capital amount. It is used in lieu of the Federal rate to compute hold harmless and fully prospective payments for PPS hospitals in Puerto Rico.

20.4.5 - Old and New Capital

(Rev. 1, 10-01-03)

A3-3611.5

Old capital is a hospital asset that:

- Has been put in use for patient care on or before December 31, 1990; or
- Has been legally committed to by an enforceable contract entered into on or before December 31, 1990, and put in patient use before October 1, 1994.

All other assets are considered new for Medicare purposes.

20.4.6 - New Hospitals

(Rev. 1, 10-01-03)

A3-3611.6

New hospitals that open during the national 10-year transition are exempt from capital PPS payment for their first two years of operation. A new hospital is one that does not have a 12-month cost reporting period that ended on or before September 30, 1990. The new hospital exemption does not apply to:

- A new acute care hospital that operated as a PPS excluded hospital for 2 or more years before its transition to PPS;
- A hospital which has been open more than 2 years, but has participated in Medicare fewer than 2 years;
- A hospital that closes and reopens within 2 years under the same or different ownership; or
- A hospital that builds a new or replacement facility at the same or a new location, even if a change of ownership or new leasing arrangements are involved.

A new hospital is paid 85 percent of its reasonable costs for capital during the exemption period. The hospital's second year of operation is the base period for determination of the hospital-specific rate and old capital assets. Effective with its third year of operation, the hospital is paid:

- The fully prospective methodology if the hospital-specific rate is less than the Federal rate. The FI uses the blend rate applicable to the Federal FY in which the base period begins. For example, a new hospital with a hospital-specific rate less than the Federal rate and a base year beginning in FY 1995 is paid 70 percent of its hospital-specific rate and 30 percent of the Federal rate; or
- The hold harmless methodology if the hospital-specific rate is greater than the Federal rate. Hold harmless payments may continue for up to 8 years. They may continue beyond the first cost reporting period that begins on or after October 1, 2000.

20.4.7 - Capital PPS Exception Payments

(Rev. 1, 10-01-03)

A3-3611.7, 42 CFR 412.348

Exception payments are provided for hospitals with inordinately high levels of capital obligations. Payment is made to a hospital paid under either the fully prospective

payment methodology, or the hold-harmless payment methodology. Exception payments will expire at the end of the 10-year transition period. Exception payments ensure that:

- Sole community hospitals receive 90 percent of their Medicare inpatient capital costs;
- Urban hospitals with 100 or more beds and a disproportionate share patient percentage of at least 20.2 percent receive 80 percent of their Medicare inpatient capital costs; and
- All other hospitals receive 70 percent of their Medicare inpatient capital costs.

Pricer adds interim exception payments to the basic capital payment, using the rate entered in positions 189-194 of the provider-specific file. The FI adjusts these interim payments, as needed, at cost report settlement.

A hospital is entitled to an additional payment if its capital payments for the cost reporting period would otherwise be less than the applicable minimum payment level. The additional payment equals the difference between the applicable minimum payment level and the capital payments that the hospital would otherwise receive minus any offset amount.

A limited exception is also provided during the 10-year transition period for hospitals that experience unanticipated extraordinary circumstances that require an unanticipated major capital expenditure. Events such as a tornado, earthquake, catastrophic fire, or a hurricane are examples of extraordinary circumstances. The capital project must cost at least $5 million (net of proceeds from other payment sources such as insurance, litigation decisions and other State, local or Federal government funding programs) to qualify for this exception. An eligible hospital's minimum payment level under this exception is 85 percent of costs associated with the unanticipated capital expenditure and the applicable minimum payment level for its other Medicare inpatient capital costs.

Total estimated payments under the exception process may not exceed 10 percent of the total estimated capital prospective payments (exclusive of hold-harmless payments for old capital) for the same fiscal year.

These limited exceptions must be approved by CMS prior to payment. If approved, the FI includes the limited exception payment amount per discharge in the exception field of the provider specific file.

20.4.8 - Capital Outliers

(Rev. 1, 10-01-03)

A3-3611.8

Total Federal PPS payments are reduced by an amount equal to anticipated outlier payments for the year to fund capital and operating outlier payments. Outlier payments

apply only to the Federal portions of capital payments. Pricer calculates outlier payments.

Pricer used a combined methodology to determine the day outlier payment rate for capital and operating day outliers (Day outliers were eliminated after FY 1997). A second combined methodology is used to determine the cost outlier payment rate for capital and operating costs. A capital or operating cost outlier is paid only if both capital and operating costs related to an admission exceed the combined outlier threshold. Pricer pays the higher of the combined total cost outlier payment or the total day outlier payment. An exception applies to a transferring hospital. A transferring hospital may be paid a cost outlier, but may not be paid a day outlier unless DRG 385 or 456 applies. The outlier computation methodology is contained in the FI Pricer installation guide. (See §20.7 for the common thresholds that apply to both operating and capital outliers.)

20.4.9 - Admission Prior to and Discharge After Capital PPS Implementation Date

(Rev. 1, 10-01-03)

A3-3611.9

The capital payment issued for an inpatient hospital stay that begins prior to and ends after the onset of capital PPS is the amount determined by Pricer for that DRG. No reasonable cost capital pass through payment is payable for the portion of the stay that pre-dates capital PPS. The FI may not split a bill for the periods before and after the onset of capital PPS that fall into the same billing period.

It bases any outlier payment due on the entire stay, not only that portion of the stay that began after the start of capital PPS.

20.4.10 - Market Basket Update

(Rev. 1, 10-01-03)

A3-3611.10

For FY 1992 through FY 1995, the update to the Federal and the hospital-specific rates is based on actual increases in capital-related costs per discharge adjusted for case mix change. For example, FY 1993 rate updates are based on a comparison of inpatient capital costs per case in Medicare cost reports beginning in FY 1990 and the costs per case in the cost reports beginning in FY 1988. The update computation will be modified after FY 1995 to reflect the capital market basket index, changes in capital requirements and new technology. Annual updates for periods after FY 1992 will be effective October 1 for all PPS hospitals, rather than the start of cost report periods that begin during that FY.

20.5 - Rural Referral Centers (RRCs)

(Rev. 1, 10-01-03)

A3-3610.16, HO-415.17

Section 1886(d)(5)(C) of the Act provides for exceptions and adjustments to the standardized prospective payment amounts to take into account the special needs of RRCs. The adjustment allowed for approved RRCs is that they are paid based upon the urban, rather than rural, prospective payment rates as adjusted by the applicable DRG weighting factor and the rural area index. In addition, OBRA 89 (P.L. 101-239) extended RRC status through cost reporting periods beginning before October 1992 to any hospital classified as an RRC as of September 30, 1989.

To retain status as an RRC effective with the cost reporting period beginning on or after October 1, 1992, a hospital must have met the criteria for classification as an RRC in at least two of the prior three years, or qualify on the basis of the requirements for initial RRC certification for the current year. The FI will not review the RRC status of a hospital before the end of its third full cost reporting year as an RRC. It will limit review of RRCs in operation more than three years at the beginning of FY 1993 to a hospital's most recent three years. RRCs that pass review as meeting RRC status for at least two of the last three years receive a 3-year extension of their RRC status.

The rates in Pricer include a reduction in the adjusted standardized amounts for all hospitals to ensure that total PPS payment neither increase nor decrease as a result of the increase in payments to RRCs.

To qualify for initial RRC status for cost reporting periods beginning on or after October 1, 1992, a rural hospital must have had at least 275 beds, or the hospital must have met one of three criteria in 42 CFR 412.96(c) (3), (4) and (5), and both of the following requirements:

- The hospital's case-mix index value for FY 91 must have been at least 1.2760, or equal to the median case-mix index value for urban hospitals (excluding hospitals with approved teaching programs) calculated by CMS for the census region in which the hospital is located, if fewer.

- For its cost reporting period that began during FY 1991, the hospital must have had 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.

The CMS publishes the median case-mix index value and the median number of discharges annually in the PPS update in the "Federal Register."

20.6 - Criteria and Payment for Sole Community Hospitals and for Medicare Dependent Hospitals

(Rev. 1, 10-01-03)

A3-3610.17, HO-415.18

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:

- Located more than 35 miles from other like hospitals;
- 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.
- 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.
- 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 that 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 met all of the following:

- Had 100 or fewer beds;

- Was not classified as an SCH; and
- For its cost reporting period that began during FY 87, was 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 the following rates:

The Federal rate applicable to the hospital;

- The updated hospital-specific rate based on FY 1982 costs per discharge;
- The updated hospital-specific rate based on FY 1987 costs per discharge;
- A phase-in blended rate of the updated hospital-specific rate based on FY 1982 costs per discharge and a FY 1996 hospital-specific rate; or
- A phase-in blended rate of the updated hospital-specific rate based on FY 1987 costs per discharge and a FY 1996 hospital-specific rate.

For discharges beginning in FY 2004, the additional optional rate would be 100 percent of the FY 1996 hospital-specific rate.

The actual payment amount for each bill is determined by Pricer based upon information the FI maintains in its provider specific file. Review and possible lump sum adjustment applies when the cost report is reviewed.

D - Claims Processing

The FI uses the following provider type codes to enable Pricer to calculate the appropriate rates for these facilities:

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

The FI calculates the higher of the 1982 or 1987 adjusted base period costs per discharge (hospital specific rate) and adjusts to the 1990 level. It enters this amount in field 21, position 81-87 effective for the first day of the cost report period beginning April 1, 1990, or later. It enters this even if it expects 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. The FI leaves 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. The FI carries this amount forward in the hospital-specific payment field to its PS&R record for use at cost settlement.

20.7 - Billing Applicable to PPS

(Rev. 1, 10-01-03)

20.7.1- Stays Prior to and Discharge After IPPS Implementation Date

(Rev. 1, 10-01-03)

A3-3610.4, HO-415.7

When the admission is before the hospital's PPS effective date and the discharge is later than that date (transition claims), the Medicare payment for the period before PPS is on a reasonable cost basis and the payment for the period after PPS is on a DRG basis.

The hospital must submit two bills. The first bill is for the period before the PPS effective date and is processed and paid in accordance with requirements in effect before the hospital's PPS effective date. The second bill is processed under PPS but the amount of payment on the first bill is subtracted from it. FIs make the adjustment by subtracting the interim payment from the prospective payment (before any deduction for deductible or coinsurance) for the inpatient operating costs applicable to the days in the prior period. The interim payment applicable to the prior period is adjusted to exclude estimated costs related to capital and direct medical education, kidney acquisition costs, and for bad debts for uncollectible deductible and coinsurance. FIs will make an estimate if necessary.

For hospitals previously receiving interim payment on the basis of an average cost per diem or under PIP, the FI determines and removes a per diem amount for the excluded costs for that period from the interim payments before reducing the prospective payment amount applicable to the discharge in the subsequent period under PPS. Similarly, for hospitals that received a percentage of billed charges, the portion of the percentage applicable to the excluded cost items is removed. The net percentage to the charges billed in the prior period (cut-off bill) is applied. The resulting amount is subtracted from the PPS payment applicable to the discharge in the subsequent period.

For transition claims, payment must not exceed the higher of what would have been paid under PPS including the outlier adjustment or any earlier cost payment. The final amount is not reduced to less than zero. No further adjustments are appropriate.

The interim payments used to reduce the prospective payment amounts are considered to represent fairly the inpatient operating costs incurred and fair payment for the portion of the stay occurring in the prior period. Therefore, the adjustment is final and not subject to further modification.

On bills covering two cost reporting periods:

- Each bill includes charges and covered days that apply to the period covered.
- The cut-off bill for the cost period is completed per Chapter 25.
- The PPS bill contains principal diagnosis and surgical procedures for the entire stay.
- The PPS bill shows the admission date, but the period covered begins with the first day of the new accounting year.
- Where discharge is on the first day of the new accounting year, a PPS bill is still due. Some payment may be due the provider, and the open admission must be closed on CMS' records. There are no accommodation charges on the day of discharge; the hospital will report ancillary charges for the day of discharge on the prior bill.
- Coinsurance days and related amounts are applied separately to each bill, i.e., the proper deduction for coinsurance days reported on the second bill is taken from that bill.

20.7.2 - Split Bills

(Rev. 1, 10-01-03)

A3-3610.6, HO-415.9

Under PPS, split billing is not needed for cost reporting purposes; however, it is necessary to show on the bill the coinsurance days in each calendar year for proper application of the coinsurance amount.

For admissions prior to the cost reporting year under IPPS with a discharge after the beginning of the prospective payment year, the DRG payment for the discharge is reduced by the cost of services furnished in the prior period.

The hospital uses the day or charge statistics on the bill representing the portion of the stay in the prior period to determine the cost of the services furnished. Split bills are not needed at the end of the government's fiscal year or the calendar year as changes in DRG prices are determined by the date of discharge. This is shown in value codes 09 (first year coinsurance) and 11 (second year coinsurance). (See Chapter 25.)

PPS days on the cost report are allocated to the year of the discharge. Hospitals not on IPPS, LTCHPPS, or IRFPPS continue to submit split bills at the end of their fiscal years and allocate the days to the hospital year in which they occurred.

When split billing applies, DRG payments are made only on bills that show a discharge date and status. No DRG payment is made on PPS bills that show "still patient" status.

The hospital may not split a bill for the periods before and after the onset of capital PPS that fall into the same billing period. Capital payment issued for an inpatient hospital stay that begins prior to and ends after the onset of capital PPS is the amount determined by Pricer for that DRG. No reasonable cost capital pass through payment is payable for the portion of the stay that pre-dates capital PPS.

20.7.3 - PPS Payment for Blood Clotting Factor Administered to Hemophilia Inpatients

(Rev. 1, 10-01-03)

A3-3610.18

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 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 was 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.

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 (Anti-Hemophilic Factor, Human)	$0.79 per IU

J7191	Factor VIII (Anti-hemophilic Factor, Porcine)	$0.87 per IU
J7192	Factor VIII (Anti-Hemophilic Factor, Recombinant)	$1.03 per IU
J7194	Factor IX (Complex)	$0.45 per IU
J7196	Other Hemophilia clotting factors (e.g., anti-inhibitors) (Discontinued 12/31/1999)	$1.43 per IU
J7198	Anti-Inhibitor (effective 1/1/2000)	$1.43 per IU
J7199	Hemophilia Clotting Factor, Not Otherwise Classified (effective 1/1/2000)	
Q0160	Factor IX (Anti-Hemophilic Factor, purified, nonrecombinant) (Discontinued 12/31/2001)	$0.97 per IU
Q0161	Factor IX (Anti-Hemophilic Factor, purified, recombinant) (Discontinued 12/31/2001)	$1.00 per IU
Q0187	Factor VIIa (Coagulation Factor, Recombinant)	$1.19 per MCG
Q2022	Von Willebrand Factor Complex (Effective 7/1/2000)	$1.05 per IU

For discharges occurring on or after October 1, 2000, report HCPCS Q0187 based on 1 billing unit per 1.2 mg.

Beginning FY 2001, the payment for blood clotting factor administered to hemophilia inpatients will be equal to 95 percent of the AWP. The payment amounts will be determined using the most recent AWP data available at the time the FI performs these annual update calculations. For discharges on and after October 1, 2000, obtain the payment allowances from the carrier in the jurisdiction of the provider.

NOTE: For HCPCS code J7199, providers must report the name of the drug and how the drug is dispensed in the remarks section of the claim. Using the information provided, obtain the payment allowance, for that drug, from the carrier in the jurisdiction of the provider.

Effective for services on or after January 1, 2002, two new HCPCS billing codes are established for purified and recombinant Factor IX.

J7193	Factor IX (Antihemophilic Factor, Purified, nonrecombinant)

J7195 Factor IX (Antihemophilic Factor, recombinant)

Pricer does not calculate the payment amount. The FI calculates the payment amount and subtracts 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 that includes fractions of .50 to .99 = 1 additional billing unit. An answer that 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 46 of the Form CMS-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 46. 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 46. 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, 2000. The hospital divides the number of MCGs administered by 1000 to convert the MCGs to MGs (4,850 divided by 1000 = 4.85). The hospital calculates the number of billing units represented by 4.85 and divides by 1.2 (4.85 divided by 1.2=4.04 or 4 billing units) and enters 4 in FL 46. The payment amount is $4,760 (4 billing units x $1190 (1000 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 0636 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.

NOTE: For discharges occurring on or after October 1, 2000, report HCPCS Q0187 based on 1 billing unit per 1.2mg.

Revenue Code 0636 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 File and Record Formats, 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. Separate payment is not made to SNFs.

B - FI Action

The FI is responsible for the following:

- It accepts HCPCS codes for inpatient services;
- It edits to require HCPCS codes with Revenue Code 0636. 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). It does not edit units except to ensure a numeric value;
- It develops inpatient fee tables based on HCPCS codes and revenue code 0636. Retain the charges and revenue and HCPCS codes for CWF, and for PS&R;
- It reduces charges forwarded to Pricer by the charges for revenue code 0636. It retains the charges and revenue and HCPCS codes for CWF, and for PS&R;
- It determines what changes are needed in the remittance record to hospitals;
- It modifies data entry screens to accept HCPCS codes for hospital inpatient claims (bill types 110, 111, 112, 113, 114, 115, 117, and 118);

- It includes the HCPCS code and payment amount in the following records for each HCPCS code billed under revenue code 0636:

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

- It treats the bill as a single bill for MSP, and for charging deductible and coinsurance. It uses total charges for deductible and coinsurance calculations.

Where MSP recovery is made, the PS&R system allocates MSP primary payer payments between revenue code 0636 and the remainder of the charges. It will delete the primary payment applicable to the final revenue code 0636 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 0636 and total covered Medicare charges.

The PS&R provides a separate revenue code report for charges under revenue code 0636 for FI use at cost report review.

The September 1, 1993, IPPS 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 covered only for beneficiaries with hemophilia, the FI must 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

Effective for discharges on or after August 1,2001, payment may be made if one of the following diagnosis codes is reported:

286.5 Hemorrhagic disorder due to circulating anticoagulants

286.7 Acquired coagulation factor deficiency

C - Part A Remittance Advice

1. X12.835 Ver. 003030M

For remittance reporting PIP and/or non-PIP payments, the Hemophilia Add on will be reported in a claims level 2-090-CAS segment (CAS is the element identifier) 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

For remittance reporting PIP payments, the Hemophilia Add On will also be reported in the provider level adjustment (element identifier 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.

FIs enter MA103 (Hemophilia Add On) in an open MIA (element identifier) 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

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.

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 "ZZ" 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 "ZZ" until further notice.

FIs enter MA103 (Hemophilia Add On) in an open MIA remark code data element. This will alert the provider that the ZK, FL and ZZ entries are related to the Hemophilia Add On. (Effective with version 4010 of the 835, report ZK in lieu of FL in the QTY segment.)

3. Standard Hard Copy Remittance Advice

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.

FIs 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 X12N 835, where additional information is available.

See Chapter 22 for detailed instructions and definitions.

20.7.4 - Cost Outlier Bills With Benefits Exhausted

(Rev. 1, 10-01-03)

PM - A-99-17 (CR-749)

Providers under IPPS, LTCH PPS, and IRF PPS follow this scenario when benefits are exhausted.

The methodology for using benefit days and reimbursing cost outliers is based on the beneficiary having a lifetime reserve (LTR) benefit day which the beneficiary elects to use or a regular benefit (regular or coinsurance) day beginning the day after the day covered charges are incurred in an amount that results in a cost outlier payment for the provider. Additional charges are considered covered for every day thereafter for which a beneficiary has, and elects to use, an available benefit day.

DRG claims with cost outlier payments with discharge dates on or after October 1, 1997, must have an Occurrence Code (OC) 47 on the claim unless there are enough full and/or coinsurance days to cover all the medically necessary days or the only available benefits are LTR days and there are enough LTR days to cover all the medically necessary days.

DRG claims without cost outlier payments can never have regular benefit days combined with LTR benefit days.

Once the cost outlier threshold is known, providers must add the daily covered charges for the claim until they determine the day that covered charges reach the cost outlier threshold. Providers must exclude days and covered charges during noncovered spans, e.g., during Occurrence Span Code (OSC) 74, 76, or 79 dates. Providers must then submit the date of the first full day of cost outlier status (the day after the day that covered charges reach the cost outlier threshold) on the bill using OC 47. The OC 47 date cannot be equal to or during OSC 74, 76, or 79 dates. Providers must determine the amount of regular, coinsurance, and LTR days the beneficiary has available per CWF inquiry or their FI.

Any nonutilization days after the beneficiary exhausts coinsurance or LTR days before the OC 47 date will be identified using OSC 70. LTR days should be used as necessary and as elected by the beneficiary. If coinsurance days are exhausted during the inlier portion of the stay and there is a period of nonutilization indicated by the presence of OSC 70 and the beneficiary elects not to use LTR days, covered charges are limited to the exact amount of the cost outlier threshold and both OC A3, which shows the last covered day, and OC 47, which shows the following day which is the first full day of cost outlier status, must be shown. When coinsurance and/or LTR days are exhausted during the cost outlier portion of the stay, OC A3 should be used as appropriate to report the date benefits are exhausted. Covered charges should be accrued to reflect the entire period of the bill if the bill is fully covered or the entire period up to and including the date benefits were exhausted, if benefits were exhausted.

Assumptions for all of the following examples

1. Cost outlier threshold amount is $50,000.
2. Threshold amount is reached on the 25th day.
3. Billed charges are $1,000 each day thereafter.
4. Beneficiary elects to use any available LTR days.

EXAMPLE 1: LTR Days Cover Cost Outlier

Date of Service:	1/1 - 1/31 discharge
Medically necessary days	30
Covered charges	$55,000
Benefits available	30 LTR
Covered days	30

Noncovered days	0
Cost report days	30

All charges for Medicare approved revenue codes billed as covered

No OC 47 needed

Reimbursement:	Full DRG plus cost outlier based on $55,000 covered charges

EXAMPLE 2: LTR Days Exhaust in the Cost Outlier

Dates of service:	1/1 - 2/10 discharge
Medically necessary days:	40
Covered charges:	$65,000
Benefits available:	30 LTR
Covered days:	30
Noncovered days:	10
Cost report days:	30

30 days covered charges for Medicare approved revenue codes and 10 days noncovered charges.

OC 47:	1/26
OC A3:	1/30
Reimbursement:	Full DRG plus cost outlier based on $55,000 covered charges ($50,000 inlier and $5,000 outlier

EXAMPLE 3: LTR Days Exhaust Prior to Cost Outlier

Dates of service:	1/1 - 1/31 discharge
Medically necessary days:	30
Covered charges:	$55,000
Benefits available:	20 LTR

Covered days:	20
Noncovered days:	10
Cost report days:	25

25 days covered charges for Medicare approved revenue codes and 5 days noncovered charges

OC 47:	1/26
OC A3	1/25
OSC 70:	1/21 -1/25
Reimbursement:	Full DRG payment, no cost outlier

EXAMPLE 4: Coinsurance Days Exhaust Prior to Cost Outlier and No LTR Days Are Available

Date of Service:	1/1 - 1/31 discharge
Medically necessary days	30
Covered charges	$55,000
Benefits available:	20 coinsurance
Covered days:	20
Noncovered days:	10
Cost report days:	25

25 days covered charges for Medicare approved revenue codes and 5 days noncovered charges

OC 47:	1/26
OC A3:	1/25
OSC 70:	1/21 - 1/25
Reimbursement:	Full DRG payment, no cost outlier

EXAMPLE 5: Coinsurance Days Exhaust Prior to Cost Outlier. LTR Days Exhausts in the Cost Outlier

Date of Service:	1/1 - 2/10 discharge
Medically necessary days	40
Covered charges	$65,000
Benefits available:	20 coinsurance and 10 LTR
Covered days:	30
Noncovered days:	10
Cost report days:	35

35 days covered charges for Medicare approved revenue codes and 5 days noncovered charges

OC 47:	1/26
OC A3:	2/4
OSC 70:	1/21 - 1/25
Reimbursement:	Full DRG payment, plus cost outlier based on $60,000 covered charges ($50,000 inlier, $10,000 outlier, $5,000 noncovered)

EXAMPLE 6: Full and Coinsurance Days Cover Cost Outlier

Date of Service:	1/1 - 1/31 discharge
Medically necessary days	30
Covered charges	$55,000
Benefits available:	10 full and 20 coinsurance
Covered days:	30
Noncovered days:	0
Cost report days:	30

All charges for Medicare approved revenue codes billed as covered.

OC 47:	Not needed
Reimbursement:	Full DRG payment plus cost outlier based on $55,000 covered charges.

EXAMPLE 7: Coinsurance Days and LTR Days Exhaust in the Cost Outlier

Date of Service:	1/1 - 2/28 discharge
Medically necessary days	58
Covered charges	$83,000
Benefits available:	10 full, 30 coinsurance and 10 LTR
Covered days:	50
Noncovered days:	8
Cost report days:	50

50 days covered charges for Medicare approved revenue codes and 8 days noncovered charges

OC 47:	1/26
OC A3:	2/19
Reimbursement:	Full DRG payment, plus cost outlier based on $75,000 covered charges ($50,000 inlier, $25,000 outlier, $8,000 noncovered)

EXAMPLE: 8: LTR Days Exhaust Prior to Cost Outlier and Noncovered Span(s) Present

Dates of service:	1/1 - 1/31 discharge
Medically necessary days:	28
OSC 76	1/10 - 1/11
Covered charges:	$55,000
Benefits available:	20 LTR
Covered days:	20

Noncovered days: 10

Cost report days: 25

25 days covered charges for Medicare approved revenue codes and 5 days noncovered charges

OC 47: 1/28

OC A3 1/27

OSC 70: 1/23 -1/27

Reimbursement: Full DRG payment, no cost outlier

20.8 - Payment to Hospitals and Units Excluded from IPPS for Direct Graduate Medical Education (DGME) and Nursing and Allied Health (N&AH) Education for Medicare+Choice (M+C) Enrollees

(Rev. 1, 10-01-03)

A-03-045

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.

Non-IPPS hospitals and units may submit their M+C claims to their respective FIs 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 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 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 may similarly submit their M+C claims to their respective FIs 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.

Non-IPPS hospitals, hospitals with rehabilitation and psychiatric units, and hospitals that operate an approved N&AH program must submit claims to their regular FI in UB-92 format, with condition codes 04 and 69 present on record type 41, fields 4-13, (Form Locator 24-30). The provider uses Condition code 69 to indicate that the claim is being submitted as a no-pay bill 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 FI submits the claim to the Common Working File (CWF). The CWF determines 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 FI adds 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 FI 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 is the beneficiary's utilization updated by CWF for this stay. If CWF enrollment records do not indicate that the beneficiary is a M+C enrollee, CWF rejects the claim and the FI notifies 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 made using the same interim payment calculation FIs currently employ. Specifically, FIs must calculate the additional DGME payments using the inpatient days attributable to M+C enrollees. 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.

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 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 FI for these cases in accordance with the

this section's instructions. 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.

30 - Medicare Rural Hospital Flexibility Program and Critical Access Hospitals (CAHs)

(Rev. 68, 01-16-04)

A3-3610.19, HO-415.19, A3-3610.20, HO-415.20

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, or must be located in a Metropolitan Statistical Area (MSA) of such a State and be treated as being located in a rural area based on a law or regulation of the State, as described in 42 CFR 412.103. It also must be located more than a 35-mile drive from any other hospital or critical access hospital unless it is designated by the State, prior to January 1, 2006, 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 25 beds for acute (hospital-level) inpatient care or in the case of a CAH with a swing bed agreement, swing beds used for SNF-level care. The CAH maintains a length of stay, as determined on an annual average basis, of no longer than 96 hours.

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 CMS.

A - Grandfathering Existing Facilities

As of October 1, 1997, no new Essential Access Community Hospital (EACH) designations can be made. The EACHs designated by CMS 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.

30.1 - Requirements for CAH Services, CAH Skilled Nursing Care Services and Distinct Part Units

(Rev. 144, 04-23-04)

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 FI based on patient census data and reported to the CMS regional office (RO). If a CAH exceeds the length of stay limit, it will be required to develop and implement a corrective action plan acceptable to the CMS RO, 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 its inpatients. 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 CMS;
2. The facility operates up to 25 beds for either acute (CAH) care or SNF swing bed care (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 CMS.

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 CMS 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.

A CAH may establish psychiatric and rehabilitation distinct part units effective for cost reporting periods beginning on or after October 1, 2004. The CAH distinct part units must meet the following requirements:

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

2. The distinct part unit must also meet the conditions of participation requirements for hospitals;

3. The distinct part unit must also meet the requirements, other than conditions of participation that would apply if the unit were established in an acute care hospital;

4. Services provided in these distinct part units will be paid under the payment methodology that would apply if the unit were established in an acute care (non-CAH) hospital paid under the hospital inpatient PPS; Inpatient Rehabilitation Facilities are paid under the Inpatient Rehabilitation Facility PPS (see Pub 100-04, Chapter 3, section 140 for billing requirements) and the Inpatient Psychiatric Units are paid on a reasonable cost basis until a prospective payment system is created (expected in 2005);

5. Beds in these distinct part units are excluded from the 25 bed count limit for CAHs;

6. The bed limitations for each distinct part unit is 10; and

If a distinct part unit does not meet applicable requirements with respect to a cost reporting period, no payment may be made to the CAH for services furnished in the unit during that period. Payment may resume only after the CAH has demonstrated that the unit meets applicable requirements.

30.1.1 - Payment for Inpatient Services Furnished by a CAH

(Rev. 68, 01-16-04)

A3-3610.22, R1860A3, HO-415.22, HO-415.24

For cost reporting periods beginning after October 1, 1997, payment for inpatient services of a CAH is the reasonable cost of providing the services. Effective for cost reporting periods beginning after January 1, 2004, payment for inpatient services of a CAH is 101% of 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,

- The reasonable compensation equivalent (RCE) limits for physician services to hospitals and

- The payment window provisions for preadmission services treated as inpatient services under §40.3.

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.

Payment for a cost reporting period subsequent to the initial 12-month period for which the CAH operates is made on the basis of adjusting the amount determined for the initial 12-month period. Under §1886(b)(3)(B)(i) of the Act, the adjustment added to the per diem amount is the market basket percentage increase for the subsequent cost reporting period applicable to hospitals located in rural areas.

30.1.2 - Payment for Post-Hospital SNF Care Furnished by a CAH

(Rev. 68, 01-16-04)

HO-415.23, HO-415.24, A3-3610.23, A3-3610.24

The SNF-level services provided by a CAH, are paid at 101% of reasonable cost. Since this is consistent with the reasonable cost principles, FIs will now pay for those services at 101% reasonable cost. Hospitals must follow the rules for payment in §60 for swing-bed services.

All CAH swing bed SNF-level care bills are submitted and processed with a "z" in the third position of the provider number.

Coinsurance and deductible are applicable for inpatient CAH payment.

All items on Form CMS-1450 are completed in accordance with Chapter 25.

30.1.3 - Costs of Emergency Room On-Call Physicians.

(Rev. 1, 10-01-03)

For cost reporting periods beginning on or after October 1, 2001, the reasonable costs of outpatient CAH services may include the reasonable compensation and related costs for an emergency room physician who is on call but not present at the premises of the CAH, if the physician is not otherwise furnishing physicians' services and is not on call at any other provider or facility. The costs are allowable only if they are incurred under a written contract that requires the physician to come to the CAH when the physician's presence is medically required. An emergency room physician must be a doctor of medicine or osteopathy who is immediately available by telephone or radio contact, and available on site, on a 24-hour a day basis, within 30 minutes, or within 60 minutes in areas described in 42 CFR 485.618(d)(2).

30.1.4 - Costs of Ambulance Services

(Rev. 1, 10-01-03)

Effective for services furnished on or after December 21, 2000, payment for ambulance services furnished by a CAH or by an entity that is owned and operated by a CAH is, under certain circumstances, the reasonable cost of the CAH or the entity in furnishing those services. Payment is made on this basis only if the CAH or the entity is the only provider or supplier of ambulance services located within a 35-mile drive of the CAH or the entity. Reasonable cost will be determined without regard to any per-trip limits or fee schedule that would otherwise apply.

The distance between the CAH or entity and the other provider or supplier of ambulance services will be determined as the shortest distance in miles measured over improved roads between the CAH or the entity and the site at which the vehicles of the nearest provider or supplier of ambulance services are garaged. An improved road is any road that is maintained by a local, State, or Federal government entity and is available for use by the general public. An improved road includes the paved surface up to the front entrance of the CAH and the front entrance of the garage.

40 - Billing Coverage and Utilization Rules for PPS and Non-PPS Hospitals

(Rev. 1, 10-01-03)

HO-415.1

A - General

Days of utilization are charged based upon actual days of coverage including grace and waiver days. The number of covered days used are maintained by CMS to track the beneficiary's eligible days in a benefit period. The hospital collects the coinsurance, if applicable, for only the number of days charged against the beneficiary's utilization record maintained by CMS. For example, if the mean length of stay for a DRG is 10 days and the beneficiary is discharged after 3, only 3 days of utilization is charged. In a like situation, if the DRG mean length of stay is 10 days and the beneficiary is discharged after 15, the 15 days are charged against the utilization record.

NOTE: There are some exceptions to this rule under LTCH PPS. See §150.4.

Coinsurance, if applicable, is payable by the beneficiary for the number of days used. The hospital subtracts the coinsurance amount from the DRG payment. Days after benefits are exhausted are not charged against the beneficiary's utilization even though the hospital may receive the full DRG payment.

The basic prospective payment amount will be paid if:

- There is at least l day of utilization left at the time of admission and that day is also a day of entitlement (e.g., a day before the beneficiary discontinued voluntary Part A entitlement by not paying the premium).

- There is at least l day for which payment may be made under the guarantee of payment. (If benefits are exhausted prior to admission and no payment may be made under guarantee of payment, only Part B benefits are available.)

- The beneficiary becomes entitled after admission. The hospital may not bill the beneficiary or other persons for days of care preceding entitlement except for days in excess of the outlier threshold.

Utilization is not counted for any days treated as noncovered, except as described below:

- Utilization is not counted for any nonentitlement days, or days after benefits are exhausted (including guarantee of payment days), even if those days are treated as covered for outlier calculation or treated as Medicare patient days for the cost report.

- The length of stay exceeds the day outlier threshold (Day outliers were discontinued at the end of FY 1997), utilization is counted for medically unnecessary days which are noncovered but for which the hospital may not charge

the beneficiary because the requirements of §40.2 were not met. See §40.2.2 for identification of these days.

- If the adjusted cost of the stay exceeds the cost outlier threshold, utilization is counted for any medically unnecessary days on which all Part A services are treated as noncovered under §40.2.B and for which the hospital may not charge the beneficiary. (Where only ancillary services are denied, all days are counted as covered.)

Lifetime reserve days for an inpatient hospital stay for which prospective payment may be made is subject to the following:

- If the beneficiary had one or more regular benefit days remaining in the spell of illness when admitted, there is no advantage in using lifetime reserve days. The beneficiary is deemed to have elected not to use lifetime reserve days for the nonoutlier (Day outliers were discontinued at the end of FY 1997) portion of the stay. After regular benefits have been exhausted, lifetime reserve days will be used automatically for outlier days unless the beneficiary elects not to use them, or the average daily charges for outlier days to be reimbursed as lifetime reserve days do not exceed the lifetime reserve day coinsurance amount. (In the latter case the beneficiary is deemed to have elected not to use lifetime reserve days for outlier days.) An election not to use lifetime reserve for outlier days applies to all outlier days in an admission.

- If the beneficiary had no regular benefit days remaining when admitted, available lifetime reserve days are used automatically for each day of the stay. Exceptions exist if the beneficiary elects not to use lifetime reserve days, or the charges for which the beneficiary is liable, if electing not use lifetime reserve days, do not exceed the charges for which the beneficiary would be liable if the lifetime reserve days were used. Using lifetime reserve days, the beneficiary would be responsible for the sum of the coinsurance amounts for the lifetime reserve days that would be used plus the total charges for outlier days, if any, for which no lifetime reserve days are available. (In the latter case the beneficiary will be deemed to have elected not to use any lifetime reserve days.)

An election by the beneficiary not to use lifetime reserve days applies to the entire stay and precludes any payment for the stay. A deemed election not to use lifetime reserve days applies to the entire stay and precludes any payment for the stay unless payment may be made under the guarantee of payment.

The number of days for which utilization is charged may be different from the number used in Pricer to compute outlier status or the number of Medicare patient days shown on the cost report.

40.1 - "Day Count" Rules for All Providers

(Rev. 1, 10-01-03)

A3-3620

See §40.2.A for general rules on counting days.

A - Day of Admission

For all hospitals, the FI counts the day of admission for the cost report and for utilization. For PPS hospitals, it counts the day of admission for Pricer purposes unless the rules for same day transfer apply.

B - Day of Discharge, Death, or Beginning a Leave of Absence

The FI does not count the day of discharge or death for cost report, utilization or Pricer purposes unless the admission and discharge day are the same day. Where admission and discharge occur on the same day, it counts one day for cost report, utilization and Pricer purposes. If the patient is admitted with the expectation that the patient will remain overnight, but is discharged or dies before midnight, it counts the day for the cost report, utilization and Pricer. It does not count any days in a leave of absence (occurrence span code 74), for cost report, utilization or Pricer purposes.

C - Same Day Transfer From Participating Hospital to Nonparticipating Hospital or Nonparticipating Distinct Part of Hospital

If the beneficiary is admitted to a PPS hospital with the expectation that the beneficiary will remain overnight, but is transferred to a nonparticipating provider or a nonparticipating distinct part of the same provider before midnight, the FI counts the day for the cost report, utilization and Pricer. If the beneficiary is admitted to a non-PPS hospital with the expectation that the beneficiary will remain overnight, but is transferred to a nonparticipating hospital or a nonparticipating distinct part of a hospital before midnight, the FI counts the day for cost report and utilization purposes.

D - Same Day Transfer From Participating Hospital to Participating Hospital

If the beneficiary is transferred to a participating hospital or distinct part of a participating hospital, the FI counts the day, if it is determined to be covered, for the cost report and for Pricer at both hospitals. However, it charges utilization on the bill only for the later admission to avoid charging the beneficiary twice for the same day. The earlier admission, for which the FI does not charge utilization, can be recognized by condition code 40 (same day transfer), and the same date entered in the "From" and "Through" dates in CWF.

E - Guarantee of Payment Days

There can be up to fourteen guarantee of payment days (8 days plus weekends and Federal holidays) beginning with the date in occurrence code 20. The FI does not charge

utilization, as the beneficiary has no days remaining, but counts guarantee of payment days for the cost report and Pricer.

F - Provider Liability Issue

When the FI or the QIO finds the provider liable, the FI or the QIO determines the cause for provider liability prior to making any decision regarding utilization. If the provider is technically liable, i.e., liable for reasons other than custodial care or medical necessity of the services, the FI shows the dates of provider liability in occurrence span code 77, and counts the days for utilization, but not for cost report or Pricer purposes. If the provider is liable because services were not medically necessary or were custodial care, the FI shows the dates of provider liability in occurrence span code 79 and does not count the days for cost report, utilization or Pricer purposes.

G - Special Rules Which Differ for PPS and Other Providers

If Part A payment may be made for a hospital stay under PPS (i.e., there is at least one Medicare patient day, guarantee of payment day, or day for which the program is liable to the hospital under the limitation of liability provision), the FI treats all days as covered for cost report purposes, except as provided below. It applies this same rule when per diem payments are made to a transferring PPS hospital, whether for all or part of a stay, or when a PPS hospital requests outlier payment, whether or not such payment is made.

For non-PPS hospitals, PPS exempt units and SNFs, it counts the number of days available to the beneficiary for all purposes.

Where outlier status is involved and there are either pre-entitlement days or days after benefits were exhausted, the FI reduces cost report days by the lesser of the number of pre-entitlement/post-benefits exhausted days or the number of days in the stay in excess of the outlier threshold.

1 - Length of Stay Does Not Exceed the Day Outlier Threshold (Day outliers discontinued after FY 97)

The FI counts all days (including day of admission, but not the day of discharge or death, unless it is also the day of admission) as covered for cost report and Pricer purposes. It does not count those medically unnecessary days for which the provider meets notice requirements and other conditions for charging the beneficiary. (See §40.2.2 C and D.) It does not count those medically unnecessary days for cost report or Pricer purposes. It counts the actual number of days available to the beneficiary for utilization.

2 - Length of Stay Exceeds the Day Outlier Threshold (Day outliers discontinued after FY 97)

The FI counts all days (including the day of admission, but not the day of discharge or death unless it is also the day of admission) in the stay for cost report and Pricer purposes except as follows:

a. Pre-entitlement Days

The FI does not count pre-entitlement days for the cost report or for utilization in non-PPS hospitals, exempt units or SNFs. For PPS hospitals, it does not count pre-entitlement days for utilization or for Pricer. The number of days counted as noncovered for the cost report is limited to the number of days in the stay in excess of the day outlier threshold. To determine which preentitlement days are counted as noncovered, the FI begins at the end of the stay (the day before the day of discharge, death, etc.) and working backward, counts off days identified as pre-entitlement days until it has counted all preentitlement days or, until the number of days counted equals the total number of days in excess of the outlier threshold.

b. Post-Exhaustion of Benefit Days

The FI treats post-exhaustion of benefit days exactly like pre-entitlement days.

To resolve any Medicare Secondary Payor (MSP) issues, see the Medicare Secondary Payer Manual.

40.2 - Determining Covered/Noncovered Days and Charges

(Rev. 1, 10-01-03)

A3-3620, HO-415.2

The CMS must record a day or charge as either covered or noncovered because of the following:

Beneficiary utilization is recorded based upon days during which the patient received hospital or SNF accommodations, including days paid by Medicare and days for which the provider was held liable for reasons other than medical necessity or custodial care. Days denied as not medically necessary or as custodial care are not charged against a beneficiary's utilization record when the provider is determined to be liable.

The provider may claim credit on its cost report only for covered accommodations, days and charges for which actual payment is made, i.e., provider liable days and charges are not included. Data from the bill payment process are used in preparing the cost report.

The number of days and charges provided to the Pricer program affects the day and cost outlier determinations and the DRG payment amount. Non-PPS provider days are excluded from Pricer consideration.

It is possible to use a different number of days on a single bill for each of the above purposes, although the same number of days will generally apply in actual practice. For example, if the beneficiary had at least one day of eligibility remaining at admission, days that occur after benefits are exhausted up through the day outlier threshold for the applicable DRG are counted for cost reporting purposes under PPS.

A - General Rule on Counting of Days

A3-3620, HO-415.2

These following are general rules for counting days. However, these rules are also subject to special rules for determining day of admission, discharge, death, beginning a leave of absence, same day transfer, guarantee of payment days, provider liability issues and outlier days for PPS outliers. See §40.1 and §40.1.G for an explanation of these special rules.

The provider calculates and enters on the bill the number of claimable Medicare patient days on the cost report. (Medicare patient days always refer to cost report days.) For PPS facilities the FI counts, for the cost report, utilization and Pricer purposes, all days for which Part A payment may be made to the hospital. This includes days for which the provider is not liable under the limitation of liability provision. It does not count days for which no Part A payment may be made for cost report, utilization or Pricer purposes.

For non-PPS providers, the FI does not count the days for Pricer purposes, because DRG payment or outlier calculations are not made.

B - Medically Unnecessary Days for Which the Provider May Charge the Beneficiary

Days on which the hospital furnished no covered Part A services are not charged to utilization and are not counted as Medicare patient days.

If the hospital or SNF stay includes any medically unnecessary days for which the provider has met the requirements of §§40.2.2 C or D for charging the beneficiary, the FI counts those days as noncovered under Part A for cost report, utilization and Pricer purposes.

Since the provider may not be aware of the date benefits are exhausted or when the outlier threshold is reached, the FI verifies the provider's counts. If, for any reason, the FI or the QIO determines fewer days are claimable (e.g., if the FI or the QIO indicates that benefits are exhausted), the FI will adjust cost report days for its PS&R system. If the FI or the QIO determines fewer days are claimable for the cost report, it determines the proper number of days of utilization to charge the beneficiary and the proper number of days for the length of stay used by Pricer. It uses the factors in §40.1 and §40.1G to make these calculations.

C - Medically Unnecessary Outlier Costs for Which the Hospital May Not Charge

If the hospital requests payment for cost outlier, and the Medicare covered charges converted to cost exceed the cost outlier threshold, the services which are not reasonable and necessary (or constitute custodial care) which are noncovered, but for which the hospital may not charge the beneficiary are determined as follows:

- The hospital determines the lesser of the following:

- The cost of the medically unnecessary services (converting the charges for the medically unnecessary services to cost); or

- The amount by which the adjusted cost of the stay exceeds the cost outlier threshold.

Ancillary services, which are not required to be furnished on an inpatient basis, are treated as medically unnecessary, but nevertheless may be covered under Part B.

- If the costs in excess of the outlier threshold exceed the cost of the medically unnecessary services, the cost of all of the medically unnecessary services are treated as noncovered costs. If these costs exceed the costs in excess of the cost outlier threshold, beginning with the cost of the last medically unnecessary service in the stay, the hospital must identify, and add on, in reverse order, the cost of other medically unnecessary services until the total cost of medically unnecessary services reaches the costs in excess of the cost outlier threshold. If the cost of the last service to be added on in this manner brings the cost of medically unnecessary services over the amount of costs in excess of the cost outlier threshold, only the portion of the cost of that last medically unnecessary service (in the order of the addition) needed to bring the total of the medically unnecessary costs up to the costs in excess of the cost outlier threshold is added on. In this case, the costs in excess of the cost outlier threshold are treated as the noncovered costs.

- Once the costs of medically unnecessary services to be treated as noncovered are determined, convert them to charges for each applicable service/revenue category, e.g., accommodations, radiology, pharmacy, by dividing the costs treated as not medically necessary in each category by 72 percent. The medically unnecessary charges determined are treated as noncovered charges. Days for which all costs are found to be noncovered are treated as noncovered days.

- The hospital determines which medically unnecessary services and days treated as noncovered are services and days for which the beneficiary can be charged under §40.2.2C or E. The remainder of the services and days are the medically unnecessary services and days treated as noncovered even though the hospital may not charge the beneficiary. However, the distinction between medically unnecessary services and days for which the hospital may charge, and those for which it may not, will not be reflected in the charges shown on the inpatient hospital billing. Both are combined and shown as noncovered services and days.

The determination of medically unnecessary cost outliers is not affected by non-entitlement days or days after benefits are exhausted. If the stay is covered or treated as covered, the beneficiary is treated as entitled to Part A, and as having benefits available throughout the stay.

40.2.1 - Noncovered Admission Followed by Covered Level of Care

(Rev. 1, 10-01-03)

HO-415.16, A3-3610.12

Where a beneficiary receives noncovered care at admission, and is notified as such, but subsequently is furnished covered level of care during the same hospital stay, the admission is deemed to have occurred when covered services became medically needed and rendered. This is applicable to PPS and non-PPS billings.

The following billing entries identify this situation:

- Admission date (not the deemed date) in FLs 6 and 17.
- Occurrence code "31" and the date the hospital provided notice to the beneficiary are in FLs 32 - 35.
- Occurrence span code 76 indicates the noncovered span from admission date through the day before covered care started.
- Value code 31 in FLs 39 - 41 is used to indicate the amount which was charged the beneficiary for noncovered services.
- Noncovered charges related to the noncovered services.
- The principal diagnosis is shown as the diagnosis that caused the covered level of care.

Only procedures performed during the covered level of care are shown on the bill.

If a no payment bill for the noncovered level of care has been processed, the hospital prepares and forwards a new initial bill.

40.2.2 - Charges to Beneficiaries for Part A Services

(Rev. 1, 10-01-03)

A3-3610.1, HO-415.3, HO-400E

The hospital submits a bill even where the patient is responsible for a deductible which covers the entire amount of the charges for non-PPS hospitals, or in PPS hospitals, where the DRG payment amount will be less than the deductible.

A beneficiary's liability for payment is governed by the limitation on liability notification rules in Chapter 30 where the admission is found not to be reasonable and necessary and no payment will be made for the stay under limitation on liability. A hospital receiving payment for a covered hospital stay (or PPS hospital that includes at least one covered

day, or one treated as covered under guarantee of payment or limitation on liability) may charge the beneficiary, or other person, for items and services furnished during the stay only as described in subsections A through H.

A - Deductible and Coinsurance

The hospital may charge the beneficiary or other person for applicable deductible and coinsurance amounts. The deductible is satisfied only by charges for covered services. The FI deducts the deductible and coinsurance first from the PPS payment. Where the deductible exceeds the PPS amount, the excess will be applied to a subsequent payment to the hospital. (See Chapter 3 of the Medicare General Information, Eligibility, and Entitlement Manual for specific policies.)

B - Blood Deductible

The Part A blood deductible provision applies and reporting of the number of pints is applicable to both PPS and non-PPS hospitals. (See Chapter 3 of the Medicare General Information, Eligibility, and Entitlement Manual for specific policies.)

C - Inpatient Care No Longer Required

The hospital may charge for services that are not reasonable and necessary or that constitute custodial care, furnished on or after the third day following the date of the written notification when the following requirements are met:

- The hospital (acting directly or through its URC) determined that the beneficiary no longer required inpatient hospital care. (For this purpose, a beneficiary is considered to require inpatient hospital care if the beneficiary needed a SNF level of care but an SNF-level bed was unavailable.) The hospital cannot issue a notice of noncoverage if a bed is not available. Medicare pays for days awaiting placement until a bed is available and it is documented in the medical record that SNF placement is actively being sought.

- The attending physician agreed with the hospital's determination in writing, i.e., by issuing a written discharge order. Or, if the physician disagreed with the hospital's determination, the hospital requested a review by the QIO and the QIO concurred with the hospitals' notice.

Prior to charging for the noncovered period, the hospital (acting directly or through the URC) notified the beneficiary (or person acting on the beneficiary's behalf) in writing that:

- In its opinion and with the concurrence of the attending physician (or of the QIO), the beneficiary no longer requires inpatient hospital care (See §§130 for coordination with a QIO); or

- Customary charges will be made for continued hospital care beginning with the third day following the date of the notice.

The beneficiary may request that the QIO make a formal determination on the validity of the hospital's finding if the beneficiary remains in the hospital after becoming liable for charges. If the beneficiary wants an immediate review by the QIO, the beneficiary must request it within 3 days of receiving the hospital's notice. Any patient during the course of a stay will receive the QIO decision within 2 workdays.;

The determination of the QIO may be appealed if it is unfavorable to the beneficiary in any way and the QIO decision will be made within 30 days.

To the extent that a finding is made that the beneficiary required continued hospital care beyond the point indicated by the hospital, the charges for the continued care will be invalidated and any money paid by the beneficiary, or on the beneficiary's behalf, refunded.

The manner in which the hospital gives the notice to the beneficiary is in Chapter 30.

If a hospital furnishing covered inpatient hospital services is able to determine in advance that the beneficiary will not require inpatient hospital care as of a certain date, it may give the notice in advance of that date, but ordinarily no earlier than 3 days before that date. If a hospital determines, however, that a beneficiary needs (or by the third day thereafter, will need) only a SNF-level of care but a SNF bed is not or will not be available, it may notify the beneficiary (or the beneficiary's representative) that the beneficiary will be subject to charges beginning with the third day after the date of the notice that the SNF bed becomes available. This can be done as an advance beneficiary notice. The hospital needs to notify the beneficiary or representative the day the bed becomes available or has knowledge of the bed available.

The beneficiary has the same right to appeal the QIO's determination that the beneficiary no longer required inpatient hospital care as of a certain date as applies to QIO determinations regarding medical necessity. The hospital also has the right to appeal a QIO's determination that is unfavorable to the beneficiary.

When the hospital appeals in such cases the following entries are required on the bill:

- Occurrence code 3l (and date) to indicate the date the hospital notified the patient in accordance with the first bullet above;

- Occurrence span code 76 (and dates) to indicate the period of noncovered care for which it is charging the beneficiary;

- Occurrence span code 77 (and dates) to indicate the period of noncovered care for which the provider is liable, when it is aware of this prior to billing; and

- Value code 3l (and amount) to indicate the amount of charges it may bill the beneficiary for days for which inpatient care was no longer required. They are included as noncovered charges on the bill.

D - Change in the Beneficiary's Condition

If the beneficiary remains in the hospital after receiving notice as described in subsection C, and the hospital, the physician who concurred in the hospital's determination, or the QIO, subsequently determines that the beneficiary again requires inpatient hospital care, the hospital may not charge the beneficiary or other person for services furnished after the beneficiary again required inpatient hospital care until the conditions in subsection C. are again met. If a patient who needs only a SNF level of care remains in the hospital after the SNF bed becomes available, and the bed ceases to be available, the hospital may continue to charge the beneficiary. It need not provide the beneficiary with a subsequent notice when the patient chose not to be discharged to the SNF bed.

E - Admission Denied

If the entire hospital admission is determined to be not reasonable or necessary:

- If the beneficiary was notified in writing prior to, or upon admission, the hospital may charge for the entire period of hospitalization.

- If the beneficiary was notified in writing on the day following the admission or subsequently, the hospital may charge the beneficiary for the hospitalization beginning with the day following the day the written notice was given. In this circumstance, the provider is liable for the period between admission and the day after the beneficiary was notified.

The notice to the beneficiary must state:

- The basis of the determination that inpatient hospital care is not necessary or reasonable (e.g., coverage exclusions);

- That customary charges will be made for hospital care beginning with the day following the day on which the notice is given to either the beneficiary or to a representative on his behalf;

- The beneficiary may request that the QIO make a formal determination on the validity of the hospital's finding if the beneficiary remains in the hospital. If the beneficiary wishes immediate QIO review, it must be requested within 3 days of receiving the hospital's notice;

- The beneficiary may appeal the determination of the QIO if it is unfavorable to the beneficiary in any way. The hospital also has the right to appeal a QIO's decision; and

- If a finding is made that the beneficiary required the hospitalization, the charges for the hospital stay will be invalidated, and money paid by the beneficiary or on his behalf will be refunded.

In such cases the following entries are required on the bill:

- Occurrence code 3l (and date) to indicate the date the hospital notified the beneficiary.
- Occurrence span code 76 (and dates) to indicate the period of noncovered care for which the hospital is charging the beneficiary.
- Occurrence span code 77 (and dates) to indicate any period of noncovered care for which the provider is liable (e.g., the period between issuing the notice and the time it may charge the beneficiary) when the provider is aware of this prior to billing.
- Value code 3l (and amount) to indicate the amount of charges the hospital may bill the beneficiary for hospitalization that was not necessary or reasonable. They are included as noncovered charges on the bill.

F - Procedures, Studies and Courses of Treatment That Are Not Reasonable or Necessary

If diagnostic procedures, studies, therapeutic studies and courses of treatment are excluded from coverage as not reasonable and necessary (even though the beneficiary requires inpatient hospital care) the hospital may charge the beneficiary or other person For the services or care under the following circumstances:

- If the beneficiary was notified in writing prior to receipt of the care or services that the hospital may charge for the excluded care or services; and
- The notice to the beneficiary must state:
    - The basis of the determination that inpatient hospital care is not necessary or reasonable (i.e., coverage exclusions);
    - The determination is the hospital's opinion. (If the hospital obtained concurrence from the FI or the QIO this may be stated);
    - Customary charges will be made if the beneficiary receives the services;
    - The beneficiary may request the FI, or the QIO when medical necessity is involved, to make a formal determination on the validity of the hospital's finding if the beneficiary receives the items or services. If the beneficiary wants immediate QIO review, the beneficiary must request it within 3 days of receiving the hospital's notice;
    - The FI's determination, or the QIO's where a medical necessity determination is involved, may be appealed by the beneficiary if unfavorable to the beneficiary in any way. The hospital also has the right to appeal the FI's or the QIO's decision; and

- The charges for the services will be invalidated and refunded if they are found to be covered.

The hospital may consult with the FI (on coverage exclusions) or the QIO (on medical necessity determinations) prior to issuing the notice to the beneficiary.

The following bill entries apply to these circumstances:

- Occurrence code 32 (and date) to indicate the date the hospital provided the notice to the beneficiary.

- Value code 3l (and amount) to indicate the amount of such charges to be billed to the beneficiary. They are included as noncovered charges on the bill.

G - Nonentitlement Days and Days after Benefits Exhausted

If a hospital stay exceeds the day outlier threshold, the hospital may charge for some, or all, of the days on which the patient is not entitled to Medicare Part A, or after the Part A benefits are exhausted (i.e., the hospital may charge its customary charges for services furnished on those days). It may charge the beneficiary for the lesser of:

- The number of days on which the patient was not entitled to benefits or after the benefits were exhausted; or

- The number of outlier days. (Day outliers were discontinued at the end of FY 1997.)

If the number of outlier days exceeds the number of days on which the patient was not entitled to benefits, or after benefits were exhausted, the hospital may charge for all days on which the patient was not entitled to benefits or after benefits were exhausted. If the number of days on which the beneficiary was not entitled to benefits, or after benefits were exhausted, exceeds the number of outlier days, the hospital determines the days for which it may charge by starting with the last day of the stay (i.e., the day before the day of discharge) and identifying and counting off in reverse order, days on which the patient was not entitled to benefits or after the benefits were exhausted, until the number of days counted off equals the number of outlier days. The days counted off are the days for which the hospital may charge.

H - Contractual Exclusions

In addition to receiving the basic prospective payment, the hospital may charge the beneficiary for any services that are excluded from coverage for reasons other than, or in addition to, absence of medical necessity, provision of custodial care, non-entitlement to Part A, or exhaustion of benefits. For example, it may charge for most cosmetic and dental surgery.

I - Private Room Care

Payment for medically necessary private room care is included in the prospective payment. Where the beneficiary requests private room accommodations, the hospital must inform the beneficiary of the additional charge. (See the Medicare Benefit Policy Manual, Chapter 1.) When the beneficiary accepts the liability, the hospital will supply the service, and bill the beneficiary directly. If the beneficiary believes the private room was medically necessary, the beneficiary has a right to a determination and may initiate a Part A appeal.

J - Deluxe Item or Service

Where a beneficiary requests a deluxe item or service, i.e., an item or service which is more expensive than is medically required for the beneficiary's condition, after the hospital informs the beneficiary of the additional charge, it may collect the additional charge. That charge is the difference between the customary charge for the item or service most commonly furnished by the hospital to private pay patients with the beneficiary's condition, and the charge for the more expensive item or service requested. If the beneficiary believes that the more expensive item or service was medically necessary, the beneficiary has a right to a determination and may initiate a Part A appeal.

40.2.3 - Determining Covered and Noncovered Charges - Pricer and PS&R

(Rev. 1, 10-01-03)

Accommodation charges for days covered by Medicare are covered charges. Ancillary charges incurred on these days are also covered charges as long as these services are covered under Medicare. The FI enters them into its PS&R unless it or the QIO denies them as exclusions from coverage or as medically unnecessary. For PPS hospitals, the FI counts these charges for Pricer unless the charges are included as pass-through costs.

The FI does not count for Pricer or the PS&R:

- Charges the provider has shown as noncovered. (If the provider has complied with the notice requirements in Chapter 30, it may bill the beneficiary.);
- Services on noncovered days;
- Charges for personal comfort and/or convenience items;
- Accommodations and routine charges for the day of discharge, death, or beginning of a leave of absence, unless it is also the day of admission; and
- Charges for ancillary services on the day of discharge, death, or beginning of a leave of absence if the preceding day is noncovered under §40.2.B.

MSP Issues

The FI resolves any MSP issues not handled by §40.1.G using the instructions in the Medicare Secondary Payer Manual specific for reasonable cost providers and the instructions in specifically for PPS providers.

G - Determining Covered and Noncovered Charges - Part B

The FI counts as covered under Part B, for cost report and deductible purposes, the charges for which Part B payment may be made, except as follows:

- It counts as covered for deductible, but not cost report purposes, those charges for which the provider is liable for technical reasons; and
- It does not count charges for which the provider is liable because services are not medically necessary for either deductible or cost report purposes.

40.2.4 – IPPS Transfers Between Hospitals - Click here to see Jul 04 update

(Rev. 73, 01-23-04)

A3-3610.5, HO-415.8

A transfer between hospitals occurs when a patient is admitted to a hospital and is subsequently transferred to another for additional treatment once the patient's condition has stabilized or a diagnosis established. The following procedures apply. See §20.2.3 for proper Pricer coding to ensure that these requirements are met.

NOTE: CMS established Common Working File Edits (CWF) in January 2004 to ensure accurate coding and payment for discharges and/or transfers.

A - Transfers Between Prospective Payment Hospitals

Payment is made to the final discharging hospital at the full prospective payment rate. Payment to the transferring hospital is based upon a per diem rate (i.e., the prospective payment rate divided by the average length of stay for the specific DRG into which the case falls, and multiplied by the patient's length of stay at the transferring hospital). If less than l day, l day is paid. A day is counted if the patient was admitted with the expectation of staying overnight. A per diem payment is appropriate. However, this day does not count against the patient's Medicare days (utilization days), since this Medicare day is applied at the receiving hospital. Deductible or coinsurance, where applicable, is also charged against days at the receiving hospital. (See §40.1.D) If the patient is treated in the emergency room without being admitted and then transferred, only Part B billing is appropriate.

The prospective payment rate paid is the hospital's specific rate. Similarly, the wage indexes and any other adjustments are those that are appropriate for each hospital. Where a transfer case results in treatment in the second hospital under a DRG different than the DRG in the transferring hospital, payment to each is based upon the DRG under which

the patient was treated. Day outlier payments are payable based upon the admission and discharge dates. For transfers on or after, October 1, 1984, the transferring hospital may be paid a cost outlier payment but may not be paid a day outlier payment (Day outliers were discontinued at the end of FY 1997).

An exception to this policy applies to DRGs 385 and 456. The weighting factors for these assume that the patient will be transferred, since a transfer is part of the definition. Therefore, a hospital that transfers a patient classified into one of these DRGs is paid the full amount of the prospective payment rate associated with the DRG rather than the per diem rate, plus any outlier payment, if applicable.

B - Transfers to Hospitals or Units Excluded from Prospective Payment

When patients are transferred to hospitals or units excluded from prospective payment, the full prospective payment is made to the transferring hospital. The receiving hospital is paid on the basis of reasonable costs.

A per diem payment is made to the transferring hospital when patients are transferred to a Maryland hospital or to a New York Finger Lakes hospital that would ordinarily be paid under prospective payment, but is excluded because of participation in a state or area wide cost control program. Also, a per diem payment is made where a patient is transferred to a hospital or hospital unit that has not been officially determined as being excluded from PPS.

C - Transfers – Postacute Care Transfers (Previously Special 10 DRG Rule)

For discharges occurring on or after October 1, 1998, a discharge of a hospital inpatient is considered to be a transfer for purposes of this part when the patient's discharge is assigned, as described in 42 CFR 412.4(c), to one of the qualifying diagnosis-related groups (DRGs) listed in paragraph (d) of this section and the discharge is made under any of the following circumstances:

- To a hospital or distinct part hospital unit excluded from the inpatient prospective payment system (under Subpart B at 42 CRF 412).
- To a skilled nursing facility.
- To home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge.

D - Qualifying DRGs

The qualifying DRGs for purposes of paragraph (c) of this section are DRGs 14, 113, 209, 210, 211, 236, 263, 264, 429, and 483.

Effective October 1, 2003, DRGs 263 and 264 are deleted from the postacute care transfer policy.

Effective for discharges on or after October 1, 2003, the following DRGs were added to the policy: 12, 24, 25, 88, 89, 90, 121, 122, 127, 130, 131, 239, 277, 278, 294, 296, 297, 320, 321, 395, and 468.

40.2.5 - Repeat Admissions

(Rev. 1, 10-01-03)

HO-400B

A patient who requires follow-up care or elective surgery may be discharged and readmitted or may be placed on a leave of absence.

Hospitals may place a patient on a leave of absence when readmission is expected and the patient does not require a hospital level of care during the interim period. Examples could include, but are not limited to, situations where surgery could not be scheduled immediately, a specific surgical team was not available, bilateral surgery was planned, or when further treatment is indicated following diagnostic tests but cannot begin immediately. Institutional providers may not use the leave of absence billing procedure when the second admission is unexpected.

QIOs review acute care hospital admissions occurring within 30 days of discharge from an acute care hospital if both hospitals are in the QIO's area and if it appears that the two confinements could be related. Two separate payments would be made for these cases unless the QIO denies a readmission to the same hospital.

NOTE: QIO review and the QIO's authority to deny readmissions is not limited to readmissions within 30 days. The QIO has the authority to deny the second admission to the same hospital no matter how many days elapsed since the patient's discharge.

Placing a patient on a leave of absence will not generate two payments. Only one bill and one DRG payment is made. The QIO does not consider leave of absence bills two admissions. It may select such bills for review for other reasons.

40.2.6 - Leave of Absence

(Rev. 1, 10-01-03)

HO-400.C

Providers submit one bill for covered days and days of leave when the patient is ultimately discharged.

The provider bills for covered days with days of leave included in FL 8, Noncovered Days. Noncovered charges for leave of absence days (holding a bed) may be omitted from the bill or may be shown under revenue code 018x. Providers will be instructed by

their FI on which billing method to use. Occurrence span code 74 is used to report the dates the leave began and ended. Although the Medicare program may not be billed for days of leave, the provider is not permitted to charge a beneficiary for them.

Where a patient on leave of absence from a non-PPS hospital who was shown as "Still Patient" (patient status code 30, FL 22) on an interim bill:

- Has not returned within 60 days, including the day leave began, or
- Has been admitted to another institution at any time during the leave of absence, submit an adjusted bill.

The hospital shows the day the patient left the hospital as the date of discharge. (A beneficiary cannot be an inpatient of two institutions at the same time.)

NOTE: Home health or outpatient services provided during a leave of absence do not affect the leave and no discharge bill is required unless the above events occur.

40.3 - Outpatient Services Treated as Inpatient Services

(Rev. 156, 04-30-04)

A3-3610.3, HO-415.6, HO-400D, A-03-008, A-03-013, A-03-054

A - Outpatient Services Followed by Admission Before Midnight of the Following Day (Effective For Services Furnished Before October 1, 1991)

When a beneficiary receives outpatient hospital services during the day immediately preceding the hospital admission, the outpatient hospital services are treated as inpatient services if the beneficiary has Part A coverage. Hospitals and FIs apply this provision only when the beneficiary is admitted to the hospital before midnight of the day following receipt of outpatient services. The day on which the patient is formally admitted as an inpatient is counted as the first inpatient day.

When this provision applies, services are included in the applicable PPS payment and not billed separately. When this provision applies to hospitals and units excluded from PPS, services are shown on the bill and included in the Part A payment. See Chapter 1 for FI requirements for detecting duplicate claims in such cases.

B - Preadmission Diagnostic Services (Effective for Services Furnished On or After January 1, 1991)

Diagnostic services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or operated by the hospital (or by another entity under arrangements with the hospital), within 3 days prior to the date of the beneficiary's admission are deemed to be inpatient services and included in the inpatient payment, unless there is no Part A coverage. For example, if a patient is admitted on a Wednesday, services provided by the hospital on Sunday,

Monday, or Tuesday are included in the inpatient Part A payment. This provision does not apply to ambulance services. (See the Medicare Benefit Policy Manual, Chapter 10.)

This provision does not apply to providers subject to LTCH PPS or IRF PPS.

For services provided before October 31, 1994, this provision applies to both hospitals subject to the hospital inpatient prospective payment system (PPS) as well as those hospitals and units excluded from PPS. For services provided on or after October 31, 1994, for hospitals and units excluded from PPS, this provision applies only to services furnished within one day prior to the date of the beneficiary's admission.

An entity is considered to be "wholly owned or operated" by the hospital if the hospital is the **sole** owner or operator. A hospital need not exercise administrative control over a facility in order to operate it. A hospital is considered the sole operator of the facility if the hospital has exclusive responsibility for implementing facility policies (i.e., conducting or overseeing the facility's routine operations), regardless of whether it also has the authority to make the policies.

For this provision, diagnostic services are defined by the presence on the bill of the following revenue and/or HCPCS codes:

0254 -	Drugs incident to other diagnostic services
0255 -	Drugs incident to radiology
030X -	Laboratory
031X -	Laboratory pathological
032X -	Radiology diagnostic
0341 -	Nuclear medicine, diagnostic
035X -	CT scan
040X -	Other imaging services

046X -	Pulmonary function
048X -	Cardiology, with HCPCS codes 93015, 93307, 93308, 93320, 93501, 93503, 93505, 93510, 93526, 93541, 93542, 93543, 93544 - 93552, 93561, or 93562

053X -	Osteopathic services
061X -	MRT
062X -	Medical/surgical supplies, incident to radiology or other diagnostic services
073X -	EKG/ECG
074X -	EEG
092X -	Other diagnostic services

The CWF rejects services furnished January 1, 1991, or later when outpatient bills for diagnostic services with through dates or last date of service (occurrence span code 72) fall on the day of admission or any of the 3 days immediately prior to admission to a PPS or an excluded hospital. This reject applies to the bill in process, regardless of whether the outpatient or inpatient bill is processed first. Hospitals must analyze the two bills and report appropriate corrections. For services on or after October 31, 1994, for hospitals and units excluded from PPS, CWF will reject outpatient diagnostic bills that occur on the day of or one day before admission. For PPS hospitals, CWF will continue to reject outpatient diagnostic bills for services that occur on any of the 3 days prior to admission.

Hospitals in Maryland that are under the jurisdiction of the Health Services Cost Review Commission are subject to the 3-day payment window.

C - Other Preadmission Services (Effective for Services Furnished On or After October 1, 1991)

Nondiagnostic outpatient services that are related to a patient's hospital admission and that are provided by the hospital, or by an entity wholly owned or operated by the hospital (or by another entity under arrangements with the hospital), to the patient during the 3 days immediately preceding the date of the patient's admission are deemed to be inpatient services and are included in the inpatient payment. This provision applies only when the patient has Part A coverage.

Hospitals in Maryland that are under the jurisdiction of the Health Services Cost Review Commission are subject to the 3-day payment window.

LTCH PPS providers and IRF PPS providers are not subject to the 3-day payment widow (72-hour rule) for pre-admission services.

This provision does not apply to ambulance services. (See the Medicare Benefit Policy Manual, Chapter 10.) For services provided before October 31, 1994, this provision applies to both hospitals subject to the hospital inpatient (PPS) as well as those hospitals and units excluded from PPS.

For services provided on or after October 31, 1994, for hospitals and units excluded from PPS, this provision applies only to services furnished within 1 day prior to the date of the beneficiary's admission. Preadmission services are related to the admission if they are

furnished in connection with the principal diagnosis that necessitates the patient's admission as an inpatient (i.e., if the outpatient principal diagnosis is the same as the inpatient principal diagnosis). Thus, whenever Part A covers an admission, the hospital may bill nondiagnostic preadmission services to Part B as outpatient services **only** if they are **not** related to the admission. The FI will assume, in the absence of evidence to the contrary, that such bills are not admission related and, therefore, are not deemed to be inpatient (Part A) services.

40.3.1 - Billing Procedures to Avoid Duplicate Payments

(Rev. 1, 10-01-03)

HO-400H

The hospital must install adequate billing procedures to avoid submission of duplicate claims. This includes duplicate claims for the same service and outpatient bills for nonphysician services considered included in the DRG for a related inpatient admission in the facility or in another hospital.

Where the hospital bills separately for nonphysician services provided to a patient either on the day before admission to a PPS hospital or during a patient's inpatient stay, the claim will be rejected by the FI as a duplicate and the hospital may be subject to sanction penalties per §1128A of the Act.

50 - Adjustment Bills

(Rev. 1, 10-01-03)

A3-3664, HO-411.1, HO-IM 411.1, HH-445, A3-3610.8, HO-415.11

Adjustment bills are the most common mechanism for changing a previously accepted bill. They are required to reflect the results of QIO medical review. Adjustments may also be requested by CMS via CWF if it discovers that bills have been accepted and posted in error other than the omission of a charge. Adjustments may be initiated as a result of OIG and MSP requests. The FI will ask the provider to submit an adjustment request for certain situations.

For hard copy Form CMS-1450 adjustment requests, the provider places the ICN/DCN of the original bill in FL 37 for Payer A, B, or C. For EMC bills in CMS national UB-92 format (version 060), the provider must submit the ICN/DCN of the original bill in Record Type 31, positions 155-177.

Where payment is handled through the cost reporting and settlement processes, the provider accumulates a log for those items not requiring an adjustment bill. For cost settlement, the FI pays on the basis of the log. This log must include:

- Patient name;
- HICN;
- Dates of admission and discharge, or from and thru dates;
- Adjustment in charges (broken out by ancillary or routine service); and
- Any unique numbering or filing code necessary for the hospital to associate the adjustment charge with the original billing.

NOTE: Providers in Maryland, which are not paid under PPS or cost reports, submit an adjustment bill for inpatient care of $500 or more, and keep a log as described above for lesser amounts. Because there are no adjustment bills, the FI enters the payment amounts from the summary log into the PPS waiver simulation and annually pays the items on the log after the cost report is filed.

An original bill does not have to be accepted by CMS prior to making related adjustments to the provider. However, for all adjustments other than QIO adjustments (e.g., provider submitted and/or those the FI initiates), the FI submits an adjustment bill to CWF following it's acceptance of the initial bill. To verify CMS' acceptance, it take ones or both of the following actions:

A - General Rules for Submitting Adjustment Requests

Adjustment requests that only recoup or cancel a prior payment are "credits" and must match the original in the following fields:

- intermediary control number (ICN/DCN);
- Surname;
- HICN;

When a definite match cannot be made on the 3 fields above, the provider's FI will use the fields below as needed. Note that for older claims, ICN/DCN probably will not match.

- Date of birth;
- Admission date (Start of Care Date for Home Health), unless changed by this adjustment requests; and
- From/thru dates (Date of First Visit/Date of Last Visit for Home Health), unless changed by this adjustment request.

Cancel-only adjustment requests must be submitted only in cases of incorrect provider identification numbers and incorrect HICNs. After the cancel-only request for the incorrect bill is resolved, the provider must submit correct information as a new bill.

The provider must submit all other adjustment requests as debits only. It shows the ICN/DCN of the bill to be adjusted as described above, with the bill type shown as XX7. It submits adjustment requests to its FI either electronically or on hard copy. Electronic submission is preferred.

The FI must enter the following bill types that relate to the entity generating the adjustment request:

XX7	Provider (debit)
XX8	Provider (cancel)
XXF	Beneficiary
XXG	CWF
XXH	CMS
XXI	FI
XXM	MSP
XXP	QIO/QIO
XXJ	Other
XXK	OIG

The provider submits adjustment requests as bill type XX7 or XX8. Since several different sources can initiate an adjustment for MSP purposes, the FI will change the bill type to XXM, which takes priority over any other source of an adjustment except OIG. These priorities refer only to the designation of the source of the adjustment. The difference between CWF generating the adjustment request and CMS generating the request is:

An adjustment is CWF-generated if the FI receives a CWF alert or an CMS-L1002.

The FI prepares an adjustment if instructed by CMS CO or CMS RO to make a change. Typically, the FI receives such direction from CMS when it decides to retroactively change payment for a class or other group of bills. Occasionally, CMS will discover an error in the processing of a single bill and direct the FI to correct it.

If the FI furnished the Part B carrier a copy of the original bill which is being adjusted, it must furnish them a copy of the adjusted bill.

If adjustment bills are rejected by CWF for additional corrections, they need to be corrected and resubmitted. Even if the adjustment action is requested by letter from CMS, the FI must submit the adjustment bill in its CWF record. If a rejected adjustment bill is determined to be unnecessary, the FI stops the adjustment action upon receipt of correction.

Where an adjustment bill changes subsequent utilization, the FI notes this and processes adjustments to subsequent bills if it services the provider.

If the FI does not service the provider, CMS will contact the FIs, which submitted bills with subsequent billing dates that are affected by the adjustments via an SSA-L389 or SSA-L1001 upon receipt of the adjusted bills in CWF. (An indicator is set by CMS on its records upon advising an FI of the appropriate adjustment actions.)

B - Adjustment Bills Involving Time Limitation for Filing Claims

If a provider fails to include a particular item or service on its initial bill, an adjustment bill(s) to include such an item(s) or service(s) is not permitted after the expiration of the time limitation for filing a claim. However, to the extent that an adjustment bill otherwise corrects or supplements information previously submitted on a timely claim about specified services or items furnished to a specified individual, it is subject to the rules governing administrative finality, rather than the time limitation for filing.

Under prospective payment, adjustment requests are required from the hospital where errors occur in diagnoses and procedure coding that change the DRG, or where the deductible or utilization is affected. A hospital is allowed 60 days from the date of the FI payment notice for adjustment bills where diagnostic or procedure coding was in error. Adjustments reported by the QIO have no corresponding time limit and are adjusted automatically by the FI without requiring the hospital to submit an adjustment bill. However, if diagnostic and procedure coding errors have no effect on the DRG, adjustment bills are not required.

Under PPS, for long-stay cases, hospitals may bill 60 days after an admission and every 60 days thereafter if they choose. The FI processes the initial bill through Grouper and Pricer. The provider must submit an adjustment to cancel the original interim bill(s) and rebill the stay from the admission date through the discharge date. When the adjustment bill is received, it processes it as an adjustment. In this case, the 60-day requirement for correction does not apply.

Where payment is handled through cost reporting and settlement processes, the provider accumulates a log for those items not requiring an adjustment bill. Maryland inpatient hospital providers also keep a log of late charges when the amount is under $500. They submit the log with their cost reports. After cost reports are filed, the FI makes a lump sum payment to cover these charges as shown on the summary log. The provider uses the summary log for late charges only under cost settlement (outpatient hospital), except in Maryland.

Maryland and cost providers are required to meet the 27-month timeframe for timely filing of claims, including late charges.

NOTE: Providers in Maryland which are not paid under PPS or cost reports, submit an adjustment bill for inpatient care of $500 or more, and submit a log for the lesser amounts.

50.1 - Tolerance Guidelines for Submitting Adjustment Requests

(Rev. 1, 10-01-03)

A3-3664.1.A

When a bill is submitted and the hospital or the FI discovers an error, the hospital submits an adjustment request using the Form CMS-1450, if the error is a change in the:

- Number of inpatient days (including a change in the length of stay, or a different allocation of covered/non-covered days;
- Blood deductible;
- Inpatient cash deductible of more than $1;
- Servicing provider;
- Discharge status in a PPS hospital;
- Diagnosis or Procedures that impact the assigned DRG code; or
- Outlier payment amount.

The provider submits most adjustment requests as debits, using bill type XX8.

Also, it submits a debit-only adjustment request to the FI if the hospital previously submitted an interim bill for a PPS hospital stay or wishes to change the number of days in any inpatient stay.

The FI then submits the adjustment to CWF. An adjustment from the QIO for any of the above also requires a submission to CMS via CWF.

If PPS is involved and the DRG has been changed as a result of medical review after an original bill has been forwarded to CMS, adjustment debit/credit bills are required. The corrected bill must be an exact duplicate of the original, except for any changed fields including diagnostic and procedure codes.

50.2 - Claim Change Reasons

(Rev. 1, 10-01-03)

HO-411.2, HO-IM411.2, HH-445

A - Claim Change Reason Codes

The provider submits one of the following claim change reason codes to its FI with each debit-only or cancel-only adjustment request:

Bill Type	Reason Code	Explanation
XX7	D0 (zero)	Change to service dates
XX7	D1	Change in charges
XX7	D2	Change in revenue codes/HCPCS
XX7	D3	Second or subsequent interim PPS bill - inpatient only
XX7	D4	Change in GROUPER input (diagnoses or procedures) - inpatient only
XX8	D5	Cancel-only to correct a HICN or provider identification number
XX8	D6	Cancel-only to repay a duplicate payment or OIG overpayment (includes cancellation of an outpatient bill containing services required to be included on the inpatient bill.)
XX7	D7	Change to make Medicare the secondary payer
XX7	D8	Change to make Medicare the primary payer
XX7	D9	Any other change
XX7	E0 (zero)	Change in patient status

The provider may not submit more than one claim change reason code per adjustment request. It must choose the single reason that best describes the adjustment it is requesting. It should use claim change reason code D1 only when the charges are the only change on the claim. Other claim change reasons frequently change charges, but the provider may not "add" reason code D1 when this occurs.

The claim change reason code is entered as a condition code on the hard copy Form CMS-1450. For electronic CMS-1450, enter the claim change reason code as a condition code on record type 41 in fields 4-13. For reason codes D0-D4 and D7-D9, submit a debit-only adjustment request, bill type XX7. For reason codes D5 and D6, submit a cancel-only adjustment request, bill type XX8.

B - Edits on Claim Change Reason Codes

The following edits are based on the claim change reason code. The FI must apply them to each incoming adjustment request.

If the type of bill is equal to XX7 and the claim change reason code is not equal to D0-D4, D7-D9, or E0, the FI rejects the request back to the provider with the following error message, "Claim change reason code must be present and equal to D0-D4, D7-D9, or E0 for a debit-only adjustment request."

- If the type of bill is equal to XX8 and the claim change reason code is not equal to D5-D6, the FI rejects the request back to the provider with the following error message, "Claim change reason code must be present and equal to D5-D6 for a cancel-only adjustment request."

- If the type of bill is equal to XX7 or XX8 and the ICN/DCN of the claim being adjusted is not present, the FI rejects the request back to the provider with the following message, "ICN/DCN of the claim being adjusted is required for an adjustment request."

- If more than one claim change reason code is present on the provider's request, the FI rejects the request back to the provider with the following message, "only one claim change reason code may apply to a single adjustment request from a provider. Choose the single claim change reason code that best describes the reason for the provider's request and resubmit."

- If the provider submits an adjustment request as type of bill not equal to XX7 or XX8, the FI rejects the request back to the provider with the message, "Provider submitted adjustment request must use type of bill equal to XX7 or XX8."

- If the claim change reason code is equal to D0, the FI compares the beginning and ending dates on the provider's request to those on the claim to be adjusted on its history. If these dates are the same, it rejects the request back to the provider with the message, "Dates of service must change for claim change reason code D0."

- If the claim change reason code is equal to D1, the FI compares the total and line item charges on the provider's request to those on the claim to be adjusted on its history. If these changes are the same, the FI rejects the request back to the provider with the message, "Charges must be changed for claim change reason code D1."

- If the claim change reason code is equal to D2, the FI compares revenue codes/HCPCS on the provider's request to those on the claim to be adjusted on its history. If these codes are the same, it rejects the request back to the provider with the message, "Revenue codes/HCPCS must change for claim change reason code D2."

- If the claim change reason code is equal to D3, the FI compares the ending date on the provider's request to that on the claim to be adjusted on its history. If these dates are the same, it rejects the request back to the provider with the message, "Thru dates must change for the claim change reason code D3."

- If the claim change reason code is equal to D4, the FI compares diagnosis and procedure codes on the provider's request to those on the claim to be adjusted on its history. If these codes are the same and are in the same sequence, it rejects the request back to the provider with the message, "Diagnoses and/or procedures must change for claim change reason code D4."

- If the claim change reason code is equal to D5 or D6, type of bill must be equal to XX8 on the provider's request. If type of bill is not equal to XX8, the FI rejects the request back to the provider with the message, "Type of bill must be equal to XX8 for claim change reason codes D5 or D6."

- If the claim change reason code is equal to D7, an MSP value code (12-16, 41-43, or 47) must be present, if a value code, 12-16, 41-43, or 47, is not present, the FI rejects the request back to the provider with the message, "An MSP value code (12-16, 41-43, or 47) must be present for claim change reason code D7."

- If the claim change reason code is equal to D7, and one or more of value codes 12-16, 41-43, and/or 47 is present but each value amount is equal to 0 (zero) or spaces, the FI rejects the request back to the provider with the message, "invalid value amount for claim change reason code D7."

- If the claim change reason code is equal to D8, and a value code 12-16, 41-43, or 47 is present, the FI rejects the claim back to the provider with the message, "Invalid value code for claim change reason D8."

- If the claim change reason code is equal to E0, the FI compares patient status on the provider's request to that on the claim to be adjusted. If patient status is the same, the FI rejects the request back to the provider with the message, "Patient status must change for claim change reason E0."

If an adjustment the provider initiates results in a change to a higher weighted DRG, the FI edits the adjustment request to insure it was submitted within 60 days of the date of the remittance for the claim to be adjusted. If it is, the FI processes the claim for payment. If the remittance date is more than 60 days prior to the receipt date of the adjustment request and results in a change to a lower weighted DRG, the FI processes the claim for payment and forwards it to CWF.

The FI must suspend for investigation all adjustment requests with claim change reason codes D4, D8, and D9. Providers that consistently use D9 will be investigated and, if a pattern of abuse is evident, may be reported to the OIG.

C - Additional edits

The FI must perform the following additional edits and investigate adjustment requests the provider submits:

- A full denial once the bill is paid, except to accomplish retraction of a duplicate payment;
- A change in DRG based on a change in age or sex;
- A change in deductible;
- An adjustment request that changes a previously submitted QIO adjustment request;
- An adjustment of a bill due to a change in utilization or spell data on another bill;
- A reopening to change a no-payment bill to a payment bill;
- A reopening to pay a previously denied line item;
- An adjustment request the provider initiates with a claim change reason code equal to D7, with the Medicare payment amount equal to or greater that the previously paid amount; or
- An adjustment request with a claim change reason code equal to E0, and the claim is for a PPS provider. The FI must investigate if the change is from patient status 02, transferred to another acute care facility.

50.3 - Late Charges

(Rev. 1, 10-01-03)

HO-411.3, HO-IM411.3

Providers billing under Inpatient Hospital PPS, Outpatient PPS, SNF PPS, or HHA PPS may not bill late charges, nor will the contractor accept such bills, for any type of PPS service, inpatient or outpatient. Charges omitted from the original bill must be submitted on an adjustment bill that contains all pertinent charges including those billed earlier. When the provider submits late charges on bills to the FI as bill type XX5, these bills contain only additional charges. Adjustment requests and not late charge bills should be submitted for

- Services on the same day as outpatient surgery subject to the ASC limit,

- ESRD services paid under the composite rate,
- All inpatient accommodation charges, and
- All inpatient PPS ancillaries as adjustment requests.

The provider may submit the following charges omitted from the original paid bill to the FI as late charges:

- Any outpatient services other than the exceptions stated in this paragraph. This includes late charges for HHA services under either Part A or Part B, hospice services, hospital outpatient services except those on the day of ambulatory surgery subject to the ASC payment limitation, RHC services, OPT services, SNF outpatient services, CORF services, FQHC services, CHMC services, and ESRD services not included in the composite rate; and
- Any inpatient SNF ancillaries or inpatient hospital ancillaries other than from PPS hospitals. The hospital may not submit late charges (XX5) for inpatient accommodations. The hospital must submit these as adjustments (bill type XX7).

The FI has the capability to accept XX5 bill types electronically and process them as initial bills except as described in the following paragraph.

The FI also performs the following edit routines on any XX5 type bills received:

- Pass all initial bill edits, including duplicate checks.
- Must not be for any of: Inpatient PPS ancillaries, inpatient accommodations in any facility, services on the same day as outpatient surgery subject to the ASC payment limitation, or ESRD services included in the composite rate. These are rejected back to the hospital with the message, "This change requires an XX7 debit-only or XX8 cancel-only request from you. Late charges are not acceptable for inpatient PPS ancillaries, inpatient accommodations in any facility, services on the same day as outpatient surgery subject to the ASC payment limitation, or ESRD services included in the composite rate."
- When an XX5 suspends as a duplicate, (dates of service equal or overlapping, provider ID equal, HICNs equal, and patient surname equal), the FI must determine the status of the original paid bill. If it is denied, the FI must deny the late charge bill.
- If an xx5 does not suspend as a potential duplicate, the FI rejects it back to the provider with the message, "No original bill paid. Please combine and submit a single original bill (XX1)."
- If the original bill was approved and paid, the FI compares the revenue codes on the original paid bill with the associated late charge bill:

- For all providers (any bill type), if any are the same, and are revenue codes 041x, 042x, 043x, 044x, 063x, 076x, or 091x, the FI rejects the bill back to the provider with the message, “You must submit an adjustment (7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill.”

- For HHAs (bill type 32X, 33X, or 34X), the FI must apply the same logic for the following additional revenue codes. If any are the same and are revenue codes 0291, 0293, 055x, 056x, 057x, 058x, 059x, 060x, 066x, the FI rejects the bill back to the provider with the message, "You must submit an adjustment (xx7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill."

- For hospital outpatient services (bill type 13X only), the FI must apply the same logic for the following additional revenue codes. If any are the same and are revenue codes 0255, 032x, 033x, 034x, 035x, 040x, 062x, 073x, 074x, 092x, or 0943, the FI rejects the bill back to the hospital with the message, "You must submit an adjustment (xx7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill."

- For RDFs (bill type 72X or 73X), the FI must apply the same logic for the following additional revenue codes; if any are the same and are revenue codes 0634, 0635, 082x, 083x, 084x, 085x, or 088x, the FI rejects the bill back to the provider with the message, “You must submit an adjustment (XX7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill.”

- If the late charges bill relates to two or more "original" paid bills, and one of these is denied, the FI must suspend and investigate the late charge bill.

- The FI must compare total charges on the original paid bill with those on the associated late charge bill, and suspend and investigate any XX5 bill type with total charges in excess of those on the original paid bill. This edit suggests the provider may have rebilled the already paid services.

The FI may decide to perform additional edits on late charge bills.

60 - Swing-Bed Services

(Rev. 1, 10-01-03)

A3-3634, HO-421

Swing-bed services require the provider to bill inpatient hospital services and SNF services separately. The provider must meet the 3-day hospital stay requirement and the timely transfer requirement. (See the Medicare Benefit Policy Manual, Chapter 8.)

Swing-bed hospitals use their regular provider numbers when billing for hospital services and an alpha letter in the third position of their provider numbers to identify hospital swing-bed SNF bills. The following alpha letters identify hospital swing-bed SNF bills:

- "U" = short-term/acute care hospital swing-bed;
- "W" = long-term hospital swing-bed; and
- "Y" = rehabilitation hospital swing-bed.

A - Inpatient Hospital Services in a Swing-Bed

Where there is no change to a SNF level of care, hospitals bill services in accordance with hospital billing instructions. Where the beneficiary's level of care changes from hospital to SNF level, the provider shows patient status code 03 on the hospital bill in FL 22 to indicate transfer to a SNF level of care. (This constitutes a discharge for purposes of Medicare payment for inpatient hospital services under PPS.) The FI indicates in FL 6 the last day of care at the hospital level.

B - SNF Services in a Swing-Bed

Services are billed, in accordance with Chapter 25 with the following exceptions:

- The date of admission on the swing-bed SNF bill is the date the patient began to receive SNF level of care services;
- State level agreements may call for varying types of bill coding in FL 4. CMS does not perform edits on type of bill coding on bills with 8 in the 2nd digit (bill classification), in FL 18 of the CWF inpatient record if the record is identified in FL 1 as hospital or SNF. Therefore, the FI accepts, with subsequent conversion, any bill type agreed to at the State level to identify swing-bed billing, e.g., 18X, 28X, 11X, 21. It must be sure the record identification of CWF FL 1 is consistent with the provider number shown; and
- If the hospital has 50-99 beds, the following additional processing rules apply:
    - The hospital may not be paid for more than the number of capped days for swing bed stays. See subsection C for determining the limitation.
    - When the hospital is notified that a SNF bed is available, the hospital is not paid for services furnished after the 5-day transfer period (excluding weekends and holidays). This rule does not apply if the patient's physician certified within the 5-day period that a transfer to a SNF was not medically necessary.
    - If the physician certified the transfer, occurrence code 26 must be shown. This code identifies the date a SNF bed became available on or after the date the patient was healthy enough for transfer.

The FI is responsible for review to ensure that the provider has considered availability of a SNF bed and obtained appropriate certification. The FI assumes that payment is appropriate on initial bills and is subject to the cap limitation. The QIO may later deny the bill and notify the FI.

See the Medicare Benefit Policy Manual, Chapter 8 for additional coverage policy information.

C - Application of Capped Amount (50-99) Bed Provider

Payment is limited to swing bed providers of 50 - 99 beds. The cap is determined by multiplying .15 times the product of the number of days in the cost reporting period and the average number of licensed beds at the hospital for the period. From its State licensing agency, the FI determines the number of licensed beds at the beginning of a cost reporting period or from the date of the swing-bed approval, if later.

In States that do not license beds, hospitals use the total number of hospital beds reported on their most recent Certificate of Need (CON) (excluding bassinets). If during the cost reporting period there is an increase or decrease in the number of licensed beds, the FI multiplies the number of licensed beds for each part of the period by the number of days for which that number of licensed beds was available. After totaling the results, it computes 15 percent of the total available licensed bed days to determine the payment limitation.

The FI maintains a record for each swing-bed provider of 50-99 beds. This record must contain the following information:

- The number of days that may be paid under the cap;
- The SNF days paid for the period (or the days remaining if the FI prefers); and
- The date the cap is met (not the date the FI records it).

The FI notifies the hospital if a beneficiary's extended care stay cannot be covered because the cap has been reached. In such a case, the law prohibits payment under Part A. However, payment may be made under Part B for certain medical and other health services. (See Chapter 1.)

On each bill from a provider with 50-99 beds, the FI determines whether the provider had already met the cap limit before the date of admission to the SNF level of care. If an admission occurs prior to the date the capped days are exhausted, the entire stay is paid (if otherwise covered) even though the cap is met during the stay.

70 - All-Inclusive Rate Providers

(Rev. 1, 10-01-03)

A3-3660.4

70.1 - Providers Using All-Inclusive Rates for Inpatient Part A Charges

(Rev. 1, 10-01-03)

A3-3660.4

Some providers have been approved to bill a flat fee charge for inpatient services based on either a daily basis or total stay basis for services furnished. This is an "All-Inclusive Rate." These charges may cover room and board, including ancillary services, or room and board only. These instructions explain the essential data entries that must be made on the Form CMS-1450 by providers that use all-inclusive rates as charges. All-inclusive rate providers are identified by one of the following charge structures:

- One total all-inclusive charge rate for both accommodations and ancillary services, including the cost of blood in the rate;
- One total all-inclusive charge rate for both accommodations and ancillary services, not including the cost of blood in the rate;
- One all-inclusive charge rate for accommodations and another for ancillary services, including the cost of blood in the all-inclusive rate; or
- One all-inclusive charge rate for accommodations and another for ancillary services, not including the cost of blood in the all-inclusive rate.

Providers follow these special instructions for completing FLs 42-48 of the billing form.

A - Accommodations

Revenue Codes - Codes that identify the accommodations furnished, ancillary services provided or billing calculation are entered in FL 42. The code indicates whether the rate includes charges for ancillary services or only room and board.

> If the patient was furnished more than one type of accommodation, the lines for each type of accommodation are completed. This is necessary whether or not the provider charges an all-inclusive rate according to accommodations.
>
> Where the all-inclusive rate varies with the type of accommodation, FL 84 (Remarks) is annotated for a five-or-more bed accommodation showing the reason for the accommodation.

Unit of Service - A quantitative measure for services furnished, by revenue category, to or for the patient which includes items such as the number of accommodation days, pints of blood, or renal dialysis treatments, is entered in FL 46.

Total Charges - The total charges pertaining to the related revenue code for the current billing period is entered in FL 47.

Noncovered Charges - The total non-covered charges pertaining to the related revenue code for the current billing period is entered in FL 48.

B - Ancillary Services

One All-Inclusive Charge Rate - Hospitals with one all-inclusive charge rate, including ancillary services, are reflected in the revenue code in FL 42. The total charge in FL 47 reflects the charge for both accommodations and ancillary services.

Separate Ancillary All-Inclusive Rate - Some providers segregate charges for ancillary services for billing purposes. Where a separate flat rate charge for ancillary services is incurred either on a daily or total stay basis, the provider enters separate codes in FLs 42-46 for the services. These codes indicate whether the total charge includes only ancillary cost or includes other costs (i.e., blood).

If applicable, the following additional billing instructions are applied:

Blood

Whenever whole blood is furnished the patient, FLs 39-41 are completed. If the all-inclusive rate does not include the charge for whole blood or packed cells, FL 42-46 are completed in the same way a provider not using all-inclusive rates would complete them. When the provider discounts its customary charges for unreplaced blood to which the deductible is applicable, it shows the charges before the discount.

If the all-inclusive rate covers the cost of providing blood whenever a patient needs it, the number of pints furnished, replaced, not replaced, and the estimated cost per pint is entered in FLs 39-41. No amount can be shown in the Total Charges column since the rate includes the cost of blood. It is not necessary to show the cost for any replaced blood.

All-Inclusive Charges According to Disease, Injury, or Type of Treatment

Providers that have a charge system based on the patient's illness or injury or type of treatment complete the line(s) for type of accommodation furnished showing number of days, rate, and total charges. The rate amount and total amounts must be the same. Blood entries are indicated as above.

Physician's Component

As with providers having a schedule of charges for individual services, the amount of any physician's component included in the all-inclusive charge is removed from the total covered charges before applying the inpatient deductible or coinsurance.

Combined Billing

CMS does not encourage the all-inclusive rate provider to combine bill. However, if it does, it must develop the capability and indicate in FL 84, Remarks, the number and type of each service it is combined billing. To identify such cases, the remark "Combined Billing" must be written in FL 84, Remarks.

NOTE: Combined billing was eliminated with Outpatient PPS

80 - Hospitals That Do Not Charge

(Rev. 1, 10-01-03)

A3-3660.5

Participating hospitals that do not charge individuals and also meet the exceptions to the law that normally exclude payment for expenses paid for directly or indirectly by a governmental entity, may be reimbursed the reasonable cost of furnishing covered services to Medicare beneficiaries. The following special procedures apply to their bills.

- Part A Services

Computing Medicare Billing Rate

The Medicare billing rate per day is determined by the following equation:

Total allowable inpatient cost = cost per day per patient

Total inpatient days

Thus, the billing rate that appears is the average inpatient cost per day per inpatient as calculated from entries on the latest cost settlement report approved by Medicare. Where this is the provider's first year in the program, the FI determines this rate based on the provider's books and records the appropriate billing rate for services rendered to Medicare beneficiaries.

Computing Medicare Billing Rate (Inpatient)

The Medicare billing rate is determined in the following manner:

Total available inpatient cost = Cost per day per patient

Total inpatient days

The FI multiplies the cost per day per patient by 93 percent for short-term hospitals and by 98 percent for long-term hospitals. (See §2208.lE of the Provider Reimbursement Manual, Part I, for definitions of "short-term" and "long-term" hospitals.) Then it applies the following fixed percentages. The result is the Medicare billing rate.

Computing Medicare Billing Rate (Outpatient)

The Medicare billing rate is determined by the following equation:

Total allowable outpatient cost = average cost per visit

Total visits (occasions of service)

Thus, the billing rate is the average cost per outpatient visit as calculated from entries on the latest cost settlement report approved by Medicare. Where this is the provider's first year in the program, the FI determines this rate based on the provider's books and records the appropriate billing rate for services rendered to Medicare beneficiaries.

80.1 - Medicare Summary Notice (MSN) for Services in Hospitals That Do Not Charge

(Rev. 1, 10-01-03)

A3-3660.5.A

Where the hospital does not charge for outpatient services, the FI does not send the individual an MSN. This avoids confusion and the appearance that the beneficiary is liable for services received.

90 - Billing Transplant Services

(Rev. 1, 10-01-03)

90.1 - Kidney Transplant - General

(Rev. 1, 10-01-03)

A3-3612, HO-E414

A major treatment for patients with ESRD is kidney transplantation. This involves removing a kidney, usually from a living relative of the patient or from an unrelated person who has died, and surgically placing the kidney into the patient. After the beneficiary receives a kidney transplant, Medicare pays the transplant hospital for the transplant and appropriate standard acquisition charges. Special provisions apply to payment.

A transplant hospital may acquire cadaver kidneys by:

- Excising kidneys from cadavers in its own hospital; and
- Arrangements with a freestanding organ procurement organization that provides cadaver kidneys to any transplant hospital.

A transplant hospital that is also a certified organ procurement organization may acquire cadaver kidneys by:

- Having its organ procurement team excise kidneys from cadavers in other hospitals;
- Arrangements with participating community hospitals, whether they excise kidneys on a regular or irregular basis; and
- Arrangements with an organ procurement organization that services the transplant hospital as a member of a network.

When the transplant hospital also excises the cadaver kidney, the cost of the procedure is included in its kidney acquisition costs and is considered in arriving at its standard cadaver kidney acquisition charge. When the transplant hospital excises a kidney to provide another hospital, it may use its standard cadaver kidney acquisition charge or its standard detailed departmental charges to bill that hospital.

When the excising hospital is not a transplant hospital, it bills its customary charges for services used in excising the cadaver kidney to the transplant hospital or organ procurement agency.

If the transplanting hospital's organ procurement team excises the cadaver kidney at another hospital, the cost of operating such a team is included in the transplanting hospital's kidney acquisition costs, along with the reasonable charges billed by the other hospital of its services.

90.1.1 - The Standard Kidney Acquisition Charge

(Rev. 1, 10-01-03)

A3-3612.1, A3-3612.3, HO-E417, HO-406, HO-E408, HO-E410, HO-E412, HO-E416, HO-E418, HO-E420

There are two basic standard charges that must be developed by transplant hospitals from costs expected to be incurred in the acquisition of kidneys:

- The standard charge for acquiring a live donor kidney; and
- The standard charge for acquiring a cadaver kidney.

The standard charge is not a charge representing the acquisition cost of a specific kidney; rather, it is a charge that reflects the average cost associated with each type of kidney acquisition.

When the transplant hospital bills the program for the transplant, it shows its standard kidney acquisition charge on a separate line on the billing form.

Acquisition services are billed from the excising hospital to the transplant hospital. A billing form is not submitted from the excising hospital to the FI. The transplant hospital keeps an itemized statement that identifies the services furnished, the charges, the person receiving the service (donor/recipient), and whether this is a potential transplant donor or recipient. These charges are reflected in the transplant hospital's kidney acquisition cost center and are used in determining the hospital's standard charge for acquiring a live donor's kidney or a cadaver's kidney. The standard charge is not a charge representing the acquisition cost of a specific kidney. Rather, it is a charge that reflects the average cost associated with each type of kidney acquisition. Also, it is an all-inclusive charge for all services required in acquisition of a kidney, i.e., tissue typing, post-operative evaluation, etc.

A - Billing For Blood And Tissue Typing of the Transplant Recipient Whether or Not Medicare Entitlement Is Established

Tissue typing and pre-transplant evaluation can be reflected only through the kidney acquisition charge of the hospital where the transplant will take place. The transplant hospital includes in its kidney acquisition cost center the reasonable charges it pays to the independent laboratory or other hospital which typed the potential transplant recipient, either before or after his entitlement. It also includes reasonable charges paid for physician tissue typing services, applicable to live donors and recipients (during the pre-entitlement period and after entitlement, but prior to hospital admission for transplantation).

B - Billing for Blood and Tissue Typing and Other Pre-Transplant Evaluation of Live Donors

The entitlement date of the beneficiary who will receive the transplant is not a consideration in reimbursing for the services to donors, since no bill is submitted directly to Medicare. All charges for services to donors prior to admission into the hospital for excision are "billed" indirectly to Medicare through the live donor acquisition charge of transplanting hospitals.

C - Billing Donor And Recipient Pre-Transplant Services (Performed by Transplant Hospitals or Other Providers) to the Kidney Acquisition Cost Center

The transplant hospital prepares an itemized statement of the services rendered for submittal to its cost accounting department. Regular Medicare billing forms are not necessary for this purpose, since no bills are submitted to the FI at this point.

The itemized statement should contain information that identifies the person receiving the service (donor/recipient), the health care insurance number, the service rendered and the charge for the service, as well as a statement as to whether this is a potential transplant donor or recipient. If it is a potential donor, the provider must identify the prospective recipient.

EXAMPLE

Mary Jones
Health care insurance number
200 Adams St.
Anywhere, MS

Transplant donor evaluation services for recipient:

John Jones
Health care insurance number
200 Adams St.
Anywhere, MS

Services performed in a hospital other than the potential transplant hospital or by an independent laboratory are billed by that facility to the potential transplant hospital. This holds true regardless of where in the United States the service is performed. For example, if the donor services are performed in a Florida hospital and the transplant is to take place in a California hospital, the Florida hospital bills the California hospital (as described in above). The Florida hospital is paid by the California hospital which recoups the monies through the kidney acquisition cost center.

D - Billing for Cadaveric Donor Services

Normally, various tests are performed to determine the type and suitability of a cadaver kidney. Such tests may be performed by the excising hospital (which may also be a transplant hospital) or an independent laboratory. When the excising-only hospital performs the tests, it includes the related charges on its bill to the transplant hospital or to the organ procurement agency.

When the tests are performed by the transplant hospital, it uses the related costs in establishing the standard charge for acquiring the cadaver kidney. The transplant hospital includes the costs and charges in the appropriate departments for final cost settlement purposes.

When the tests are performed by an independent laboratory for the excising-only hospital or the transplant hospital, the laboratory bills the hospital that engages its services or the organ procurement agency. The excising-only hospital includes such charges in its charges to the transplant hospital, which then includes the charges in developing its standard charge for acquiring the cadaver kidney. It is the transplant hospitals' responsibility to assure that the independent laboratory does not bill both hospitals.

The cost of these services cannot be billed directly to the program, since such tests and other procedures performed on a cadaver are not identifiable to a specific patient.

E - Billing For Physicians' Services Prior to Transplantation

Physicians' services applicable to kidney excisions involving live donors and recipients (during the pre-entitlement period and after entitlement, but prior to entrance into the hospital for transplantation) as well as all physicians' services applicable to cadavers are considered Part A hospital services (kidney acquisition costs).

F - Billing for Physicians' Services After Transplantation

All physicians' services rendered to the living donor and all physicians' services rendered to the transplant recipient are billed to the Medicare program in the same manner as all Medicare Part B services are billed. All donor physicians' services must be billed to the account of the recipient (i.e., the recipient's Medicare number).

G - Billing For Physicians' Renal Transplantation Services

To ensure proper payment when submitting a Part B bill for the renal surgeon's services to the recipient, the appropriate HCPCS codes must be submitted, including HCPCS codes for concurrent surgery, as applicable.

The bill must include all living donor physicians' services, e.g. Revenue Center code 081X.

90.1.2 - Billing for Kidney Transplant and Acquisition Services

(Rev. 1, 10-01-03)

A3-3612.2

Applicable standard kidney acquisition charges are identified separately in FL 42 by revenue code 0811 (Living Donor Kidney Acquisition) or 0812 (Cadaver Donor Kidney Acquisition). Where interim bills are submitted, the standard acquisition charge appears on the billing form for the period during which the transplant took place. This charge is in addition to the hospital's charges for services rendered directly to the Medicare recipient.

The FI deducts kidney acquisition charges for PPS hospitals for processing through Pricer. These costs, incurred by approved kidney transplant hospitals, are not included in the prospective payment DRG 302 (kidney transplant). They are paid on a reasonable cost basis. Interim payment is paid as a "pass through" item. (See the Provider Reimbursement Manual, Part 1, §2802 B.8.) The FI includes kidney acquisition charges under the appropriate revenue code in CWF.

90.2 - Heart Transplants

(Rev.10, 10-17-03)

A3-3613, HO-416

Cardiac transplantation is covered under Medicare when performed in a facility which is approved by Medicare as meeting institutional coverage criteria. On April 6, 1987, CMS Ruling 87-1, "Criteria for Medicare Coverage of Heart Transplants" was published in the "Federal Register." For Medicare coverage purposes, heart transplants are medically reasonable and necessary when performed in facilities that meet these criteria. If a hospital wishes to bill Medicare for heart transplants, it must submit an application and documentation, showing its ongoing compliance with each criterion.

The facility mails the application to the address below in a manner which provides it with documentation that it was received, e.g., return receipt requested.

Director
Division of Integrated Delivery Systems
Centers for Medicare & Medicaid Services
Mailstop C4-25-02
7500 Security Blvd.
Baltimore, MD 21244-1850

If an FI has any questions concerning the effective or approval dates of its hospitals, it should contact its RO.

For a complete list of transplant centers, please visit http://www.cms.hhs.gov/providers/transplant/hartlist.asp.

A - Effective Dates

The effective date of coverage for heart transplants performed at facilities applying after July 6, 1987, is the date the facility receives approval as a heart transplant facility. Coverage is effective for discharges October 17, 1986 for facilities that would have qualified and that applied by July 6, 1987.

CMS informs each hospital of its effective date in an approval letter.

B - Drugs

Medicare Part B covers immunosuppressive drugs following a covered transplant in an approved facility.

C - Noncovered Transplants

Medicare will not cover transplants or re-transplants in facilities that have not been approved as meeting the facility criteria. If a beneficiary is admitted for and receives a

heart transplant from a hospital that is not approved, physicians' services, and inpatient services associated with the transplantation procedure are not covered.

If a beneficiary received a heart transplant from a hospital while it was not an approved facility and later requires services as a result of the noncovered transplant, the services are covered when they are reasonable and necessary in all other respects.

D. Charges for Heart Acquisition Services

The excising hospital bills the transplant (implant) hospital for applicable services. It should not submit a bill to its FI. The transplant hospital must keep an itemized statement that identifies the services rendered, the charges, the person receiving the service (donor/recipient), and whether this person is a potential transplant donor or recipient. These charges are reflected in the transplant hospital's heart acquisition cost center and are used in determining its standard charge for acquiring a donor's heart. The standard charge is not a charge representing the acquisition cost of a specific heart; rather, it reflects the average cost associated with each type of heart acquisition. Also, it is an all inclusive charge for all services required in acquisition of a heart, i.e., tissue typing, post-operative evaluation, etc.

E. - Bill Review Procedures

The FI takes the following actions to process heart transplant bills. It may accomplish them manually or modify its MCE and Grouper interface programs to handle the processing.

1 - Change MCE Interface

The MCE creates a Limited Coverage edit for procedure code 37.51 (heart transplant). Where this procedure code is identified by MCE, the FI checks the provider number to determine if the provider is an approved transplant center, and checks the effective approval date. If payment is appropriate (i.e., the center is approved and the service is on or after the approval date) it overrides the limited coverage edit.

2 - Handling Heart Transplant Billings From Nonapproved Hospitals

Where a heart transplant and covered services are provided by a nonapproved hospital, the bill data processed through Grouper and Pricer must exclude transplant procedure codes and related charges.

90.2.1 - Artificial Hearts and Related Devices

Rev. 10, 10-17-03

Medicare does not cover the use of artificial hearts, either as a permanent replacement for a human heart or as a temporary life-support system until a human heart becomes available for transplant (often referred to a "bridge to transplant").

Medicare does cover a Ventricular Assist Device (VAD). A ventricular assist device (VAD) is used to assist a damaged or weakened heart in pumping blood. VADs are used as a bridge to a heart transplant, for support of blood circulation postcardiotomy or destination therapy. Please refer to the NCD Manual, section 20.9 for coverage criteria.

The MCE creates a Limited Coverage edit for procedure code 37.66. This procedure code has limited coverage due to the stringent conditions that must be met by hospitals. Where this procedure code is identified by MCE, the FI shall determine if coverage criteria is met and override the MCE if appropriate.

90.3 - Stem Cell Transplantation

(Rev. 1, 10-01-03)

A3-3614, HO-416.1

Stem cell transplantation is a process in which stem cells are harvested from either a patient's or donor's bone marrow or peripheral blood for intravenous infusion. The transplant can be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy (HDCT) and/or radiotherapy used to treat various malignancies. Allogeneic stem cell transplant may also be used to restore function in recipients having an inherited or acquired deficiency or defect.

Allogeneic and autologous stem cell transplants are covered under Medicare for specific diagnoses. Effective October 1, 1990, these cases were assigned to the DRG 481, Bone Marrow Transplant.

The FI's Medicare Code Editor (MCE) will edit stem cell transplant procedure codes against diagnosis codes to determine which cases meet specified coverage criteria. Cases with a diagnosis code for a covered condition will pass (as covered) the MCE noncovered procedure edit. When a stem cell transplant case is selected for review based on the random selection of beneficiaries, the QIO will review the case on a post-payment basis to assure proper coverage decisions

Procedure code 41.00 (bone marrow transplant, not otherwise specified) will be classified as noncovered and the claim will be returned to the hospital for a more specific procedure code.

90.3.1 - Allogeneic Stem Cell Transplantation

(Rev. 1, 10-01-03)

A3-3614.1, HO-416.2, A3-3614.2, HO-416.3

A - General

Allogeneic stem cell transplantation (ICD-9-CM Procedure Codes 41.02, 41.03, 41.05, and 41.08, CPT-4 Code 38240) is a procedure in which a portion of a healthy donor's stem cells are obtained and prepared for intravenous infusion to restore normal hematopoietic function in recipients having an inherited or acquired hematopoietic deficiency or defect. See the National Coverage Determinations Manual for more information.

Expenses incurred by a donor are a covered benefit to the recipient/beneficiary but, except for physician services, are not paid separately. Services to the donor include physician services, hospital care in connection with screening the stem cell, and ordinary follow-up care.

B - Covered Conditions

1. Effective for services performed on or after August 1, 1978:

    - For the treatment of leukemia, leukemia in remission (ICD-9-CM codes 204.00 through 208.91), or aplastic anemia (ICD-9-CM codes 284.0 through 284.9) when it is reasonable and necessary; and

2. Effective for services performed on or after June 3, 1985:

    - For the treatment of severe combined immunodeficiency disease (SCID) (ICD-9-CM code 279.2), and for the treatment of Wiskott - Aldrich syndrome (ICD-9-CM 279.12).

C - Noncovered Conditions

3. Effective for services performed on or after May 24, 1996:

    - Allogeneic stem cell transplantation is not covered as treatment for multiple myeloma (ICD-9-CM codes 203.00 and 203.01).

NOTE: Coverage for conditions other than these specifically designated as covered or noncovered in this section or National Coverage Determination Manual are left to individual FI's discretion.

90.3.2 - Autologous Stem Cell Transplantation

(Rev. 1, 10-01-03)

A3-3614.2, HO-416.3

A - General

Autologous stem cell transplantation (ICD-9-CM procedure code 41.01, 41.04, 41.07, and 41.09 and CPT-4 code 38241) is a technique for restoring stem cells using the patient's own previously stored cells.

B - Covered Conditions

1. Effective for services performed on or after April 28, 1989:

    - Acute leukemia in remission (ICD-9-CM codes 204.01, lymphoid; 205.01, myeloid; 206.01, monocytic; 207.01, acute erythremia and erythroleukemia; and 208.01 unspecified cell type) patients who have a high probability of relapse and who have no human leucocyte antigens (HLA)-matched;

    - Resistant non-Hodgkin's lymphomas (ICD-9-CM codes 200.00-200.08, 200.10-200.18, 200.20-200.28, 200.80-200.88, 202.00-202.08, 202.80-202.88, and 202.90-202.98) or those presenting with poor prognostic features following an initial response;

    - Recurrent or refractory neuroblastoma (see ICD-9-CM Neoplasm by site, malignant); or

    - Advanced Hodgkin's disease (ICD-9-CM codes 201.00-201.98) patients who have failed conventional therapy and have no HLA-matched donor.

2. Effective for services performed on or after 10/01/00:

    - Multiple myeloma (ICD-9-CM code 203.00 and 238.6), for beneficiaries who have Durie-Salmon stage II or III newly diagnosed or responsive multiple myeloma and adequate cardiac, renal, pulmonary and hepatic functioning. Multiple rounds of autologous stem cell transplantation (known as tandem transplantation) will, however, remain non-covered.

    - Primary amyloidosis (ICD-9-CM code 277.3), for beneficiaries under the age of 64, coverage is at the FI's discretion.

C - Noncovered Conditions

Insufficient data exist to establish definite conclusions regarding the efficacy of autologous stem cell transplantation for the following conditions:

- Acute leukemia not in remission (ICD-9-CM codes 204.00, 205.00, 206.00, 207.00 and 208.00);
- Chronic granulocytic leukemia (ICD-9-CM codes 205.10 and 205.11);
- Solid tumors (other than neuroblastoma) (ICD-9-CM codes 140.0-199.1);
- Multiple myeloma (ICD-9-CM code 203.00 and 238.6), through 9/30/00
- Tandem transplantation (multiple rounds of autologous stem cell transplantation) for patients with multiple myeloma (ICD-9-CM code 203.00 and 238.6)
- Non-primary (AL) amyloidosis (ICD-9-CM code 277.3), effective 10/01/00; or
- Primary (AL) amyloidosis (ICD-9-CM code 277.3) for Medicare beneficiaries age 64 or older, effective 10/01/00.

NOTE: Coverage for conditions other than these specifically designated as covered or non-covered is left to the FI's discretion.

90.3.3 - Billing for Stem Cell Transplantation

(Rev. 1, 10-01-03)

A3-3614.2, A3-3614.3, HO-416.4

A - Billing for Acquisition Services

The hospital identifies stem cell acquisition charges separately in FL 42 of Form CMS-1450 by using revenue codes 0819 (Other Organ Acquisition) and/or 0891 (Other Donor Bank, Bone Marrow). The FI does not make separate payment for these acquisition charges, since they are included in the DRG payment.

For allogeneic stem cell transplants (procedure codes 41.02 or 41.03) where the hospital submits interim bills, the acquisition charge will appear on the billing form for the period during which the transplant took place. Since claims for stem cell transplants are paid using PPS, the hospital submits an adjustment bill whenever an interim bill has been processed. Charges will appear on the transplant bill if there are no interim bills involved.

The transplant hospital keeps an itemized statement that identifies the services furnished, the charges, the person receiving the service (donor/recipient), and whether this is a potential transplant donor or recipient. These charges will be reflected in the transplant hospital's stem cell/bone marrow acquisition cost center. Revenue codes 0819 and 0891 are to include all services required in acquisition of stem cell, e.g., tissue typing or post-operative evaluation.

For allogeneic stem cell transplants (procedure codes 41.02 and 41.03, 41.05, or 41.08), the hospital includes charges for acquisition and any applicable storage charges on the recipient's transplant bill. Acquisition charges do not apply to autologous stem cell acquisitions. On the transplant bill, the hospital reports the charges, cost report days, and utilization days for the stay in which the stem cell was obtained.

B - Billing for Allogeneic Stem Cell Transplants

The donor is covered for medically necessary inpatient hospital days of care in connection with the bone marrow transplant operation. Expenses incurred for complications are covered only if they are directly and immediately attributable to the stem cell donation procedure

If the donor receives hospital services in connection with a stem cell transplant, they are covered under Part A. The hospital reports the charges on the billing form for the recipient. It does not charge the donor's days of care against the recipient's utilization record. For cost reporting purposes, it includes the covered donor days and charges as Medicare days and charges. It bills for physicians' services under Part B to the carrier. Physicians' services are paid at 80 percent of reasonable charges.

The hospital shows charges for the transplant itself in revenue center code 0362. Selection of the cost center is up to the hospital.

C - Billing for Autologous Stem Cell Transplants

Since there are no covered acquisition charges for autologous stem cell transplant, the hospital shows all charges in the usual manner. It shows charges for the transplant, procedure code 41.01, in revenue center code 0362 or other appropriate cost center.

90.4 - Liver Transplants

(Rev. 1, 10-01-03)

A3-3615, A3-3615.5, HO-416.5

A - Background

For Medicare coverage purposes, liver transplants are considered medically reasonable and necessary for specified conditions when performed in facilities that meet specific criteria.

To review the current list of Approved Liver Transplant Centers, see http://www.cms.hhs.gov/providers/transplant/livrlist.asp

90.4.1 - Standard Liver Acquisition Charge

(Rev. 1, 10-01-03)

A3-3615.1, A3-3615.3

Each transplant facility must develop a standard charge for acquiring a cadaver liver from costs it expects to incur in the acquisition of livers.

This standard charge is not a charge that represents the acquisition cost of a specific liver. Rather, it is a charge that reflects the average cost associated with a liver acquisition.

Services associated with liver acquisition are billed from the organ procurement organization or, in some cases, the excising hospital to the transplant hospital. The excising hospital does not submit a billing form to the FI. The transplant hospital keeps an itemized statement that identifies the services furnished, the charges, the person receiving the service (donor/recipient), and the potential transplant donor. These charges are reflected in the transplant hospital's liver acquisition cost center and are used in determining the hospital's standard charge for acquiring a cadaver's liver. The standard charge is not a charge representing the acquisition cost of a specific liver. Rather, it is a charge that reflects the average cost associated with liver acquisition. Also, it is an all-inclusive charge for all services required in acquisition of a liver, e.g., tissue typing, transportation of organ, and surgeons' retrieval fees.

90.4.2 - Billing for Liver Transplant and Acquisition Services

(Rev. 1, 10-01-03)

A3-3615.2

Form CMS-1450 or its electronic equivalent is completed, in accordance with instructions in Chapter 25 for the beneficiary who receives a covered liver transplant. Applicable standard liver acquisition charges are identified separately in FL 42 by revenue code 0817 (Donor-Liver). Where interim bills are submitted, the standard acquisition charge appears on the billing form for the period during which the transplant took place. This charge is in addition to the hospital's charge for services furnished directly to the Medicare recipient.

The FI deducts liver acquisition charges for PPS hospitals prior to processing through Pricer. Costs of liver acquisition incurred by approved liver transplant facilities are not included in prospective payment DRG 480 (Liver Transplant). They are paid on a reasonable cost basis. This item is a "pass-through" cost for which interim payments are made. (See the Provider Reimbursement Manual, Part 1, §2802 B.8.) The FI includes liver acquisition charges under revenue code 0817 in the HUIP record that it sends to CWF and the QIO.

A - Bill Review Procedures

The FI takes the following actions to process liver transplant bills.

1 - Operative Report

The FI requires the operative report with all claims for liver transplants, or sends a development request to the hospital for each liver transplant with a diagnosis code for a covered condition.

2 - MCE Interface

The MCE creates an exception for procedure codes 50.51 and 50.59 (liver transplant). Where one of these procedure codes is identified by the MCE, the FI must check the provider number and effective date to determine if the provider is an approved liver transplant facility at the time of the transplant. If yes, the claim is suspended for review of the operative report to determine whether the beneficiary has at least one of the covered conditions when the diagnosis code is for a covered condition. If payment is appropriate (i.e., the facility is approved, the service is furnished on or after the approval date, and the beneficiary has a covered condition), the FI sends the claim to Grouper and Pricer.

If none of the diagnoses codes are for a covered condition, or if the provider is not an approved liver transplant facility, the FI denies the claim.

NOTE: Some non-covered conditions are included in the covered diagnostic codes. (The diagnostic codes are broader than the covered conditions. For example, primary biliary cirrhosis is a covered condition, secondary biliary cirrhosis is not a covered condition. Both primary and secondary biliary cirrhosis have the same diagnosis code ICD 9 571.6) Do not pay for noncovered conditions.

3 - Grouper

If the bill shows a discharge date before March 8, 1990, the procedure is not covered. If the discharge date is March 8, 1990 or later, the FI processes the bill through Grouper and Pricer. If the discharge date is after March 7, 1990, and before October 1, 1990, Grouper assigns DRG 191 or 192. The FI sends the bill to Pricer with review code 08. Pricer overlays DRG 191 or 192 with DRG 480 and the weights and thresholds for DRG 480 to price the bill. If the discharge date is after September 30, 1990, Grouper assigns DRG 480 and Pricer is able to price without using review code 08.

4 - Liver Transplant Billing From Non-approved Hospitals

Where a liver transplant and covered services are provided by a non-approved hospital, the bill data processed through Grouper and Pricer must exclude transplant procedure codes and related charges.

When CMS approves a hospital to furnish liver transplant services, it informs the hospital of the effective date in the approval letter. The FI will receive a copy of the letter.

90.5 - Pancreas Transplants

(Rev. 1, 10-01-03)

A3-3615.6

A - Background

Effective July 1, 1999, Medicare will cover pancreas transplantation when it is performed simultaneously with or following a kidney transplant (ICD-9-CM procedure code 55.69). Pancreas transplantation is performed to induce an insulin independent, euglycemic state in diabetic patients. The procedure is generally limited to those patients with severe secondary complications of diabetes including kidney failure. However, pancreas transplantation is sometimes performed on patients with labile diabetes and hypoglycemic unawareness.

Medicare has had a policy of not covering pancreas transplantation. The Office of Health Technology Assessment performed an assessment on pancreas-kidney transplantation in 1994. They found reasonable graft survival outcomes for patients receiving either simultaneous pancreas-kidney (SPK) transplantation or pancreas after kidney (PAK) transplantation.

B - Billing for Pancreas Transplants

There are no special provisions related to managed care participants. Managed care plans are required to provide all Medicare covered services. Medicare does not restrict which hospitals or physicians may perform pancreas transplantation.

The transplant procedure and revenue code 0360 for the operating room are paid under these codes. Procedures must be reported using the current ICD-9-CM procedure codes for pancreas and kidney transplants. Providers must place at least one of the following transplant procedure codes on the claim:

52.80 Transplant of pancreas

52.82 Homotransplant of pancreas

The Medicare Code Editor (MCE) has been updated to include 52.80 and 52.82 as covered procedures. (Effective October 1, 2000, ICD-9-CM code 52.83 was moved in the MCE to non-covered. The FI must override any deny edit on claims that came in with 52.82 prior to October 1, 2000 and adjust, as 52.82 is the correct code.)

If the discharge date is July 1, 1999, or later: the FI processes the bill through Grouper and Pricer.

Pancreas transplantation is reasonable and necessary for the following diagnosis codes. However, since this is not an all-inclusive list, the FI is permitted to determine if any additional diagnosis codes will be covered for this procedure.

Diabetes Diagnosis Codes

250.00	Diabetes mellitus without mention of complication, type II (non-insulin dependent) (NIDDM) (adult onset) or unspecified type, not stated as uncontrolled.
250.01	Diabetes mellitus without mention of complication, type I (insulin dependent) (IDDM) (juvenile), not stated as uncontrolled.
250.02	Diabetes mellitus without mention of complication, type II (non-insulin dependent) (NIDDM) (adult onset) or unspecified type, uncontrolled.
250.03	Diabetes mellitus without mention of complication, type I (insulin dependent) (IDDM) (juvenile), uncontrolled.
250.1X	Diabetes with ketoacidosis
250.2X	Diabetes with hyperosmolarity
250.3X	Diabetes with coma
250.4X	Diabetes with renal manifestations
250.5X	Diabetes with ophthalmic manifestations
250.6X	Diabetes with neurological manifestations
250.7X	Diabetes with peripheral circulatory disorders
250.8X	Diabetes with other specified manifestations
250.9X	Diabetes with unspecified complication

NOTE: X=0-3

- Hypertensive Renal Diagnosis Codes:

403.01	Malignant hypertensive renal disease, with renal failure
403.11	Benign hypertensive renal disease, with renal failure
403.91	Unspecified hypertensive renal disease, with renal failure
404.02	Malignant hypertensive heart and renal disease, with renal failure

404.03 Malignant hypertensive heart and renal disease, with congestive heart failure or renal failure

404.12 Benign hypertensive heart and renal disease, with renal failure

404.13 Benign hypertensive heart and renal disease, with congestive heart failure or renal failure

404.92 Unspecified hypertensive heart and renal disease, with renal failure

404.93 Unspecified hypertensive heart and renal disease, with congestive heart failure or renal failure

585 Chronic Renal Failure Code

NOTE: If a patient had a kidney transplant that was successful, the patient no longer has chronic kidney failure, therefore it would be inappropriate for the provider to bill 585 on such a patient. In these cases one of the following V-codes should be present on the claim or in the beneficiary's history.

The provider uses the following V-codes only when a kidney transplant was performed before the pancreas transplant:

V42.0 Organ or tissue replaced by transplant kidney

V43.89 Organ tissue replaced by other means, kidney or pancreas

NOTE: If a kidney and pancreas transplants are performed simultaneously, the claim should contain a diabetes diagnosis code and a renal failure code or one of the hypertensive renal failure diagnosis codes. The claim should also contain two transplant procedure codes. If the claim is for a pancreas transplant only, the claim should contain a diabetes diagnosis code and a V-code to indicate a previous kidney transplant. If the V-code is not on the claim for the pancreas transplant, the FI will search the beneficiary's claim history for a V-code.

C - Drugs

If the pancreas transplant occurs after the kidney transplant, immunosuppressive therapy will begin with the date of discharge from the inpatient stay for the pancreas transplant.

D - Charges for Pancreas Acquisition Services

A separate organ acquisition cost center has been established for pancreas transplantation. The Medicare cost report will include a separate line to account for pancreas transplantation costs. The 42 CFR 412.2(e)(4) was changed to include pancreas in the list of organ acquisition costs that are paid on a reasonable cost basis.

Acquisition costs for pancreas transplantation as well as kidney transplants will occur in Revenue Center 081X. The FI overrides any claims that suspend due to repetition of revenue code 081X on the same claim if the patient had a simultaneous kidney/pancreas transplant. It pays for acquisition costs for both kidney and pancreas organs if transplants are performed simultaneously. It will not pay for more than two organ acquisitions on the same claim.

E - Medicare Summary Notices (MSN) and Remittance Advice Messages

If the provider submits a claim for simultaneous pancreas kidney transplantation or pancreas transplantation following a kidney transplant, and omits one of the appropriate diagnosis/procedure codes, the FI denies the claim, using the following MSN:

- MSN 16.32, "Medicare does not pay separately for this service."

- Use the following Remittance Advice Message:

  Claim adjustment reason code B15, "Claim/service denied/reduced because this procedure or service is not paid separately."

- If a claim is denied because no evidence of a prior kidney transplant is presented, use the following MSN message:

- MSN 15.4, "The information provided does not support the need for this service or item."

The FI uses the following Remittance Advice Message:

- Claim adjustment reason code 50, "These are non-covered services because they are not deemed medically necessary by the payer."

To further clarify the situation, the FI should also use new claim level remark code MA 126, "Pancreas transplant not covered unless kidney transplant performed."

90.6 - Intestinal and Multi-Visceral Transplants

(Rev. 1, 10-01-03)

A3-3615.7, Transmittal R1878A3

A. Background

Effective for services on or after April 1, 2001, Medicare covers intestinal and multi-visceral transplantation for the purpose of restoring intestinal function in patients with irreversible intestinal failure. Intestinal failure is defined as the loss of absorptive capacity of the small bowel secondary to severe primary gastrointestinal disease or surgically induced short bowel syndrome. Intestinal failure prevents oral nutrition and may be associated with both mortality and profound morbidity. Multi-Visceral

transplantation includes organs in the digestive system (stomach, duodenum, liver, and intestine). See the National Coverage Determinations Manual for further information.

B. Approved Transplant Facilities

Medicare will cover intestinal transplantation if performed in an approved facility. The approved facilities are located at http://cms.hhs.gov/providers/transplant/default.asp.

C. Billing

ICD-9-CM procedure code 46.97 is effective for discharges on or after April 1, 2001. The Medicare Code Editor (MCE) lists this code as a non-covered procedure with no exceptions. The FI is to override the MCE when this procedure code is listed and the coverage criteria are met in an approved transplant facility.

For this procedure where the provider is approved as transplant facility, and the service is performed on or after the transplant approval date, the FI must suspend the claim for clerical review of the operative report to determine whether the beneficiary has at least one of the covered conditions listed when the diagnosis code is for a covered condition.

This review is not part of the FI's medical review workload. Instead, the FI should complete this review as part of it's claims processing workload.

Charges for ICD-9-CM procedure code 46.97 should be billed under revenue code 0360, Operating Room Services.

For discharge dates on or after October 1, 2001, acquisition charges are billed under revenue code 081X, Organ Acquisition. For discharge dates between April 1, 2001, and September 30, 2001, hospitals were to report the acquisition charges on the claim, but there was no interim pass-through payment made for these costs.

Bill the procedure used to obtain the donor's organ on the same claim, using appropriate ICD-9-CM procedure codes.

The 11X bill type should be used when billing for intestinal transplants.

Immunosuppressive therapy for intestinal transplantation is covered and should be billed consistent with other organ transplants under the current rules.

There is no specific ICD-9-CM diagnosis code for intestinal failure. Diagnosis codes exist to capture the causes of intestinal failure. Some examples of intestinal failure include, but are not limited to:

- Volvulus 560.2,
- Volvulus gastroschisis 756.79, other [congenital] anomalies of abdominal wall,
- Volvulus gastroschisis 569.89, other specified disorders of intestine,

- Necrotizing enterocolitis 777.5, necrotizing enterocolitis in fetus or newborn,
- Necrotizing enterocolitis 014.8, other tuberculosis of intestines, peritoneum, and mesenteric,
- Necrotizing enterocolitis and splanchnic vascular thrombosis 557.0, acute vascular insufficiency of intestine,
- Inflammatory bowel disease 569.9, unspecified disorder of intestine,
- Radiation enteritis 777.5, necrotizing enterocolitis in fetus or newborn, and
- Radiation enteritis 558.1.

D. Acquisition Costs

A separate organ acquisition cost center was established for acquisition costs incurred on or after October 1, 2001. The Medicare Cost Report will include a separate line to account for these transplantation costs. For intestinal and multi-visceral transplants performed between April 1, 2001, and October 1, 2001, the DRG payment was payment in full for all hospital services related to this procedure.

E. Medicare Summary Notices (MSN), Remittance Advice Messages, and Notice of Utilization Notices (NOU)

If an intestinal transplant is billed by an unapproved facility after April 1, 2001, the FI must deny the claim and use MSN message 21.6, "This item or service is not covered when performed, referred, or ordered by this provider;" 21.18, "This item or service is not covered when performed or ordered by this provider;" or, 16.2, "This service cannot be paid when provided in this location/facility;" and Remittance Advice Message, Claim Adjustment Reason Code 52, "The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed."

100 - Billing Instructions for Specific Situations

(Rev. 1, 10-01-03)

100.1 - Billing for Abortion Services

(Rev. 1, 10-01-03)

A3-3652

Effective October 1, 1998, abortions are not covered under the Medicare program except for instances where the pregnancy is a result of an act of rape or incest; or the woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

A - "G" Modifier

The "G7" modifier is defined as "the pregnancy resulted from rape or incest, or pregnancy certified by physician as life threatening."

Beginning July 1, 1999, providers should bill for abortion services using the new Modifier G7. This modifier can be used on claims with dates of services October 1, 1998, and after. CWF will be able to recognize the modifier beginning July 1, 1999.

B - FI Billing Instructions

1 - Hospital Inpatient Billing

Hospitals will bill the FI on Form CMS-1450 using bill type 11X. Medicare will pay only when condition code A7 or A8 is used in FLs 24-30 of UB92 along with an appropriate ICD-9-CM principal diagnosis code that will group to DRG 380 or with an appropriate ICD-9-CM principal diagnosis code and one of the four appropriate ICD-9-CM operating room procedure codes listed below that will group to DRG 381.

69.01	69.02	69.51	74.91

Providers must use ICD-9-CM codes 69.01 and 69.02 to describe exactly the procedure or service performed.

The FI must manually review claims with the above ICD-9-CM procedure codes to verify that all of the above conditions are met.

2 - Outpatient Billing

Hospitals will bill the FI on Form CMS-1450 using bill type 13X, 83X and 85X. Medicare will pay only if one of the following CPT codes is used with the "G7" modifier.

59840	59851	59856
59841	59852	59857
59850	59855	59866

C - Common Working File (CWF) Edits

For hospital outpatient claims, CWF will bypass its edits for a managed care beneficiary who is having an abortion outside their plan and the claim is submitted with the "G7" modifier and one of the above CPT codes.

For hospital inpatient claims, CWF will bypass its edits for a managed care beneficiary who is having an abortion outside their plan and the claim is submitted with one of the above ICD-9-CM procedure codes.

D - Medicare Summary Notices (MSN)/Explanation of Your Medicare Benefits Remittance Advice Message

If a claim is submitted with one of the above CPT procedure codes but no "G7" modifier, the claim is denied. The FI states on the MSN the following message:

> This service was denied because Medicare covers this service only under certain circumstances." (MSN Message 21.21).

For the remittance advice the FI uses existing American National Standard Institute (ANSI) X12-835 claim adjustment reason code B5, "Claim/service denied/reduced because coverage guidelines were not met or were exceeded."

100.2 - Payment for CRNA or AA Services

(Rev. 1, 10-01-03)

A3-3660.9

Anesthesia services furnished on or after January 1, 1990, at a qualified rural hospital by a hospital employed or contracted CRNA or AA can be paid on a reasonable cost basis. The FI determines the hospital's qualification using the following criteria.

The hospital must be located in a rural area (as defined for PPS purposes) to be considered. A rural hospital that qualified and was paid on a reasonable cost basis for CRNA or AA services during calendar year 1989 could continue to be paid on a reasonable cost basis for these services furnished during calendar year 1990 if it could establish before January 1, 1990, that it did not provide more than 500 surgical procedures, both inpatient and outpatient, requiring anesthesia services during 1989.

A rural hospital that was not paid on a reasonable cost basis for CRNA or AA services during calendar year 1989 could be paid on a reasonable cost basis for these services furnished during calendar year 1990 if it established before January 1, 1990, that:

- As of January 1, 1988, it employed or contracted with a CRNA or AA (but not more than one full-time equivalent CRNA or AA); and

- In both 1987 and 1989, it had a volume of 500 or fewer surgical procedures, including inpatient and outpatient procedures, requiring anesthesia services.

Each CRNA or AA employed by, or under contract with the hospital, must agree in writing not to bill on a fee schedule basis for services furnished at the hospital. A rural hospital can qualify and continue to be paid on a reasonable cost basis for qualified CRNA or AA services for a calendar year beyond 1990 if it could establish before January 1 of that year that it did not provide more than 500 surgical procedures, both inpatient and outpatient, requiring anesthesia services during the preceding year. For a calendar year beyond 1990, it must make its election after September 30, but before

January 1. The FI determines the number of anesthetics by annualizing the number of surgical procedures for the 9-month period ending September 30.

A rural hospital that first elects reasonable cost payment for CRNA services for a calendar year after 1990 must demonstrate that:

- It had a volume of 500 or fewer surgical procedures, including inpatient and outpatient, requiring anesthesia services in the preceding year; and
- It meets the criteria that would have been met by a rural hospital first electing reasonable cost in calendar year 1990.

To prevent duplicate payments, the FI informs carriers of the names of CRNAs or AAs, the hospitals with which they have agreements, and the effective dates of the agreements. If the CRNA or AA bills Part B for anesthesia services furnished prior to the hospital's election of reasonable cost payments, the carrier must recover the overpayment from the CRNA or AA.

100.3 - Resident and Interns Not Under Approved Teaching Programs

(Rev. 1, 10-01-03)

A3-3669

A - General

A provider's cost for the services furnished by residents and interns not under approved teaching programs (including physicians employed by the provider who are authorized to practice only in a provider setting) are covered under Part B. (Part A covers only the costs of services performed for inpatients by residents and interns who are under approved teaching programs.) See the Medicare Benefit Policy Manual, Chapter 6 for further information on the coverage of these services.

The provider determines that part of the inpatient charges which represents the cost of the services of residents and interns who are not under approved teaching programs and bills these separately under Part B, using type of bill code 121 and revenue code 096X, 097X, or 098X as applicable.

B - Provider Procedures

The cost of Part B residents' and interns' services to inpatients is calculated on a per diem basis by the hospital in consultation with its FI. The FI apportions the total cost of such services (including fringe benefits, etc.) between inpatient and outpatient services on the basis of the time spent on each. It obtains the inpatient per diem figure by dividing the total annual inpatient cost for these services by the estimated annual number of inpatient days for all patients.

For the patients who are enrolled under Part B, regardless of whether Part A benefits are payable, the provider is reimbursed for 80 percent of the cost of providing these services. The provider collects or bills the complementary insurer for 20 percent of the per diem rate for the services of residents and interns covered under Part B times the number of inpatient days provided. The administrative cost of determining Part B deductible status involving the cost of query, response, recording, and accounting on an individual basis in the aggregate, exceeds the potential patient deductible obligation. Therefore, as long as the patient is entitled to Part A benefits no determination of the patient's deductible liability need to be made for inpatient Part B interns' and residents' services.

Patients not enrolled under Part B are liable for the entire cost of intern and resident services. The provider maintains a record of the inpatient days of these individuals so that this cost may be excluded from the amount of program obligation at the time of final cost settlement.

C - FI Procedures

Its FI assists the provider in arriving at the inpatient per diem rate for the cost of services covered under Part B provided by residents and interns. (See the Provider Reimbursement Manual, Part I, §2120 for apportioning costs between inpatient and outpatient per diem and §2406 for establishing interim rates.) The normal interim reimbursement rate applied to other provider services applies to Part B residents' and interns' services.

100.4 - Billing for Services After Termination of Provider Agreement

(Rev. 1, 10-01-03)

HO-404, HH-433

An agreement with a hospital is not time-limited and has no fixed expiration date.

A - Part A Billing

A hospital whose provider agreement terminates (voluntarily or involuntarily), may be reimbursed for covered Part A inpatient services for up to 30 days for services furnished on or after the effective date of termination for beneficiaries who were admitted prior to the termination date.

EXAMPLE

Termination date: 6/30/01

Beneficiary admitted on or before 6/29/01

Payment can be made: 6/30/01, up to and including 7/29/01

B - Assuring That Hospitals Continue to Bill for Covered Services

Upon cessation of a hospital's participation in the program, it supplies the Regional Office the names and HICNs of Medicare beneficiaries entitled to have payment made on their behalf, and continues to bill for covered services in accordance with subsection A. It continues to submit "no-payment" death or discharge bills for Medicare beneficiaries admitted prior to the termination of the provider's agreement.

C - Part B Billing

Following termination of its agreement, a hospital is considered to be a "nonparticipating hospital." An inpatient of such a hospital who has Part B coverage, but for whom Part A benefits have been exhausted, or are otherwise not available, is entitled to reimbursement for those services that are covered in a nonparticipating institution. Services, if rendered, must be billed on Form CMS-1500 and sent to the Part B carrier. If a hospital has been billing on the CMS-1554 for physician services, it continues to do so.

If a terminated hospital meets the necessary criteria, it may be certified to provide emergency services, and will be assigned an emergency provider number (E suffix). This procedure is not automatic, however, and hospitals which are terminated for Life Safety Code violations may never be able to qualify as emergency providers. Should a terminated hospital later qualify as an emergency provider, billings are handled by the designated emergency FI.

100.4.1 - Billing Procedures for a Provider Assigned Multiple Provider Numbers or a Change in Provider Number

(Rev. 1, 10-01-03)

HO-404.1, HH-432

Where a multiple-facility provider is assigned separate provider numbers for each component facility or where a provider is assigned a different number, it is required to use the new number for all notices of admission, start of care notices, bills, etc., beginning with the date the new number is effective.

A - Inpatient

The component provider to which the new number is assigned must apportion costs for all patients who are inpatients in that component as of the first day of the next fiscal period when the new provider number goes in effect. The hospital must submit a discharge bill with the old provider number and an admission notice with the new. The date of discharge and the date of admission are the same date, which is the first day of the new fiscal period. All subsequent billings are submitted under the new provider number.

If a no-payment situation where the entire billing period represents charges for which no Part A payment can be made, it is not necessary to submit a discharge bill and admission notice. In this situation, only a final no-payment bill with a discharge date is submitted

under the old provider number. Services furnished during the "no-payment" period may subsequently be determined to be covered. Where such covered services were furnished before the date of change in provider number, the hospital submits one corrected bill covering the entire period showing the old provider number. However, where services subsequently determined to be covered were furnished after the date of change, the hospital submits a corrected discharge bill with the old provider number and a new admission notice and billing with the new provider number.

B - Outpatient Services, Part B Ancillary Services and Home Health Agency Services

For outpatient services and Part B ancillary services, and home health agency services, the provider uses the old provider number for services provided up through the day before the effective date of the new provider number. Thereafter, it uses the new number when submitting bills.

100.5 - Review of Hospital Admissions of Patients Who Have Elected Hospice Care

(Rev. 1, 10-01-03)

HO-418

Review of admissions to inpatient general hospitals of beneficiaries who have elected hospice care assures that:

- Nonhospice Medicare coverage is provided to those beneficiaries only when the hospitalization was for a condition not related to the terminal illness, and

- When inpatient hospital services were provided as a hospice benefit, the services rendered were stipulated in the individual's plan of care as established by the hospice's interdisciplinary group.

A - Review for Nonrelated Hospital Admissions

To assure that nonhospice Medicare coverage is provided to beneficiaries who have elected hospice care only when hospitalization was for a condition not related to the terminal illness, the medical review agent reviews all inpatient hospital claims for these beneficiaries. Appropriate medical records will be requested and a determination made as to whether or not services were related to the individual's terminal illness.

Many illnesses may occur when an individual is terminally ill which are brought on by the patient's underlying condition. For example, it is not unusual for a terminally ill patient to develop pneumonia or some other illness as a result of a weakened condition. Similarly, the setting of bones after fractures which occur in a bone cancer patient would be treatment of a related condition.

If the review reveals hospitalization to be unrelated to the individual's terminal illness, a determination as to the medical necessity and appropriateness of the admission is made.

Payment will be totally denied or totally approved based on the finding. If, after review, the admission should have been totally denied, consideration under the limitation of liability provision (§1879 of the Act) applies.

If the review of medical records reveals hospitalization to be related to the individual's terminal illness, the claim is denied as services waived through the hospice election. Limitation on liability provision does not apply.

B - Review for Related Hospital Admissions

To assure that beneficiaries who have elected hospice care are receiving services as provided in the plans of care established by the hospice's interdisciplinary groups, the medical review agent reviews all inpatient hospital claims submitted by the hospice for these beneficiaries. Appropriate medical records (including the plans of care) are requested and a determination made as to whether or not services provided were related to the individual's terminal illness and stipulated in the plan of care.

If the review reveals that services provided were medically necessary and appropriate for the control of pain or acute or chronic symptom management as outlined in the individual's plan of care, the claim is approved.

If the review reveals that services provided to the hospice beneficiary were not stipulated in the plan of care as established by the hospice's interdisciplinary group, the claim is denied. Limitation on liability does not apply.

100.6 - Inpatient Renal Services

(Rev. 1, 10-01-03)

HO-E400

Section 405.103l of Subpart J of Regulation 5 stipulates that only approved hospitals may bill for ESRD services. Hence, to allow hospitals to bill and be reimbursed for inpatient dialysis services furnished under arrangements, both facilities participating in the arrangement must meet the conditions of 405.2120 and 405.2160 of Subpart U of Regulation 5. In order for renal dialysis facilities to have a written arrangement with each other to provide inpatient dialysis care both facilities must meet the minimum utilization rate requirement, i.e., two dialysis stations with a performance capacity of at least four dialysis treatments per week.

Dialysis may be billed by an SNF as a service if: (a) it is provided by a hospital with which the facility has a transfer agreement in effect, and that hospital is approved to provide staff-assisted dialysis for the Medicare program; or (b) it is furnished directly by an SNF meeting all nonhospital maintenance dialysis facility requirements, including minimum utilization requirements. (See §§1861(h)(6), 1861(h)(7), title XVIII.)

100.7 – Lung Volume Reduction Surgery

(Rev. 26, 11-04-03)

Lung Volume Reduction Surgery (LVRS) (also known as reduction pneumoplasty, lung shaving, or lung contouring) is an invasive surgical procedure to reduce the volume of a hyperinflated lung in order to allow the underlying compressed lung to expand, and thus, establish improved respiratory function.

Effective for discharges on or after January 1, 2004, Medicare will cover LVRS under certain conditions as described in §240 of Pub. 100-03, "National Coverage Determinations".

The Medicare Code Editor (MCE) creates a Limited Coverage edit for procedure code 32.22. This procedure code has limited coverage due to the stringent conditions that must be met by hospitals. Where this procedure code is identified by MCE, the FI shall determine if coverage criteria is met and override the MCE if appropriate.

The LVRS can only be performed in the facilities listed on the following Web site: www.cms.hhs.gov/coverage/lvrsfacility.pdf

Medicare previously only covered LVRS as part of the National Emphysema Treatment Trial (NETT). The study is limited to 18 hospitals, and patients are randomized into two arms, either medical management and LVRS or medical management. The study is conducted by The National Heart, Lung, and Blood Institute of the National Institutes of Health and coordinated by Johns Hopkins University (JHU). Claims for patients in the NETT are identified by the presence of Condition Code EY. The JHU instructs hospitals of the correct billing procedures for billing claims under the NETT. Claims processing procedures in place for the NETT remain the same.

110 - Emergency and Foreign Hospital Services

(Rev. 1, 10-01-03)

110.1 - Services Rendered in Nonparticipating Providers

(Rev. 1, 10-01-03)

A3-3698, HO-490

A - Services in Nonparticipating Domestic Hospital

Payment may be made for certain Part A inpatient and Part B outpatient hospital services provided in a nonparticipating U.S. hospital where they are necessary to prevent the death or serious impairment of the health of the individual. Because of the threat to the life or

health of the individual, the use of the most accessible hospital equipped to furnish such services is necessary. Items and services furnished in a domestic nonparticipating hospital may be reimbursed if the following apply:

- The hospital meets the definition of an emergency hospital. (See §110.2.)
- The services meet the definition of emergency services. (See §110.1.)
- The hospital is substantially more accessible from the site of the emergency than is the nearest participating hospital. (See §110.5.)

B - Beneficiary Services Outside United States

Items and services furnished outside the United States are excluded from coverage except for the following Canadian and Mexican services:

- Emergency inpatient hospital services where the emergency occurred:
    - While the beneficiary was physically present in the U.S. (See §110.1A.)
    - In Canada while the beneficiary was traveling, without unreasonable delay, by the most direct route between Alaska and another State. (See §110.1B.)
- Emergency or non-emergency inpatient hospital services furnished in a Canadian or Mexican hospital closer to, or substantially more accessible from the beneficiary's U.S. residence than the nearest participating U.S. hospital which was adequately equipped to deal with and available to provide treatment of the illness or injury. (See §§110.5 and 110.12.)
- Physician and ambulance services furnished in connection with, and during a period of, covered foreign hospitalization. Program payment may not be made for any other Part B Medical and Other Health Services, including outpatient services furnished outside the U.S. (See §110.7.)
- Religious Non-medical Health Care services furnished under specified conditions in a Religious Non-medical Health Care facility. (See §110.10.)

NOTE: The term "United States" means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, Northern Mariana Islands, American Samoa and, for purposes of services rendered on a ship, the territorial waters adjoining the land areas of the U.S. A hospital that is not physically situated in one of these jurisdictions is considered to be outside the United States, even if it is owned or operated by the United States Government.

For Medicare purposes, services rendered aboard a ship in an American port or within six hours of when the ship arrived at, or departed from, that port are considered to have been rendered in American waters. Services not furnished in port or furnished more than six

hours before arrival at, or after departure from, a United States port are considered to have been furnished outside the U.S. territorial waters.

110.2 - Establishing an Emergency

(Rev. 1, 10-01-03)

A3-3698.1, HO-490.1

Claims for emergency services must be accompanied by a physician's statement describing the nature of the emergency and stating that the services were necessary to prevent the death, or the serious impairment of, the beneficiary. A statement that an emergency existed is not sufficient. In addition, when inpatient services are involved, the statement must include the date when, in the physicians' judgment, the emergency ceased.

The finding of whether the patient's condition required emergency diagnosis or treatment is ordinarily based upon the physician's evaluation of the patient's condition immediately upon the beneficiary's arrival at the hospital.

However, the emergency nature of the situation may have been assessed by a physician who attended the patient where the incident resulting in hospitalization occurred (for example, a heart attack or an automobile accident). In these cases, the attending physician who ordered the hospitalization may substantiate the claim that emergency hospitalization was necessary.

Most emergencies are of relatively short duration so that only one bill is submitted. Generally, only one physician's statement is necessary. However, in the rare situation where an emergency continued over an extended period, subsequent requests for payment must be accompanied by a physician's statement containing sufficient information to indicate clearly that the emergency situation still existed. A statement that the emergency continued to exist is not acceptable.

Additional information to support a finding that the services were emergency services from the physician, the hospital, and others (e.g., the police department at the scene of an accident) may be requested.

Medical necessity can be documented by the physician on a CMS-l77l, Attending Physician's Statement and Documentation of Medicare Emergency or by the beneficiary's medical records. The CMS-1771 can be obtained from:

Centers for Medicare & Medicaid Services
Forms Management Section
7500 Security Blvd.
Baltimore, MD 21244-1850

Or, the form can be downloaded from http://www.cms.hhs.gov/forms/

110.3 - Qualifications of an Emergency Services Hospital

(Rev. 1, 10-01-03)

A3-3698.2, HO-490.2

An emergency services hospital is a nonparticipating hospital that meets the requirements of the law's definition of a "hospital" relating to full-time nursing services and licensure under State or applicable local law. (A Federal hospital need not be licensed under State or local licensing laws to meet this definition.) In addition, the hospital must be primarily engaged in providing, under the supervision of doctors of medicine or osteopathy, services of the type described in defining the term hospital.

The hospital must not be primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care. Psychiatric hospitals can qualify as emergency hospitals.

110.4 - Claims from Hospital-Leased Laboratories Not Meeting Conditions of Participation

(Rev. 1, 10-01-03)

A3-3698.3, HO-490.3

Services furnished by a laboratory that does not meet the hospital laboratory conditions of participation and is operated under a lease arrangement in a domestic emergency hospital are covered only if they are emergency inpatient services reimbursable under Part A.

A carrier may send an FI a claim from such a laboratory and identify it as an "Emergency Lead." The FI checks its files to see if a claim for emergency services was filed and, if so, determines whether the laboratory services were furnished during the period of emergency. If the emergency claim was forwarded to the appropriate FI for processing, it enters the date received on the laboratory claim.

If no emergency claim was filed, or laboratory services were not furnished in the period covered by the emergency claim, the FI develops the claim as a possible emergency. It includes the laboratory claim with any subsequent claim.

If no emergency is alleged, the FI records on the claim that no emergency existed and disallows it.

110.5 - Coverage Requirements for Emergency Hospital Services in Canada or Mexico

(Rev. 1, 10-01-03)

A3-3698.4, HO-490.4

The following requirements must be met for payment to be made for emergency services received by Medicare beneficiaries in Canadian or Mexican hospitals:

- The hospital must meet the definition of an emergency hospital and be licensed under Canadian or Mexican law.
- The services meet the criteria of emergency services.

Hospitals submit a statement from the beneficiary or representative that indicates:

- The point of entry into Canada from the U.S.

The intended point of departure from Canada;

- The route traveled at the time of the emergency;
- An explanation of any apparent deviation from the intended route; and
- An explanation of any nonroutine stopover.

The foreign hospital must be closer to or substantially more accessible from the site of the emergency than the nearest U.S. hospital that was adequately equipped and available to treat the illness or injury.

1 - Emergency Occurred in the U.S.

If the individual was physically present in the U.S. at the time the emergency occurred, the individual's reason for departure from the U.S. must have been specifically to obtain treatment at the foreign hospital. Services are not covered where the person's departure from the U.S. is part of a trip abroad and the Canadian or Mexican hospital is more accessible simply because the individual was in the process of travel. For example, the airplane on which the individual was traveling could not readily return to permit the person's removal.

2 - Emergency Occurred in Canada

If the emergency occurred in Canada, the beneficiary must have been traveling, without unreasonable delay, by the most direct route between Alaska and another State. Benefits are not payable if the emergency occurred while a beneficiary was vacationing. The requirement of travel without unreasonable delay by the most direct route will be considered met if the emergency occurred while the beneficiary was

enroute between Alaska and another State by the shortest practicable route, or while making a necessary stopover in connection with such travel.

NOTE: An emergency occurring within the Canadian inland waterway between the States of Washington and Alaska is considered to have occurred in Canada.

Ordinarily, the "shortest practicable route" is the one that results in the least amount of travel in Canada, consistent with the mode of travel used between the point of entry into Canada and the intended point of departure. The amount of travel in the U.S., prior to entering Canada is not pertinent. A route involving greater travel within Canada may be considered the "shortest practicable route" if the additional travel resulted in a saving of time or was necessary because of such factors as

- Road or weather conditions;
- The age of the traveler;
- Health, or physical condition of the traveler;
- The need to make suitable travel arrangements; or
- The need to obtain acceptable accommodations.

However, the individual would be considered to have deviated from the "shortest practicable route" if the detour was unrelated to the purpose of reaching their destination (e.g., for the principal purpose of sightseeing or vacationing).

The term "necessary stopover" means a routine stopover for rest, food, or servicing of the vehicle, and a non-routine stopover (even though of significant duration) caused by such factors as unsuitable road or weather conditions, the age, health, or physical condition of the traveler, the need to make suitable travel arrangements, or to obtain acceptable accommodations.

110.6 - Services Furnished in a Foreign Hospital Nearest to Beneficiary's U.S. Residence

(Rev. 1, 10-01-03)

A3-3698.5, HO-490.5

Coverage is provided for inpatient hospital services furnished in a Canadian/Mexican hospital that is closer to, or substantially more accessible from, the beneficiary's U.S. residence than the nearest available participating U.S. hospital that is adequately equipped to deal with the illness or injury, whether or not an emergency existed and without regard to where the illness or injury occurred.

"Residence" means the beneficiary's fixed and permanent home to which they intend to return whenever they are away or a dwelling where the beneficiary periodically spends some time (e.g., a summer home).

The Canadian or Mexican hospital must meet accreditation requirements equivalent to JCAHO standards. The Canadian Council on Hospital Accreditation (CCHA) has equivalent requirements. Thus, Canadian hospitals accredited by the CCHA meet the qualifying requirements. In the case of Mexican hospitals, the Dallas or San Francisco RO makes the determination, depending upon the hospital's location.

See §110.12.1 below for discussion of accessibility criteria.

Some claims for services furnished in a foreign hospital nearest to the beneficiary's U.S. residence will not be "emergency." In these nonemergency situations, it may be necessary to deny payment in whole or part, (even though it has been approved with regard to accessibility) because the services are not medically reasonable and necessary or involve custodial care (i.e., exclusions under §§1862(a)(1) and (9)).

Where a denial is made in a nonemergency foreign claim for reasons other than accessibility (e.g., cosmetic surgery benefits exhausted), the usual beneficiary denial notice procedures apply. However, in the case of denials under the medical necessity and custodial care exclusions, the FI applies the limitation on liability considerations under §1879 of the Act before issuing the denial notice.

The FI examines claims involving medical necessity or custodial care denials to determine if there is any evidence that the beneficiary (or the person acting on behalf of the beneficiary) was aware that the beneficiary did not require, or no longer required, a covered level of care. The foreign hospital, since it is not participating, is not under any obligation to furnish a written notice of noncoverage to a beneficiary in order to protect itself from being held liable under the §1879 waiver of liability provision. However, there may be instances where the medical records of the denied foreign claim show that the beneficiary was advised that the beneficiary did not require, or no longer required, Medicare covered services, (e.g., written notice of noncoverage from the hospital's staff or a prior CMS denial notice). It will probably be rare where a finding is made that the beneficiary had knowledge of noncoverage, so that, generally, payments are made under the waiver of liability provision. The FI uses appropriate Medicare Summary Notice (MSN) and Remittance Advice denial messages for determinations involving the limitation on liability provision. See Chapter 21.

110.7 - Coverage of Physician and Ambulance Services Furnished Outside U.S.

(Rev. 1, 10-01-03)

A3-3698.6, HO-490.6

Physician and ambulance services which meet the coverage requirements of the Act and which are furnished in connection with inpatient services meeting the requirements of §§110.4 or 110.6 are covered under Part B. When these requirements are met, Part B payment is possible even though there may be no Part A payment because Part A benefits are exhausted or there is no Part A entitlement.

Where inpatient services in a Canadian or Mexican hospital are covered, payment will be made for:

- Physicians' services rendered to the beneficiary while an inpatient.
- Physicians' services rendered to the beneficiary outside the hospital on the day of admission as an inpatient, provided the services were for the same condition for which the beneficiary was hospitalized.
- Services of a Canadian ship's physician who furnished emergency services in Canadian waters on the day the beneficiary is admitted to a Canadian hospital for a covered emergency stay.
- Ambulance services, where necessary, for the trip to the hospital in conjunction with the beneficiary's admission. Return ambulance trips from a foreign hospital are not covered.

In cases involving foreign ambulance services, the general requirements in Medicare Benefit Policy Manual, Chapter 10, and this manual, Chapter 15 are applicable, unless the foreign hospitalization was covered as emergency services, then necessity and destination requirements are met.

The definition of "physician," for purposes of coverage of services furnished outside the U.S., includes a foreign practitioner, provided the practitioner is legally licensed to practice in the country in which the services were furnished.

Only the beneficiary may file for Part B benefits. The assignment method may not be used. However, where the beneficiary is deceased, the rule for settling Part B underpayments is applicable, i.e., payment may be made to the foreign physician or ambulance company on the basis of an unpaid bill, provided the physician or ambulance company accepts the carrier's reasonable charge determination as the full charge.

The regular deductible and coinsurance requirements apply to physicians' and ambulance services.

110.8 - Claims for Services Furnished in Canada and Mexico to Qualified Railroad Retirement Beneficiaries

(Rev. 1, 10-01-03)

A3-3698.7, HO-490.7

A - Canadian Claims

Under the Railroad Retirement Act, payment is made to Qualified Railroad Retirement Beneficiaries (QRRB) by the RRB for covered hospital services furnished in Canadian hospitals as well as in the U.S. The Railroad Retirement Act does not cover physician and ambulance services; however, under an agreement between CMS and RRB, if the QRRB claims payment for Part B services in connection with Canadian hospitalization, RRB processes the Part B claim. In such cases the RRB determines:

- Whether the requirements in §§110.1.B and 110.7 are met in regard to the inpatient services; and
- Whether the physician and/or ambulance services were furnished in connection with the services.

If either is not met, RRB denies the claim and notifies the beneficiary. If met, RRB refers the claim to the RRB carrier, PGBA, to determine if the coverage criteria for physician and/or ambulance services are met.

The hospital must forward all claims for services furnished QRRBs in Canada to:

Railroad Retirement Board
844 Rush Street
Chicago, IL 60611

If a QRRB is a resident of Canada, Medicare payments are reduced by the amount of payment made for the same services by the Canadian Provincial Health Insurance Plan.

B - Mexican Claims

The RRB does not pay for health care services furnished in Mexico. The Mexican hospital must forward all claims for inpatient hospital services and/or related physician or ambulance services furnished in Mexico to QRRBs to either the Dallas or San Francisco RO (whichever services its area).

110.9 - Nonemergency Part B Medical and Other Health Services

(Rev. 1, 10-01-03)

A3-3698.8, HO-490.8

A - Coverage

Nonemergency services to Medicare beneficiaries may be paid for if the coverage requirements for the services are met, and are not covered as Part A emergency inpatient services.

Program payment may be made for the following Part B medical and other health services furnished by a U.S. nonparticipating hospital on a nonemergency basis:

- Diagnostic x-ray tests, diagnostic laboratory tests and other diagnostic tests. (The hospital must meet the applicable conditions of participation for the services.)

- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians. (The hospital must meet the applicable conditions of participation for these services.)

- Services of residents and interns, nurses, therapists, etc., which are directly related to the provision of x-ray or laboratory or other diagnostic tests, or the provisions of x-ray or radium therapy.

- Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue) or replace all or part of the functions of a permanently inoperative or malfunctioning internal body organ, including replacement of such devices.

- Leg, arm, back, and neck braces, trusses and artificial legs, arms, and eyes, including replacement, if required, because of a change in the patient's physical condition.

B - Distinction Between Emergency and Nonemergency Medical and Other Health Services

Emergency coverage, particularly Part B emergency outpatient coverage, is broader than the nonemergency Part B Medical and Other Health Services coverage provisions. When the emergency requirements are met, program payment may be made to the hospital for the full range of outpatient hospital services. In addition to the nonemergency coverage list, emergency coverage includes hospital services (including drugs and biologicals - blood is a biological - which cannot be self-administered), "incident to physicians' services rendered to outpatients," and outpatient physical therapy and speech pathology. The latter two services are not covered under the nonemergency provisions. Payment for "incident to" services can be only under the emergency rather than the nonemergency provisions.

Whether Part B payment is made under the emergency or nonemergency provisions, it may be made for diagnostic laboratory tests furnished by an emergency hospital only if the hospital meets the conditions of participation relating to hospital laboratories. It may be made only for radiology services furnished by an emergency hospital if the hospital meets the conditions of participation relating to radiology departments. Part B payment may be made for diagnostic laboratory tests furnished by a nonparticipating hospital which is not an emergency hospital only if the hospital laboratory meets the conditions of coverage of independent laboratories and for radiology services furnished by it, only if it meets the conditions of participation relating to radiology departments.

C - Claims Processing

The hospital enters the annotation "nonemergency-hospital accepts assignment" in Remarks of the Form CMS-1450. If it is determined that some or all of the services are not covered under the nonemergency provisions, the claim is returned to it (if hospital-filed) or to the beneficiary (if patient-filed) to determine whether the services might be covered as emergency services.

110.10 - Canadian or Mexican Religious Nonmedical Health Care Facility Claims

(Rev. 1, 10-01-03)

A3-3638.9, HO-490.9

A - Coverage

Payment may be made for otherwise covered religious nonmedical health care institution services furnished in a Canadian/Mexican facility under the same requirements of §§110.1.B and 110.10 provided that the foreign sanatorium is closer to or more accessible from the beneficiary's residence in the U.S., (or, if applicable, the site of the emergency) than the nearest U.S. religious nonmedical health care institution. This is true even where there is a closer or more accessible general hospital. For accreditation, it is sufficient that the First Church of Christ, Scientist, in Boston, MA, certify the Religious nonmedical health care facility.

B - Claims Processing

Claims for services in a religious nonmedical health care facility are sent to RNHC FI

Riverbend Government Benefits Administrator
730 Chestnut Street
Chatanooga TN, 37401

for accessibility and/or emergency determination and processing. If the requirements are not met, the FI denies the claim.

110.11 - Elections to Bill for Services Rendered Nonparticipating Hospitals

(Rev. 1, 10-01-03)

A3-3698.10, HO-490.10, A3-3698.11, HO-490.11

A - Nonparticipating U.S. Hospitals

As a nonparticipating U.S. hospital meeting emergency requirements the hospital has the option to bill the program during a calendar year by filing an election with its FI. If it files an election, it should submit claims for the following services furnished all Medicare beneficiaries throughout the year:

- Emergency inpatient services; and

  Emergency outpatient services.

In addition, the hospital may not bill any beneficiary beyond deductibles, coinsurance, and noncovered services in that calendar year. It must agree to refund any monies incorrectly collected. It may not file an election for the calendar year if it has already charged any beneficiary for covered services furnished in that year.

If the hospital does not file a billing election, the beneficiary can file a claim. The beneficiary may request information from the hospital or the FI as appropriate.

During November of each year, the FI will send the non-participating hospital a letter, if the §120.3.1). Also, during November of each year, the FI will send a letter to each domestic hospital, giving it an opportunity to elect to bill Medicare if it has not been doing so (§120.3.2).

If during the year the hospital requests to bill the program, its FI will send the model letter in §120.3.3.

B - Billing for Services Furnished Prior to Certification

The following rules apply if a bill is submitted for services rendered before and after a hospital's certification (participation) date:

- PPS hospitals are paid the DRG, if the date of discharge is after the certification date.

- Other hospitals are paid for services rendered after the certification date. However, the hospital must include services before certification date on its cost report.

It should annotate in the upper right hand corner of the claim "Emergency Conversion."

C - Canadian/Mexican Hospitals

Canadian and Mexican hospitals may submit a statement to the appropriate FI stating that they will bill for all claims. If they do not, the beneficiary may claim the payment. When the FI is aware that a hospital is willing to bill the program for all covered services, it solicits the hospital's agreement to:

- Bill for all covered services for the calendar year (except for deductible and coinsurance amounts);
- Not bill the beneficiary for any amounts other than for deductible and coinsurance and charges for noncovered services; and
- Refund to the beneficiary any monies incorrectly collected.

A hospital may not file an election for a calendar year if it has charged any beneficiary for covered services during that year.

D- Submitting Claims

The beneficiary or the hospital that has elected to bill the program may submit emergency claims for payment to the appropriate FI for evaluation of accessibility or emergency factors.

The hospital completes the claim (CMS-1450 or electronic equivalent) according to billing instructions in Chapter 25. It enters "hospital filed emergency admission" in Item 94 "Remarks." It sends the completed bill and the necessary emergency documentation (Form CMS-1771, Attending Physicians Statement and Documentation of Medicare Emergency) or medical records to substantiate the emergency to the appropriate FI.

NOTE: See §120.2, "Designated FIs."

If the hospital submits a claim but has not filed an election to bill the program, it will be contacted to determine if it is qualified and wish to bill the program. If it declines, the claim will be denied. A claim will be solicited from the beneficiary.

If the hospital has filed a billing election and the beneficiary files a claim, the beneficiary's claim is denied and the hospital is contacted for the claim.

110.12 - Processing Claims

(Rev. 1, 10-01-03)

A3-3698.12, HO-490.12

All claims are subject to development to determine whether the Medicare secondary payer provisions apply. (See The Medicare Secondary Payer Manual.)

A - Nonparticipating Hospitals

The processing FI is responsible for making accessibility and medical emergency determinations for physician and ambulance services.

1 - Claims Subject to Technical Denials

The following claims are subject to technical denial:

- Foreign nonemergency services claims if:
    - The residence requirement is not met. (See §110.6.)
    - The hospital rendering the service does not meet JCAHO or equivalent accreditation requirements set by a hospital approval program of the country in which it is located.
    - The accessibility requirements are not met. (See §110.12.1.)
- Canadian travel claims when the requirements in §110.5 are not met.
- Emergency services claims for which the hospital does not meet the definition of an emergency hospital.
- Claims for which the query response shows the beneficiary is not entitled to benefits.
- Any foreign claim when Part A benefits are exhausted and Part B physician or ambulance claims are not involved.

2 - Either the Accessibility or Medical Emergency Requirements are Not Met

Claim is denied but retained in case of appeal.

NOTE: Even though Part A or Part B emergency services furnished by U.S. hospitals are denied, Part B payment may be possible for Medical and Other Health Services specified in the Medicare Benefit Policy Manual, Chapter 6. Claim is retained in case of appeal.

3 - Emergency Services Partially Denied

When the medical emergency is approved but not for the entire period, the claim is processed and payment made for the covered period.

B - Canadian and Mexican Part B Physician and Ambulance Claims

The hospital must attach any Part B claim for foreign physician and ambulance services to the corresponding Part A claim and forward to the FI.

If the FI determines that the inpatient services were covered, it sends the physician and/or independent ambulance claim to the designated carrier for processing and payment. (See §110.7.)

If the Part A claim is denied on the basis of accessibility of medical emergency, the FI denies the Part B claim, and sends a denial letter to the claimant. It retains copies in case of appeal.

NOTE: Even though Part A benefits are totally or partially exhausted, payment may be made by the carrier for physician and independent ambulance services furnished if all coverage requirements are met.

If a Part A claim was partially denied because the emergency terminated, the FI makes a decision on the claim and any provider-based ambulance claim. It sends copies to the appropriate carrier for processing.

110.12.1 - Accessibility Criteria

(Rev. 1, 10-01-03)

A3-3698.13, HO-490.13

A - Emergency Claims

The FI uses the same criteria in domestic and foreign emergency claims. This includes services in a foreign religious non-medical health care institution and Canadian Travel claims. (See §110.5 and §110.9.)

Emergency determinations take into account such matters as relative distances of a participating hospital, and road conditions. The FI considers whether the nature of the emergency required immediate transportation to the nearest available hospital (i.e., the nonparticipating hospital) or, without hazard to the patient, would have permitted the additional transportation time to take the patient to a more distant participating hospital in the same general area.

The FI does not consider in its determination such factors involving selection of a hospital which reflect the personal preferences of the individual or physician, (e.g., physician does not have staff privileges at the participating hospital) nearness to beneficiary's residence, presence of previous medical records at the nonparticipating hospital, cost, or type of accommodations available.

The following sections discuss documentation of the accessibility requirement and provide guidelines for making a determination where the participating hospital is:

- Closer to the site of the emergency than is the admitting nonparticipating hospital;
- Fifteen or fewer miles farther from the site of the emergency than is the nonparticipating hospital; or

- Sixteen or more miles farther from the site of the emergency than is the admitting nonparticipating hospital.

In urban and suburban areas, where both participating and nonparticipating hospitals are similarly available, it is presumed, in the absence of clear and convincing evidence to the contrary, that the services could have been provided in the participating hospital.

1 - Participating Hospital Closer to Site of Emergency

If there is an adequately equipped participating hospital with available beds closer to the site of the emergency than the nonparticipating hospital, accessibility is not met. Claim is denied unless extenuating circumstances were present that necessitated admission to the nonparticipating hospital, e.g., because of road or traffic conditions additional travel time would have been needed.

2 - Participating Hospital 15 or Fewer Miles Farther From the Location of the Emergency Than the Admitting Nonparticipating Hospital

In this situation the accessibility is provisionally not met. The claim is reviewed to determine if the nature of the emergency required the immediate transportation to the nonparticipating hospital. If the review indicates that the nature of the emergency would have allowed the additional transportation time needed to take the patient to the participating hospital without undue hazard, the accessibility requirement is not met. The claim is denied.

3 - Participating Hospital More than 15 Miles Farther From the Location of the Emergency Than the Admitting Nonparticipating Hospital

The accessibility requirement is deemed met.

B - Foreign Nonemergency Claims

The following presumptions are applied to the relative accessibility of the nearest participating U.S. and foreign hospitals.

1 - Admitting Foreign Hospital is Closer to the Beneficiary's Residence Than the Nearest Participating U.S. Hospital

The accessibility requirement is met.

2 - Admitting Foreign Hospital is Farther From the Beneficiary's Residence Than the Nearest Participating U.S. Hospital

The accessibility requirement is not met unless evidence establishes the practical necessity for the beneficiary's admission. This requirement is met if the use of a closer participating U.S. hospital was impractical, e.g., non-availability of beds, needed equipment or personnel, or transportation not available.

In determining whether a foreign hospital is more accessible than a participating hospital, the FI does not consider the personal preference of the beneficiary, physician, or others in the selection of a hospital, the type of accommodations available, or the nonavailability of staff privileges to the attending physician.

C - Documenting Accessibility for Emergency Claims

The FI uses Form CMS-2628, Foreign HI Claim or Emergency Services Accessibility Documentation and Determination, to document accessibility in emergency claims. Access Form CMS-2628 from CMS at the following Web address: http://www.cms.hhs.gov/forms/

It checks the "met" block for claims that fall in the categories described in §§110.12.1A.2 or §110.12.1.A.3, and there are special circumstances of a nature not requiring medical judgment (e.g., Part I, Section C, Items 1, 2, and 5: bed unavailability, lack of transportation).

It checks the "not met" block for claims that fall in the category described in §110.12.A.1, and there are no special circumstances.

It checks the "not met-medical factors" for claims that fall in the category described in §110.12.A.1, and there are special circumstances requiring medical judgment (i.e., Part I, Section C, Items 4 and 6 unusual medical circumstances or nonavailability of needed equipment or personnel in the participating hospital).

110.12.2 - Medical Necessity

(Rev. 1, 10-01-03)

A3-3698.14, HO-490.14, A3-3698.15, HO-490.15

A - Emergency Services

Reimbursement for emergency inpatient hospital services is permitted only for those periods during which the patient's state of injury or disease is such that a health or life-endangering emergency existed and continued to exist, requiring immediate care that could be provided only in a hospital. The allegation that an emergency existed must be substantiated by sufficient medical information from the physician or hospital. If the physician's statement does not provide it, or is not supplemented by adequate clinical corroboration of this allegation, it does not constitute sufficient evidence.

Death of the patient does not necessarily establish the existence of a medical emergency, since in some chronic, terminal illnesses, time is available to plan admission to a participating hospital. The lack of adequate care at home or lack of transportation to a participating hospital does not constitute a reason for emergency hospital admission, without an immediate threat to the life and health of the patient. Since the existence of medical necessity for emergency services is based upon the physician's assessment of the

patient prior to admission, serious medical conditions developing after a non-emergency admission are not "emergencies" under the emergency services provisions of the Act.

The emergency ceases when it becomes safe, from a medical standpoint, to move the individual to a participating hospital, another institution, or to discharge the individual.

B - Criteria

Since the decision that a medical emergency existed can be a matter of subjective medical judgment involving the entire gamut of disease and accident situations, it is impossible to provide arbitrary guidelines.

1 - Diagnosis is Considered "Usually an Emergency"

An emergency condition is an unanticipated deterioration of a beneficiary's health which requires the immediate provision of inpatient hospital services because the patient's chances of survival, or regaining prior health status, depends upon the speed with which medical or surgical procedures are, or can be, applied. While many diagnoses (e.g., myocardial infarction, acute appendicitis) are normally considered emergencies, the hospital must check medical documentation for internal consistencies (e.g., signs and symptoms upon admission, notations concerning changes in a preexisting condition, results of diagnostic tests).

EXAMPLE

If the diagnosis is given as "coronary," the physician's statement is "coronary," without further explanatory remarks, and the statement of services rendered gives no indication that an electrocardiogram was taken, or that the patient required intensive care, etc., further information is required. On the other hand, if the diagnosis is one that ordinarily indicates a medical and/or surgical emergency, and the treatment, diagnostic procedures, and period of hospitalization are consistent with the diagnosis, further documentation may be unnecessary. An example is: admitting diagnosis - appendicitis; discharge diagnosis - appendicitis; surgical procedures - appendectomy; period of inpatient stay - 7 days.

2 - Patient Dies During Hospitalization

If an emergency existed at the time of admission and the patient subsequently expires, the claim is allowed for emergency services if the period of coverage is reasonable. However, death of the patient is not prima facie evidence that an emergency existed; e.g., death can occur as a result of elective surgery or in the case of a chronically ill patient who has a long terminal hospitalization. Such claims are denied.

3 - Patient's Physician Does Not Have Staff Privileges at a Participating Hospital

The fact that the beneficiary's attending physician does not have staff privileges at a participating hospital has no bearing on the emergency services determination. If the lack of staff privileges in an accessible participating hospital is the governing factor

in the decision to admit the beneficiary to an "emergency hospital," the claim is denied irrespective of the seriousness of the medical situation.

4 - Beneficiary Chooses to be Admitted to a Nonparticipating Hospital

The claim is denied if the beneficiary chooses to be admitted to a non-participating hospital as a personal preference (e.g., participating hospital is on the other side of town) when a bed for the required service is available in an accessible, participating hospital.

5 - Beneficiary Cannot be Cared for Adequately at Home

The patient who cannot be cared for adequately at home does not necessarily require emergency services. The claim is denied in the absence of an injury, the appearance of a disease or disorder, or an acute change in a pre-existing disease state which poses an immediate threat to the life or health of the individual and which necessitates the use of the most accessible hospital equipped to furnish emergency services.

6 - Lack of Suitable Transportation to a Participating Hospital

Lack of transportation to a participating hospital does not, in and of itself, constitute a reason for emergency services. The availability of suitable transportation can be considered only when the beneficiary's medical condition contraindicates taking the time to arrange transportation to a participating hospital. The claim is denied if there is no immediate threat to the life or health of the individual, and time could have been taken to arrange transportation to a participating hospital.

7 - "Emergency Condition" Develops Subsequent to a Non-emergency Admission to a Nonparticipating Hospital

Program payment cannot be made for emergency services furnished by a nonparticipating hospital when the emergency condition arises after a non-emergency admission. An example: treatment of postoperative complications following an elective surgical procedure or treatment of a myocardial infarction that occurred during a hospitalization for an elective surgical procedure. The existence of medical necessity for emergency services is based upon the physician's initial assessment of the apparent condition of the patient at the time of the patient's arrival at the hospital, i.e., prior to admission.

8 - Additional "Emergency Condition" Develops Subsequent to an Emergency Admission to a Nonparticipating Hospital

If the patient enters a nonparticipating hospital under an emergency situation and subsequently has other injuries, diseases or disorders, or acute changes in preexisting disease conditions, related or unrelated to the condition for which the patient entered, which pose an immediate threat to life or health, emergency services coverage continues. Emergency services coverage ends when it becomes safe from a medical

standpoint to move the patient to an available bed in a participating institution or to discharge the patient, whichever occurs first.

C - Documenting Medical Necessity

1 - Physician's Supporting Statement

Claims for emergency services by a non-participating hospital should be accompanied by an Attending Physician's Statement and Documentation of Medicare Emergency, Form CMS-l77l or its equivalent. This form describes the nature of the emergency, furnishing relevant clinical information about the patient, and certifying that the services rendered were required as emergency services. However, a copy of the patient's hospital records may be submitted instead. It should include history, physical, and admission notes, the medical record admission sheet, nurses' notes, doctors' orders, discharge summary, and all progress notes. A statement that an emergency existed, or the listing of diagnoses, without supporting information, is not sufficient. In addition, the statement must include the date, in the physician's judgment, the emergency ceased. The physician who attended the patient at the hospital makes the statement concerning emergency services. Only in exceptional situations, with appropriate justification, may another physician having full knowledge of the case, make the certification.

2 - Beneficiary's Statement in Canadian Travel Claims

In Canadian travel claims, the beneficiary's statement is considered in making a determination regarding medical necessity for emergency services; i.e., whether an emergency occurred while a beneficiary was traveling between Alaska and another State by the most direct route without unreasonable delay. (See §110.5.)

110.12.3 - Time Limitation on Emergency and Foreign Claims

(Rev. 1, 10-01-03)

A3-3698.16, HO-490.16

The regular time limits apply to requests and claims for payment for emergency hospital services and hospital services outside the U.S., for physician and ambulance services furnished in connection with foreign hospitalization, and for nonemergency services furnished by a domestic nonparticipating hospital. See Chapter 1 for a description of these requirements.

A - Beneficiary Denial Notices

Denial messages on RAs and MSNs are sent to the nonparticipating hospital and/or beneficiary, as appropriate, whenever a domestic emergency or foreign claim is fully or partially denied.

B - Termination of Emergency Services

No payment will be made for inpatient or outpatient emergency services rendered after a reasonable period of medical care in relation to the emergency condition in question. Some services may be covered in a domestic nonparticipating hospital as Part B Medical and Other Health Services. (See the Medicare Benefit Policy Manual, Chapter 6.) If, based upon all information, the total period claimed for emergency services coverage does not exceed the time required for a reasonable period of emergency medical care, the entire inpatient stay is covered. The fact that a medical record or other information states that the patient showed definite improvement several days prior to discharge is not necessarily an indication that the need for emergency services ceased as of that date. The concept of a reasonable period of emergency medical care is most easily applied when relatively short-term medical care is followed by the patient's progressive improvement. There are situations or conditions in which the determination of the end of covered emergency services may be more difficult because the patient's impairment is prolonged, there is no progressive improvement, or the patient's course may be progressively downhill, even though the condition is not critical. The stroke patient may be in this category. In such cases the need for emergency medical care usually ceases before the need for medical care in an institutional setting (i.e., hospital or SNF) ceases. Thus, the reasonable period of emergency care does not include the entire hospital stay if the stay was prolonged beyond the point when major diagnostic evaluation and treatment were carried out.

The FI will make the determination based upon all information available. As a general rule, if the period claimed for emergency services exceeds by more than 3 to 5 days the date on which the record definitely indicates that there was substantial improvement in the patient's condition so that the patient could possibly have been moved to a participating facility or discharged without damage to health, the period beyond the 3 to 5 days is denied. If the total period claimed for emergency services exceeds by no more than 3 to 5 days the date on which the record indicates substantial improvement in the patient's condition, the entire period is allowed.

This rule is intended to screen out short stay emergency hospitalization cases in which the patient was either discharged or transferred to a participating provider within a reasonable time after the medical record definitely indicated substantial improvement in the patient's condition.

The reasonable period of emergency care is that period required to provide relief of acute symptoms or for initial management of the condition while arrangements are made for definitive treatment. Two examples:

- Prostatic hypertrophy which results in acute urinary retention; and
- Mental illness with suicidal and/or homicidal tendencies.

In acute urinary retention, the reasonable period of emergency medical care includes the period required for catheterization and stabilization of the patient. The patient could then

be transferred to a participating hospital for surgery or other required treatment. For the suicidal or homicidal patient, a reasonable period of emergency medical care includes the time required for initial management of the case while arrangements are made for transfer (by commitment or otherwise) to a participating hospital. A period of 24 to 48 hours of emergency care is usually sufficient in both cases.

110.13 - Appeals on Claims for Emergency and Foreign Services

(Rev. 1, 10-01-03)

A3-3698.17, HO-490.17

A - Part A

The FI will conduct reconsiderations on claims it processes and will notify the claimant of the decision. It will follow the guidelines in the Chapter 29. It will review the initial determination of the claim, including all documentation. It will prepare the necessary beneficiary notification and retain the file for 6 months after the month of the final determination. A reconsideration determination is a final and binding determination of the Secretary, unless it is reopened and revised, or unless a hearing revises an initial determination.

NOTE: The RRB conducts reconsiderations for hospital services under the Railroad Retirement Act for services rendered in Canada.

B - Part B

Where the FI or carrier receives a request for review of an initial determination, it conducts the review and sends the determination.

C - Appeal of Reconsideration

All Part B hearing requests on claims for physician and independent ambulance services furnished in Canada or Mexico are within the jurisdiction of a carrier hearing officer regardless of who made the review determination. However, a hearing request on an FI determination is normally in connection with the Part A claim and considered and processed as such. If the enrollee had a Part A hearing and then requests a hearing on the same issue for the Part B claim, all pertinent information regarding the initial and reconsideration determinations and the hearing request are forwarded to the carrier. The beneficiary is notified of the transfer.

120 - Payment for Services Received in Nonparticipating Providers

(Rev. 1, 10-01-03)

A3-3699.1, HO-491

The Form CMS-1450 or its electronic equivalent must be used.

A - Hospital Filed Claims

1 - Inpatient Services

The payment rate for inpatient claims is the lower of: 90 percent of the hospital's average inpatient per diem cost for all patients, or 85 percent of its regular charge for the services rendered. Its average per diem cost is determined from the most recent calculation of the average per diem cost by a non-Governmental third-party payer.

The cost of the services is adjusted by any applicable deductible and coinsurance amounts for which the beneficiary is responsible.

Payment will be made to Federal hospitals that furnish emergency services, on an inpatient basis, to individuals entitled to hospital benefits. Payment will be based on the lower of the actual charges from the hospital or rates published for Federal hospitals in the "Federal Register" under Office of Management and Budget - Cost of Hospital and Medical Care and Treatment Furnished by the United States; Certain Rates Regarding Recovery from Tortiously Liable Third Persons.

Medicare will not pay Federal hospitals for emergency items or services furnished to veterans, retired military personnel or eligible dependents. However, Medicare can pay for the inpatient deductible charged by VA hospitals, or credit that amount to the Medicare Part A deductible, for emergency services furnished to veterans. If a Part A claim is denied, a denial notice will be forwarded to the beneficiary from the fiscal FI. The beneficiary can use this notice to forward to their private insurer, if applicable.

The VA or DOD hospital must file a statement of election for each calendar year to receive direct payment from Medicare for all claims filed that year.

2 - Outpatient Services

The amount paid by Medicare for emergency outpatient claims is obtained as follows:

- Eighty-five percent of the total covered charges is the estimated cost figure. The applicable Part B deductible is subtracted. Coinsurance is subtracted from the remainder.

- Subtracting the deductible from 85 percent of the total covered charges and applying the 20 percent coinsurance rate to the remainder obtains the patient's coinsurance amount. The hospital will be paid cost (85 percent of covered charges) minus deductible and coinsurance.

3 - Part B Medical and Other Health Services

Part B medical and other health services, including hospital-based ambulance services whether hospital or beneficiary filed, may be covered and paid on a non-emergency basis. To calculate the amount paid by Medicare, the hospital subtracts the Part B deductible from the total covered charges and applies the 80 percent payment rate.

4 - Special Letters for Partially or Totally Denied (Hospital-Filed) Claims for Emergency Inpatient Services

The patient receives a notice from CMS covering the emergency payment of a partially denied claim. A denial letter and a Part B explanation of benefits is sent to the patient. The FI includes its address on this letter.

B - Beneficiary Filed Claims

1 - Emergency Inpatient Claims

The payment computation follows:

- Any noncovered accommodation charge is subtracted from the total accommodation charges. The amount of the inpatient deductible or coinsurance met on this bill is subtracted. Any remainder is multiplied by 60 percent.
- The total noncovered ancillary charge is subtracted from the total ancillary charge. Any inpatient deductible or coinsurance that remains is subtracted. The remainder is multiplied by 80 percent.
- The benefit amounts obtained are added.

2 - Emergency Outpatient Services

To calculate the amount paid by Medicare, the hospital must subtract any applicable Part B deductible from the total covered charges and apply the 80 percent payment rate.

3 - Part B Medical and Other Health Services

Part B medical and other health services furnished by nonparticipating hospitals, including hospital-based ambulance services, may be covered and paid on an non-emergency basis.

To calculate the amount paid by Medicare, the hospital must subtract any applicable Part B deductible from the total covered charges and apply an 80 percent payment rate.

4 - Special Letters for Patient-Filed Claims for Emergency Inpatient Services

For emergency admissions to nonparticipating hospitals where direct payment is made to the patient, the FI sends the beneficiary one of the letters described below, as appropriate.

The letter explains the Part A payments made. Part B payments are made for ancillary services not covered by Part A and are also explained in a letter. This letter also explains the beneficiary's right of appeal.

The FI retains a duplicate of all notices sent for documentation in any appeals process. It enters the date the notice is released on both copies of all notices.

Sample paragraphs:

- "Enclosed is a check for $_____, which is the amount Medicare can pay for inpatient hospital services you received from (date of admission) to (date of discharge) in (hospital)."

- "Medicare is able to pay 60 percent of the charges for your room and board plus 80 percent of the charges for all other covered services during the period (date emergency began) to (date payment ended)."

  "Medicare is able to pay 60 percent of the charges for your room and board, 80 percent of the charges for other separately identified charges, and 66 2/3 percent of the other charges which were not separately identified on the hospital bill."

- "Medicare does not pay (the first $ ____ of charges) (the first three pints of blood) ($ ____ a day after the 60th day) in a benefit period. (Select one or more, if applicable.)"

- "If lifetime reserve days are used, add $ ___ a day from _____ to _____."

- "If you believe your Medicare hospital insurance should have covered all or more of your expenses, you may get in touch with us at the address shown on this letter."

- "If you believe that the determination is not correct, you may request a reconsideration for hospital insurance (or a review for medical insurance). You may make the request by mail to the address shown on this letter. If you come in person, please bring this notice with you."

- "This check includes a medical insurance payment for 80 percent of the charges for certain nonroutine hospital services which you received from _____ through _____. These services are listed on the enclosed form."

- "If a hospital bill is not itemized, Medicare can pay 66 2/3 percent of the total covered charges. Payment is being made at this rate for charges from (date emergency began) to (date payment ended)."

- "We are enclosing a check for $ _____. This is your payment under Part B for 80 percent of the charges for the services which you received from (admission date) through (discharge date) while in (name of hospital). These services are listed on the enclosed form."

When payment cannot be made under hospital insurance, medical insurance covers some, but not all, of the hospital services. Room and board and certain other services are not covered by medical insurance.

120.1 - Payment for Services of Canadian/Mexican Hospitals

(Rev. 1, 10-01-03)

A3-3699.2, HO-491.1

A - Hospital Filed Claim

A Canadian or Mexican hospital that elects to bill the Medicare program receives 100 percent of its customary charges, subject to applicable deductible and coinsurance amounts. The hospital establishes its customary charges for the services by submitting an itemized bill with each claim. This eliminates the need to file a cost report.

Regardless of the billing form used, the FI must:

- Recode the bill using revenue codes for the Form CMS-1450;
- Prepare an HUIP or HUOP input record for CWF; and
- Send an Medicare Summary Notice (MSN) to the beneficiary.

The Canadian or Mexican hospital must file a statement of election for each calendar year to receive direct payment from Medicare for all claims filed that year.

Payment is subject to the official exchange rate on the date the patient is discharged.

B - Beneficiary Filed Claim

To calculate the amount paid by Medicare for Part B Hospital-Based Ambulance Claims, the hospital must subtract any unmet Part B deductible from the total covered charges and apply the 80 percent payment rate.

Payment to the beneficiary is subject to the official exchange rate on the date of discharge.

120.1.1 - Attending Physician's Statement and Documentation of Medicare Emergency

(Rev. 1, 10-01-03)

A3-3699.5, HO-491.4

Form CMS-1771 - go to http://www.cms.hhs.gov/forms/

Form CMS-2628 - go to http://www.cms.hhs.gov/forms/

120.2 - Designated FIs and Carriers

(Rev. 1, 10-01-03)

A3-3699.3, HO-491.2, A3-3699.4

The appropriate FI processes claims for services provided. The hospital forwards these claims and any subsequent appeals directly to the appropriate FI. The State in which a beneficiary lives will determine which FI to send a shipboard or foreign claim. If a beneficiary lives in one state but receives emergency services from a VA or DOD provider in another state, the claims should be processed in the state where the emergency services were rendered.

A - FIs

Canada New Brunswick Newfoundland Nova Scotia Quebec Prince Edward Island	Associated Hospital Services 2 Gannett Drive Portland, ME 04106-6911
Ontario	United Government Services 401 West Michigan Street Milwaukee, Wisconsin 53202-2804
Alberta Manitoba Saskatchewan	Blue Cross & Blue Shield of Montana, Inc. 3360 10th Avenue, South Post Office Box 5004 Great Falls, Montana 59403
British Columbia Northwest Territories Vancouver Yukon Territories	Premera Blue Cross 7001 - 220th S.W. Mountlake Terrace, Washington 98043
Mexico Western Mexico (Sonora and the Bajas	United Government Services 401 West Michigan Street Milwaukee, Wisconsin 53202-2804

Eastern Mexico (Chihuahua, Coahuila, Nuevo Leon, Tamaulipas, etc.)	Trailblazer Health Enterprises, LLC 8330 LBJ Freeway Executive Center 3 Dallas, Texas 75243 P.O. Box 660156 Dallas, Texas 75266-0156

See theIntermediary Carrier Directory at: www.cms.hhs.gov/contacts/incardir.asp.

Domestic Emergency Claims and Veterans Administration/Department of Defense Claims, Foreign (other than Canada and Mexico) and Shipboard Claims

Region I	Associated Hospital Services, 2 Gannett Drive, South Portland, ME 04106-6911
Region III	Veritus Medicare Services 120 Fifth Avenue, Suite P5101 Pittsburgh, PA 15222
Region IV	Blue Cross and Blue Shield of Florida 532 Riverside Ave. 17th & 18th Floors Jacksonville, FL 32202
Region VI	Trailblazer Health Enterprises, LLC 8330 LBJ Freeway Executive Center 3 Dallas, Texas 75243 P.O. Box 660156 Dallas, Texas 75266-0156
Region VII	Blue Cross and Blue Shield of Nebraska 7261 Mercy Rd. Omaha, NB 68124 P.O. Box 3248 Main Post Office Station Omaha, NB 68180
Region IX	United Government Services 401 West Michigan Street Milwaukee, Wisconsin 53202-2804

Because there is no designated FI for Regions II, V, VIII, and X, the affected institutions must submit the claims to the servicing FI in their State. See www.cms.hhs.gov/contacts/incardir.asp for a list of FIs.

Claims for services provided in a Religious Nonmedical Health Care Institution (RNHCIs) (domestic and foreign) are submitted to:

Riverbend Government Benefits Administrator
(BCBS of Tennessee)
730 Chestnut Street
Chattanooga, Tennessee 37402

B - Designated Carriers

The following carriers are designated to process claims for physicians' and ambulance services furnished in connection with a covered hospital stay in Canada and Mexico.

Canada New Brunswick Newfoundland Nova Scotia Quebec Prince Edward Island	National Heritage Insurance Company 402 Otterson Drive Chico, CA 95928
Ontario	Wisconsin Physicians Service Insurance Corporation P.O. Box 8190 Madison, Wisconsin 53708 1601 Engel Street Madison, Wisconsin 53713
Alberta Manitoba Saskatchewan	Blue Cross & Blue Shield of Montana, Inc. 3360 10th Avenue, South Post Office Box 5017 Great Falls, Montana 59403
British Columbia Northwest Territories Vancouver Yukon Territories	Noridian Mutual Insurance Company 4305 13th Avenue, S.W. Fargo, North Dakota 58103
Mexico Western Mexico (Sonora and the Bajas	National Heritage Insurance Company 402 Otterson Drive Chico, CA 95928
Eastern Mexico (Chihuahua, Coahuila, Nuevo Leon, Tamaulipas, etc.)	Trailblazer Health Enterprises, LLC 8330 LBJ Freeway Executive Center 3 Dallas, Texas 75243 P.O. Box 660156 Dallas, Texas 75266-0156

120.3 - Model Letters, Nonparticipating Hospital and Emergency Claims

(Rev. 1, 10-01-03)

A3-3699.7, HO-491.5

120.3.1 - Model Letter to Nonparticipating Hospital That Elected to Bill For Current Year

(Rev. 1, 10-01-03)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

REFER TO:

Identification Number:

_____

Dear _____:

Your election to bill the Medicare program for emergency services furnished to Medicare beneficiaries will expire on December 31. Payment for emergency services can be made to a nonparticipating hospital only if the hospital elects to receive reimbursement from Medicare for all emergency services furnished to Medicare beneficiaries in a calendar year.

If you elect to bill the program, please return to us in the enclosed self-addressed envelope a statement signed by an authorized official of your hospital stating that you elect to claim payment under the Medicare program. An election to bill cannot be withdrawn during the year. If a statement is not received by December 31, we will assume that you do not wish to continue to bill the program at this time. However, you still retain the right to elect to bill the program at any time during the coming year if, when you make your election, you have not yet charged any Medicare beneficiary in that year for emergency hospital services rendered to him.

Hospitals electing to bill the program for emergency services may obtain information on reimbursement by contacting the FI serving nonparticipating hospitals in your State. If you do not elect to bill, the beneficiary may apply for reimbursement by submitting an itemized bill.

Please contact us if you need any further information. In addition, if at any time you decide to request full participation as a provider of hospital services under the Medicare program, please contact your Medicare FI for complete particulars.

Sincerely yours,

120.3.2 - Model Letter to Nonparticipating Hospital That Did Not Elect to Bill for Current Year

(Rev. 1, 10-01-03)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

REFER TO:

Identification Number:

_____

Dear _____:

Under the Medicare program, hospital benefits ordinarily can be paid only for care furnished to patients of hospitals that are participating in the program. However, the program can also pay for hospital services furnished to a beneficiary who is admitted to a nonparticipating hospital in an emergency. To receive payments for emergency services, a nonparticipating hospital must meet certain conditions specified in the law. We have determined that your hospital meets these conditions.

Payment for emergency services can be made to a nonparticipating hospital only if the hospital elects to receive reimbursement from Medicare for all emergency services furnished to Medicare beneficiaries in a calendar year. Although your hospital did not elect to bill the program for the current calendar year, you may wish to bill for the coming year. If you so choose, please have an authorized official of your hospital sign a statement to this effect and return in the enclosed self-addressed envelope. Retain a copy for your records. An election to bill cannot be withdrawn during the year.

If we have not received a statement from you by December 31, we will assume that you do not wish to bill the program at this time. However, you still retain the right to elect to bill the program at any time during the coming year if, when you make your election, you have not yet charged any Medicare beneficiary in that year for emergency hospital services rendered to him.

Hospitals electing to bill the program for emergency services may obtain information on reimbursement by contacting us. If a hospital does not elect to bill, the beneficiary may apply for reimbursement by submitting an itemized bill.

If at any time you decide to request full participation as a provider of hospital services under the Medicare program, please contact your Medicare intermediary for complete particulars.

Sincerely yours,

120.3.3 - Model Letter to Nonparticipating Hospital That Requests to Bill the Program

(Rev. 1, 10-01-03)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

REFER TO:

Identification Number:

_____

Dear _____:

This refers to your inquiry concerning payment for emergency hospital services rendered to a Medicare beneficiary in a hospital which is not participating in the Medicare program. Under the Medicare program, hospital benefits ordinarily can be paid only for care furnished to patients of hospitals that are participating in the program. However, the program can also pay for hospital services furnished to a beneficiary who is admitted to a nonparticipating hospital in an emergency. To receive payments for emergency services, a nonparticipating hospital must meet certain conditions specified in the law. We have determined that your hospital meets these conditions.

Payment for emergency services can be made to a nonparticipating hospital only if you elect to receive reimbursement from Medicare for all emergency services furnished to Medicare beneficiaries in a calendar year. Your hospital may now choose to bill the program for all emergency services furnished to Medicare beneficiaries during the current calendar year, if you have not yet charged any Medicare beneficiary this year for emergency hospital services rendered to him.

If you so choose, please have an authorized official of your hospital sign a statement to this effect and return in the enclosed self-addressed envelope. Retain a copy for your records. An election to bill cannot be withdrawn during the year.

Hospitals electing to bill the program for emergency services may obtain information on reimbursement by contacting us. If you do not elect to bill, the beneficiary may apply for reimbursement by submitting an itemized bill.

If at any time you decide to request full participation as a provider of hospital services under the Medicare program, please contact your Medicare intermediary for complete particulars.

Sincerely yours,

120.3.4 - Full Denial - Hospital-Filed or Beneficiary-Filed Emergency Claim

(Rev. 1, 10-01-03)

MODEL DENIAL NOTICE A

(FI'S NAME AND ADDRESS)

Date: _____

DETERMINATION ON EMERGENCY HOSPITAL SERVICES

Beneficiary: _____

Claim Number _____

We are sorry, but payment cannot be made for your stay from _____ through _____ at (hospital). This is because the (hospital) does not participate in the Medicare program and it has been determined that your treatment there does not qualify as emergency care.

Under the law, payment for services received in a nonparticipating hospital can be made only if you go, or are brought to, the hospital to receive emergency care. Emergency care under Medicare is defined as:

a. Care which is necessary to prevent the death or serious impairment to the health of the individual; and

b. Which, because of threat to the life or health of the individual, requires the use of the nearest hospital (in miles or travel time) that has a bed available and is equipped to handle the emergency.

The medical facts of your hospital admission and stay have been carefully reviewed. Based upon this review, we have found that, although it was necessary for you to be hospitalized, a medical emergency did not exist. There would have been time for you to have been admitted to a hospital participating in Medicare.

If you have questions about this notice, or if you believe the determination is not correct, you may request a reconsideration for hospital insurance. You must file your request within 6 months from the date of this notice. You may make the request through us.

120.3.5 - Partial Denial - Hospital-Filed or Beneficiary-Filed Emergency Claim

(Rev. 1, 10-01-03)

MODEL DENIAL NOTICE A

(FI'S NAME AND ADDRESS)

Date: _____

DETERMINATION ON EMERGENCY HOSPITAL SERVICES

Beneficiary: _____

Claim Number _____

This refers to your request for payment under Medicare for the services received while a patient at (hospital), from _____ through _____.

Payment can be made under the hospital insurance part of Medicare only for the costs of your hospitalization from _____ to _____.

The (hospital) does not participate in the Medicare program. Under the law, payment for services received in a nonparticipating hospital can be made only if you go, or are brought to, the hospital to receive emergency care. Emergency care under Medicare is defined as:

a. Care which is necessary to prevent the death or serious impairment to the health of the individual; and

b. Which, because of threat to the life or health of the individual, requires the use of the nearest hospital (in miles or travel time) which has a bed available and is equipped to handle the emergency.

Payment for emergency services stops when the emergency ends and it is permissible, from a medical standpoint, either to transfer the patient to a participating hospital or to discharge him.

The medical facts of your hospital admission and stay have been carefully reviewed. Based upon this review, we have found that an emergency condition existed when you were admitted. However, the medical information indicates that this emergency condition ended on _____. At that time, your condition had improved to the extent that you could have been transferred to a hospital participating in the Medicare program.

If you have questions about this notice, or you believe the determination is not correct, you may request a reconsideration. You must file your request within 6 months from the date of this notice. You may make the request through us.

120.3.6 - Denial - Military Personnel/Eligible Dependents

(Rev. 1, 10-01-03)

MODEL DENIAL NOTICE A

(FI'S NAME AND ADDRESS)

Date: _____

DETERMINATION ON EMERGENCY HOSPITAL SERVICES

Beneficiary: _____

Claim Number _____

We are sorry, but payment cannot be made for your stay from_____ through_____ at (hospital).

Under the law, medical services that have been furnished by a Federal hospital to retired members of the armed services, or their eligible dependents, are not covered under the Medicare program.

If you have questions about this notice, or you believe the determination is not correct, you may request a reconsideration. You must file your request within 6 months from the date of this notice. You may make the request through us at the above address.

Sincerely,

120.3.7 - Full Denial - Shipboard Claim - Beneficiary filed

(Rev. 1, 10-01-03)

MODEL DENIAL NOTICE

(FI'S NAME AND ADDRESS)

Date: _____

Beneficiary: _____

Claim Number:_____

DETERMINATION ON SHIPBOARD SERVICES

We are sorry, but medical services provided on the (vessel/ship's name) cruise ship are not covered. The Medicare program can make payment for medically necessary shipboard services only if all of the following requirements are met:

1. The vessel is of American Registry;

2. The performing physician is registered with the Coast Guard to furnished professional medical services; and

3. The services are furnished while the ship is within the territorial waters of the United States (in a U.S. port, or within 6 hours of departure or arrival at a U.S. port).

The vessels in the (name) line are not of American registry. For that reason, Medicare cannot make payment for the services in question.

If you have a supplemental insurance policy, you should check with the company carrying that policy to see if they cover these services and what procedures you should follow in submitting your claim.

If you have further questions concerning this issue, please send your correspondence to the above address.

Sincerely,

120.3.8 - Full Denial - Foreign Claim - Beneficiary Filed

(Rev. 1, 10-01-03)

MODEL DENIAL NOTICE

(FI'S NAME AND ADDRESS)

Date: _____

Beneficiary: _____ Claim Number:_____

DETERMINATION ON FOREIGN HOSPITAL SERVICES

We are sorry, but payment cannot be made for your stay from _____ through _____ at (hospital) in (country).

Medicare coverage outside of the United States is limited to emergency services provided in Canada or Mexico.

If you have a supplemental insurance policy, you should check with the company carrying that policy to see if they cover these services and what procedures you should follow in submitting your claim.

If you have further questions concerning this issue, please send your correspondence to the above address.

Sincerely,

130 - Coordination With the Quality Improvement Organization (QIO)

(Rev. 1, 10-01-03)

A3-3674

130.1 - Limitation on Liability Provision

(Rev. 1, 10-01-03)

A3-3674.1

(See Chapter 30 for a complete explanation of the limitation of liability provision.)

The basic premise of the limitation on liability provision (§1879 of the Act) is that beneficiaries who did not know, and did not have reason to know, that services were not covered are protected from liability in two specific denial situations:

- When the services are found not to be reasonable and necessary (which includes adverse level of care determinations); and
- When custodial care is involved.

If the beneficiary had knowledge of the noncoverage of services, the ultimate liability rests with the beneficiary. When neither the beneficiary nor the provider knew, or reasonably could have been expected to know, that services were not covered, the program accepts liability. Where the provider had such knowledge, liability falls upon the provider (i.e., the provider cannot charge the beneficiary for such services even though no program payment will be made).

Limitation on liability may apply to Part A and Part B services furnished by participating and nonparticipating hospitals (domestic and foreign), SNFs, HHAs, and other providers. Coinsurance and deductibles may be charged to the beneficiary where neither the beneficiary nor the provider is liable, and the beneficiary receives the benefit of this provision.

The QIO is responsible for making limitation on liability determinations relating to cases it reviews. The QIO informs the FI if payment should be made.

Payment may not be made for services denied by a QIO except under the limitation on liability provision. If neither the beneficiary nor provider is liable for denied services; and the QIO determines that additional time is required to arrange for post-discharge care, payment can be made for not more than 2 days ("grace days").

Medically unnecessary or custodial care days and "grace days," cannot be used to satisfy the 3-day prior hospitalization requirement for SNF payment for admissions after January 1, 1989.

130.2 - General Responsibilities of Hospitals, Quality Improvement Organizations (QIOs), and FIs

(Rev. 1, 10-01-03)

A3-3674.2

A - Responsibilities of Hospitals, QIOs, and FIs For Medical Review

A QIO is required to review services and items provided by physicians, other health care practitioners, and providers of health care services for which Medicare payment is sought. The QIO review determines if:

- Items and services are reasonable and medically necessary, and meet specific Medicare coverage requirements.
- Quality of such services meets professionally recognized standards of health care; and
- Items and services proposed to be provided in a hospital or other health care facility on an inpatient basis are medically appropriate, or whether they could be provided more effectively and economically on an outpatient basis, or in a different type of inpatient health care facility.

In addition, in hospitals subject to PPS, QIOs review:

- The validity of diagnostic information supplied by the provider;
- The completeness, adequacy, and quality of care provided;
- The appropriateness of admissions and discharges; and
- The appropriateness of care provided for which payment is sought on an "outlier" basis.

The QIO is responsible for these determinations. The FI is responsible for adjudication of other factors (e.g., eligibility and payment amount, indemnification requests), and for making the payment. This joint responsibility requires that the QIO notify the FI of its denial determinations, all preadmission determinations, and diagnostic or procedural coding changes.

Where MR is done prior to billing (preadmission review), the hospital reports the results of the QIO's review on the Form CMS-1450 in FLs 24-30, 36, 39-41. See Chapter 25. Where the QIO reviews bills after FI processing (postpayment review), the QIO reports adjustments to the FI. Currently there is no approved electronic format for this report.

B - Responsibility for Issuing Denial Notices and Making Limitation of Liability Determinations

The QIO is responsible for issuing denial notices and making limitation of liability determinations for cases it reviews. The QIO reports the results of its MR activity so the FI can prepare adjustment bills as needed. The FI does not issue a denial notice to the beneficiary or the hospital for cases that have been reviewed by the QIO. The QIO notifies the beneficiary and hospital.

The FI issues denial notices only where it make denial determinations, e.g., SNF, HHA, and outpatient bills, or denials based upon eligibility.

C - Bill Processing Requirements for Specified Procedures

The FI reviews FLs 24-30 (QIO Approval Indicator) in conjunction with its procedure table to determine whether to pay. It makes determinations as follows:

Inpatient: Where a specified procedure is coded in FLs 80, or 81, and FLs 24-30 contains:

- Code C1, C3, or C6 - Pay as billed.
- Code C4 - Do not pay, but process a no-payment bill. If a code indicates the patient's need for inpatient services was reviewed, and the QIO found that more of the stay was medically necessary, use code 4.
- Blank or code C5 - Return the claim to the provider for QIO review, unless the MOU requires sending it directly to the QIO.

Outpatient: When an ambulatory surgical procedure code, which requires preprocedure review, is present in FL 44, and FLs 24-30 contains:

- Code C1 or C6 - Pay as billed;
- Code C4 - Do not pay, but process a no-payment bill; or
- Blank - Return the claim to the provider for QIO review, unless the MOU requires sending it directly to the QIO.

If the ambulatory surgical procedure is a preprocedure denial by the QIO, the provider bills the FI. The bill type is 13X or 83X in FL 4, in FL 47 (Total Charges) revenue code 0001 is equal to zero and a code C4 is present in FLs 24-30. The FI does not send a denial notice to the beneficiary or provider. If the QIO reverses its decision, it will submit an electronic adjustment request record.

130.3 - Placeholder for Instructions for FI/QIO Coordination - (Now in Discussion Within CMS)

(Rev. 1, 10-01-03)

130.4 - QIO Monitoring of Hospital Notices for Denial of Continued Stay of Inpatient Care Under PPS

(Rev. 1, 10-01-03)

HO-414.3

A - Citations and Authority

The statutory authorities applicable to review of Hospital-Issued Notices of Noncoverage (HINNs) are found at §§1154(e) and 1879 of the Act. The regulatory authorities for issuing notices of noncoverage are found at 42 CFR 489.34, 411.404, and 412.42(c).

A hospital (including one with swing-beds) has the authority to issue notices of noncoverage to beneficiaries or their representatives if the hospital determines that the care the beneficiary is receiving, or is about to receive, is not covered because it is not medically necessary, is not delivered in the most appropriate setting, or is custodial in nature.

The HINN may be given prior to admission, at admission, or at any point during the inpatient stay.

B - Admission or Preadmission Notices of Noncoverage.

The hospital may issue notices of noncoverage under 42 CFR 411.404 before the beneficiary is admitted (preadmission notice), or upon admission (an admission notice). The utilization review committee or the hospital may issue Preadmission/admission notices of noncoverage, based on Medicare coverage guidelines, prior CMS notices, bulletins, or other written guides or directives from FIs, carriers, or QIOs.

NOTE: The hospital is not required to issue a HINN when it does not plan to bill the beneficiary (or their representative).

C - Continued Stay Notices of Noncoverage

The process for issuing a continued stay notice of noncoverage is the same for all types of hospitals. The regulatory authority under which these notices may be issued is determined by how Medicare pays the hospital.

- If the hospital is paid under the prospective payment system (PPS), and participates in State payment control systems (e.g., Maryland), or demonstration projects (e.g., The Finger Lakes area of New York), referred to hereafter as short-

term acute care hospitals in waivered States (see 42 CFR 489.34), it may issue continued stay notices of noncoverage under 42 CFR 412.42(c).

- If the hospital is paid on a reasonable cost basis, it may issue continued stay notices of noncoverage under 42 CFR 411.404.

- If the hospital is a swing-bed hospital providing skilled nursing facility (SNF) services to a beneficiary in a bed treated as a SNF bed, it may issue a continued stay HINN to the beneficiary when these services are no longer required under 42 CFR 411.404.

Section 1154(e) of the Act requires the QIO to review all hospital continued stay notices of noncoverage, upon an HINN request by a Medicare beneficiary (or their representative) or by the hospital. This statutory provision does not apply to QIO review involving SNF swing-bed services.

If a beneficiary (or their representative) receives a notice of noncoverage with the concurrence of only the attending physician, is still an inpatient, and requests a QIO immediate review before noon of the first working day after the date of receipt of the notice:

- The QIO requests the hospital to provide it with the medical records by close of business of the first working day after the date the beneficiary (or their representative) receives the notice;

- The QIO reviews the case and notifies the beneficiary (or their representative), the hospital, and the attending physician of its decision by the first full working day after the date of receipt of the beneficiary's request and the required medical records from the hospital; and

- If the beneficiary (or their representative) made such a request and did not know, nor could reasonably have been expected to know, that continued inpatient hospital stay was not necessary (§1879(a)(2) of the Act), the hospital may not charge the beneficiary before noon of the day after the day the beneficiary (or their representative) received the QIO's decision.

Section 1154(e)(2) of the Act requires the hospital to notify a beneficiary (or their representative) when the hospital requests the QIO's review of the hospital's decision because the attending physician disagrees with the hospital's issuing of the notice of noncoverage. This notice is given to the beneficiary (or their representative) concurrently when the request is made for the QIO review. (See Letter 10.)

The QIO solicits the beneficiary's views (or those of the beneficiary's representative) whenever:

- The beneficiary (or their representative) requests that the QIO review the HINN; or

- The hospital requests the QIO because the attending physician disagrees with its decision to issue an HINN.

NOTE: PPS and non-PPS hospitals can issue a notice of noncoverage when a SNF bed is available regardless of the beneficiary's (or their representative's) refusal of placement. The policy also applies to situations involving a change in the patient's level of care from acute to SNF swing bed services. Although this change is a paper transaction, the swing bed hospital must give an HINN because it has a (SNF) bed available for the patient.

130.5 - Issuance of Hospital Notices of Noncoverage

(Rev. 1, 10-01-03)

HO-414.4

A - Preadmission/Admission Notices of Noncoverage

The QIO issues a notice of noncoverage when the hospital determines that the admission is not medically necessary, is inappropriate, or is custodial in nature. (See Letter 1.) The hospital need not obtain the attending physician's concurrence or the QIO's prior to issuing the preadmission or admission notice of noncoverage. This also applies to HINNs related to direct admissions to swing beds (i.e., beneficiary is admitted to the swing bed after being discharged from another hospital), or when the hospital determines that the beneficiary does not need SNF services. (See Letter 9.)

B - Continued Stay Notices of Noncoverage

The hospital may issue a continued stay notice of noncoverage when it determines that a beneficiary no longer requires continued inpatient care and either the attending physician or the QIO concurs. Before the hospital can issue a continued stay notice of noncoverage, it must consider the admission to be covered.

1 - Attending Physician Concurs

If the attending physician concurs in writing (e.g., written discharge order) with the hospital's determination that the beneficiary no longer requires inpatient care, the hospital may issue a notice of noncoverage to the beneficiary. (See Letters 2 through 4.)

2 - Attending Physician Does Not Concur

The hospital issues a notice to the beneficiary (or their representative) (Letter 10) when the beneficiary's physician disagrees with the hospital's proposed notice of noncoverage and the QIO is requested to review the case. The hospital may use its own letterhead, but may not alter or change the language in the model letter. It gives the notice to the beneficiary (or their representative) concurrently when it requests the QIO's review. The QIO will develop procedures to monitor issuance of that notice to beneficiaries (or their representatives). For example, at the time the QIO solicits the

beneficiary's views, the QIO must ask the beneficiary (or their representative) if they received the notice.

The hospital may request, either by phone or in writing, that the QIO review the case immediately. Review must be completed within two working days of either the hospital's request or receipt of any additional information the QIO requested, (e.g., copies of medical records). The QIO will determine, on a case-by-case basis, whether a medical record is needed to make the determination as to the medical necessity and appropriateness of the admission and days of care. If the QIO concurs with the hospital's decision, the hospital will be notified that it may issue one of the notices shown in Letters 5, 6, or 7 or the QIO will issue its own denial notice.

NOTE: In cases where the beneficiary requires an SNF level of care, the hospital does not issue a notice of noncoverage if an SNF bed is not available. Medicare pays the hospital, in outlier cases, for days awaiting placement until an SNF bed is available, and the medical record documentation indicates that SNF placement is actively being sought.

3 - Advance Continued Stay HINN Notice

The hospital must project and determine when acute care furnished to a beneficiary would end, and issue a continued stay notice of noncoverage (with the attending physician's concurrence or the QIO's). If it is able to determine in advance that the beneficiary will not require acute inpatient hospital care as of a certain date, it may give the notice of noncoverage in advance of that date, but ordinarily no earlier than 3 days before the first noncovered day.

EXAMPLES

The beneficiary had hip surgery and requires rehabilitative services but not at an acute hospital level of care. The hospital determines that the most appropriate setting for those services would be a SNF, and makes arrangements to transfer the beneficiary (within 3 days) since an SNF bed will be available.

The beneficiary is recovering from an uneventful post surgical period (after a cholecystectomy). The hospital predicts that within two days the beneficiary will no longer require injections for pain control and will tolerate a regular diet and ambulation.

The advance notice does not relieve the hospital or the attending physician of the responsibility for monitoring the beneficiary's condition/level of care changes, or for making appropriate discharge planning. If after the notice is issued, the beneficiary's condition/level of care changes and acute care is further required (or the SNF bed is no longer available), the hospital rescinds its notice of noncoverage.

C - Combined Notices in Swing-Bed Situations

"Combined notices" apply to situations where the beneficiary is in an acute care hospital which has beds certified as swing beds, and no longer requires an acute level of care. Letters 4 and 7 are applicable when the beneficiary requires an SNF level of care. Letters 3 and 6 are applicable when the beneficiary requires a nursing facility (NF) level of care. Effective October 1, 1990, both SNFs and intermediate care facilities participating in the Medicaid program are referred to as NFs.

The discharge from the acute care bed and admission to the (SNF or NF) swing-bed are essentially paper transactions, with no physical movement of the beneficiary. The purpose of the combined notice is to notify the beneficiary (or their representative) that:

- Neither the acute nor SNF care is medically necessary (Letters 3 and 6), or
- The beneficiary no longer requires acute care hospital services, but will begin to receive SNF swing-bed services (Letters 4 and 7).

The combined notice also notifies the beneficiary (or their representative) that an immediate QIO review may be requested if they disagree with the hospital's decision.

The notices in Letters 4 and 7 also explain that the beneficiary (or their representative) is liable for any applicable deductible and coinsurance amounts, and for any convenience services or items normally not covered by Medicare, but related to acute hospital and SNF swing bed services.

The hospital issues the combined notice of noncoverage with either the attending physician's or the QIO's concurrence. The two post-discharge planning days applicable to PPS hospital cases (see 42 CFR 412.42(c)) would not apply to this situation. The beneficiary's (or their representative's) liability for payment begins the day following the date of receipt of the notice. The beneficiary may request the QIO's immediate review. However, the beneficiary's liability remains the same as specified in the HINN.

D - Continued Stay HINN in Swing Beds Treated as SNF Beds

The hospital does not need the concurrence of attending physician or the QIO to issue a continued stay HINN to a beneficiary when SNF swing bed services are no longer needed. (See Letter 8.) The immediate review provisions of OBRA 1986 and OBRA 1987 do not apply to stays in SNF swing beds. These notices are also subject to QIO review.

130.5.1 - Content of HINNs

(Rev. 1, 10-01-03)

HO-414.5

A - Content

HINNs must contain specific information for the protection of beneficiaries, as well as the hospital. The HINN to the beneficiary (or their representative) must conform to the content (but need not be a duplicate) of the model letters contained in Letters 1 through 9. (The notice in Letter 10 is mandatory, and cannot be altered by hospitals.)

If the hospital does not use the model notice, its notice must explain:

- Dates the care is determined to be noncovered and why (e.g., admission noncovered because the services could be performed safely and effectively on an outpatient basis);
- Who made the determination (e.g., the hospital, with the concurrence of the attending physician, or the hospital with QIO's concurrence);
- That the notice is not an official Medicare determination;
- The beneficiary's (or their representative's) review rights;
- The procedures for requesting QIO review; and
- What effects the notice and a QIO review request have on the beneficiary's liability, including exactly when liability begins.

HINNs must not mislead the beneficiary (or their representative) or misstate the hospital's authority to, or responsibility for, issuing the notice. The notice cannot contain, for example:

- Statements and implications that the decision of noncoverage was not made by the hospital, but by someone else (e.g., by CMS); or
- Inaccurate information as to the beneficiary's responsibility for payment.

B - Acknowledgment of Receipt

The hospital must document the date and time of the beneficiary's (or their representative's) receipt of the HINN. Obtain an acknowledgment of receipt (including date and time) signed by the beneficiary (or their representative). A copy of this acknowledgment is to be kept in the medical records.

If the beneficiary (or their representative) refuses to sign the acknowledgment, the hospital will immediately write on the HINN that the patient refused to sign and will

prepare a report for its files (i.e., medical records). The date of refusal is then considered the date of receipt.

The hospital is responsible for determining whether the beneficiary, upon admission, is mentally competent and capable of transacting business (as opposed to being incapable of handling their own affairs, unable to sign and negotiate checks). It will develop procedures to use when the beneficiary is incapable or incompetent and the hospital cannot obtain the signature of the beneficiary's representative through direct personal contact. When it mails the notice to the beneficiary's representative, it will simultaneously phone the beneficiary's representative. The date of the phone conversation is the date of receipt of the notice.

When direct phone contact cannot be made, the hospital sends the notice to the representative by certified mail, return receipt requested. The date that someone at the representative's address signs (or refuses to sign) the receipt is the date of receipt.

The hospital may employ other procedures that have been reviewed and approved by the QIO and when needed for review, will provide the QIO with proof of proper notification.

NOTE: In considering the different procedures that each postal station may have in handling "return receipt requested mail," the following procedure used by hospitals is considered acceptable. For an HINN sent by certified mail, return receipt requested, which is returned to the hospital with no indication of a refusal date, the hospital determines the beneficiary's representative's liability starting on the second working day after the hospital's mailing date (postmarked by the postal station).

130.5.2 - QIO Monitoring of HINNs

(Rev. 1, 10-01-03)

HO-414.6

A - Purpose

The QIO monitors the content of the HINN and the accuracy of the hospital determination. Upon a beneficiary's or hospital's request for review, the QIO determines whether the HINN is appropriate and accurate.

When HINNs are issued and no request for review is made, the QIO ensures on an ongoing basis that:

- The hospital followed the appropriate process;
- The content of the notice is accurate/appropriate; and
- That the FI's decision to issue the notice is correct.

The QIO monitors the hospital to ensure that it is issuing the Hospital Notice to Beneficiary of QIO Review of Need for Continued Hospitalization (Letter 10) timely to the beneficiary when the hospital requests QIO review.

B - Ongoing Monitoring

Identification of Cases - The QIO identifies cases, where the hospital has issued a notice of noncoverage using:

- The copy of the (preadmission, admission, or continued stay) HINN submitted to the QIO within three working days of the HINN issuance; and

- The processed claims data.

NOTE: The hospital submits a bill for all inpatient stays, including those for which no payment can be made. Although no monies are involved with "No-pay bills," a claim is required because hospitalization could extend a Medicare beneficiary's benefit period.

C - Inappropriate HINN

An inappropriately issued HINN would be any case where:

- The hospital's finding is invalid (e.g., where the admission was covered and where continued acute care was medically necessary;)

- The content of the notice is not in compliance;

- The patient was charged for services without a notice;

- The patient requires SNF care and there was no available SNF bed;

- A continued stay HINN is issued without the concurrence of the QIO or the attending physician (except in cases where the level of care changes from SNF swing bed services to NF); and

- The beneficiary did not receive written notice when discharged from acute care and admitted to SNF or NF swing bed services.

NOTE: In cases involving an admission HINN where the QIO determines that the beneficiary's condition changed from nonacute to acute, the QIO will assign a deemed date of admission. Since the QIO agreed that the HINN was not issued in error, the case will not count against the FI as long as it did not charge the beneficiary for the covered acute inpatient services.

130.5.3 - Notices in Investigational/Experimental Procedures Situations

(Rev. 1, 10-01-03)

HO-414.7

The hospital may charge a beneficiary for diagnostic procedures and studies, and therapeutic procedures and courses of treatment (e.g., experimental procedures) that are excluded from coverage as medically unnecessary, if it has informed the beneficiary in writing. (See 42 CFR 412.42(d).) Since the hospital is required to submit investigational services/items to its FI for approval, it will follow the FI's instructions as to the language to use in the HINN.

130.6 - Beneficiary Liability

(Rev. 1, 10-01-03)

HO-414.8

After the hospital issues a notice of noncoverage, the beneficiary (or their representative) is considered to have knowledge that services are not covered and is liable for customary charges as specified below.

A - Preadmission Notices of Noncoverage

The beneficiary (or their representative) is liable for customary charges for all services furnished if the beneficiary is admitted after receipt of a preadmission notice of noncoverage.

B - Admission Notices of Noncoverage

1 - Notice of Noncoverage Issued on the Day of Admission

The beneficiary (or their representative) is liable for customary charges for all services furnished after the notice is received. However, to hold a beneficiary (or their representative) liable for charges on the day of admission, the hospital must issue the notice no later than 3:00 PM on the day of admission. If it does not meet these requirements, the beneficiary (or their representative) is protected from liability until the day following receipt of the notice of noncoverage (e.g., a notice issued for an admission after 3:00 PM or a late evening admission).

2 - Notice of Noncoverage Issued after the Day of Admission

The beneficiary (or their representative) is liable for customary charges for all services furnished beginning the day following the date of receipt of the notice.

C - Continued Stay Notices of Noncoverage

1 - For Notices Issued with the Concurrence of the Attending Physician Where the Beneficiary's (or Their Representative) Requested QIO Review by Noon of the First Working Day After the Day They Received the HINN and They Meet the Conditions of §1879(a)(2) of the Act.

The beneficiary's (or their representative's) liability will begin at noon of the day following notification of the QIO's determination. The hospital will be held financially liable for costs incurred from date of notice, since it knew that services were noncovered (as demonstrated by issuance of the notice).

NOTE: If the hospital does not provide the medical records by close of business of the first working day after the date that the beneficiary (or their representative) receives the notice, the beneficiary's (or their representative's) liability will not begin until noon of the day following notification of the QIO's determination.

2 - For Notices Issued with the Concurrence of the QIO, or with the Concurrence of the Attending Physician, Where the Beneficiary (or Their Representative) Does Not Request QIO Review by Noon of the First Working Day After the Day They Received the HINN and the Beneficiary or (Their Representative) Meets the Conditions of §1879(a)(2) of the Act

If the hospital is a short term/acute care hospital paid under PPS or located in a waivered State, the beneficiary (or their representative) is liable for customary charges for services furnished beginning the third day following the date of receipt of the hospital notice.

If a hospital is paid on a reasonable cost basis, the beneficiary (or their representative) is liable for customary charges for services furnished beginning the day following the date of receipt of the hospital notice.

For HINNs involving swing-bed situations (i.e., notices issued to a beneficiary when their level of care changes from acute to SNF or NF, or from SNF to NF), the beneficiary (or their representative) is liable for customary charges for services furnished beginning the day following the date thy receive the notice.

NOTE: If the beneficiary leaves the facility on the day following the date of receipt of the notice, the beneficiary (or their representative) is liable for applicable deductible and coinsurance amounts, and for charges for convenience items or services normally not covered by Medicare.

D - Grace Days

When a hospital issues a notice of noncoverage, the beneficiary's (or their representative's) liability begins in accordance with the policies described in §§130.6 A-C above. The QIO will not approve payment for additional days for purposes of post-discharge planning (i.e., grace days).

The specific statutory, regulatory, and policy provisions take into consideration the need for post-discharge planning. For example, 42 CFR 412.42(c) specifies that the beneficiary (or their representative) is liable beginning the third day following the date of receipt of the notice. This provides time between notification and liability for post-discharge planning. (These days are not grace days.)

Section 1154(a)(2)(b) of the Act specifies that such grace days may be provided only in cases where the hospital did not know and could not reasonably have been expected to know that payment would not otherwise be made for such services under Medicare. A hospital who issues a notice of noncoverage has demonstrated knowledge that Medicare will not cover the services and, therefore, §1154(a)(2)(B) (grace days) is not applicable to HINN situations.

130.7 - Provider Liability

(Rev. 1, 10-01-03)

HO-414.9

The provider is considered to have knowledge, as of the date of notice, that furnished (or proposed) services were noncovered if it issued a notice of noncoverage to the beneficiary. (See 42 CFR 411.406(d).)

130.8 - Right to a Reconsideration

(Rev. 1, 10-01-03)

HO-414.10

A - QIO Disagrees with Hospital Determination

If the QIO disagrees with the hospital's determination of noncoverage (i.e., the QIO determines that the case was covered), the QIO's decision is not subject to reconsideration, as this is neither a denial determination nor a QIO determination under §1154 of the Act.

B - QIO Agrees with Hospital Determination

If the QIO agrees with the hospital's determination either prior to or after issuance of the hospital's notice, the QIO will issue a denial notice. The QIO's determination is subject to reconsideration in accordance with 42 CFR Part 473.

130.9 - Model Hospital Issued Letters

(Rev. 1, 10-01-03)

HO-414.11

Exhibit 1 - Hospital Issued Notices of Noncoverage - Ten Letters

Letter 1 - Model Hospital-Issued Notice of Noncoverage - Admission or Preadmission

Hospital Letterhead

_____

Date of Notice

_____ _____

Name of Patient or Representative Admission Date

_____ _____

Address Health Insurance Claim (HIC) Number

_____ _____

City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

The purpose of this notice is to inform you that we find that your admission for (specify services or condition) is not covered under Medicare because (specify services to be furnished or condition to be treated) (specify is/are medically unnecessary) or (could be safely furnished in another setting) This determination was based upon our understanding and interpretation of available Medicare coverage policies and guidelines. You should discuss with your attending physician other arrangements for any further health care you may require. If you decide to (be admitted to/remain in) the hospital, you will be financially responsible for _____.[1]

_____

[1] For preadmission notices, insert: "all customary charges for services furnished during the stay, except for those services for which you are eligible under Part B."

For admission notices issued not later than 3:00 P.M. on the date of admission, insert: "customary charges for all services furnished after receipt of this hospital notice, except for those services for which you are eligible under Part B." (If these requirements are not met, insert the liability phrase below.)

For admission notices issued after 3:00 P.M. on the day of admission, insert: "customary charges for all services furnished on the day following the day of receipt of this notice, except for those services for which you are eligible to receive payment under Part B."

This notice, however, is not an official Medicare determination. The (name of QIO) is the quality improvement organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of (name of State), and to make that determination.

- If you disagree with our conclusion: (Select as appropriate)

  Preadmission:

  - Request immediately, but no later than 3 calendar days after receipt of this notice, or, if admitted, at any point in the stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO by telephone or in writing to the address listed below.

  Admission:

  - Request immediately, or at any point during your stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO by telephone or in writing to the address listed below.

- If you do not wish an immediate review:

  - You may still request a review within 30 calendar days from the date of receipt of this notice by telephoning or writing to the address specified below.

- Results of the QIO Review:

  - The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization, and will inform you of your reconsideration and appeal rights.

  - IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., the QIO determines that your care is covered), you will be refunded any amount collected except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.

  - IF THE QIO AGREES WITH THE HOSPITAL, you are responsible for payment for all services beginning on (specify date).[1]/

---

[1]/ See footnote 1 on preceding page.

- QIO Address:

_____

(QIO Name)

_____

(Address)

_____

(Telephone Number)

Sincerely,

_____

Chairperson of Utilization Review

Committee, Medical Staff, etc

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from the (name of hospital) at (time) on (date). I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____

(Signature of beneficiary or person acting on behalf of beneficiary) (Time) (Date)

cc: QIO

Attending Physician

Letter 2 - Model Hospital-Issued Notice of Noncoverage Continued Stay (Attending Physician Concurs)

Hospital Letterhead

_____

Date of Notice

_____ _____

Name of Patient or Representative Admission Date

_____

_____ Health Insurance Claim (HIC) Number

Address

_____

_____ Attending Physician's Name

City, State, Zip Code

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

This notice is to inform you that we have reviewed the medical services you have received for (specify services or condition) from (date of admission) through (date of last day reviewed). Your attending physician has been advised and has concurred that beginning (specify date of first noncovered day) further (specify services to be furnished or condition to be treated) (specify is/are medically unnecessary) or (could be furnished safely in another setting). This determination was based upon our understanding and interpretation of available Medicare coverage policies and guidelines.

You are financially liable for all costs for the care you receive, except for those services for which you are eligible under Part B beginning on (specify date).[1]/ If you leave on (specify date)[1]/, you will not be liable for costs for care except for payment of deductible, coinsurance, or any convenience services or items normally not covered by Medicare. You should discuss other arrangements with your attending physician for any further health care you may require.

_____

[1]/ For PPS hospitals and short term/acute care hospitals in waivered States, insert: the date of the third day following the date of receipt of the hospital notice.

For specialty hospitals and PPS exempt units, insert: the date of the day following the date of receipt of the notice.

However, this notice is not an official Medicare determination. The (name of QIO) is the quality improvement organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of (name of State),and to make that determination.

- If you disagree with our conclusion:
    - Request immediately, by noon of the first working day after receipt of this notice, an immediate review by telephone, or in writing. You may make this request through us or directly to the QIO at the address listed below.
    - The QIO will request your views about your case and respond to you within one working day of receipt of your request and your medical records (sent by the hospital).
- If you do not request review by noon of the first working day after receipt of this notice:
    - You may still request QIO review at any point during your stay or within 30 days after you receive this notice, whichever is longer. Request this QIO review at the address listed below.
- QIO Review Results:
    - The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization, and will inform you of your reconsideration rights.
    - IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., it determines that your care is covered by Medicare), you will be refunded any amount collected by the hospital except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.
    - IF THE QIO AGREES WITH THE HOSPITAL:
        - You are responsible for payment for all services beginning on (specify date)[1]/ unless you have requested an immediate review.

---

[1]/ See footnote 1 on preceding page

- If you request an immediate review (i.e., you make your request for review by noon of the first working day after receipt of this notice), you will not be responsible for payment until noon of the next day after you receive the QIO's notification.

- QIO Address:

  _____

  (QIO Name)

  _____

  (Address)

  _____

  (Telephone Number)

Sincerely,

_____

Chairperson of Utilization Review

Committee, Medical Staff, etc

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from the (name of hospital) at (time) on (date). I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____

(Signature of beneficiary or person acting on behalf of beneficiary) (Time) (Date)

cc: QIO

Attending Physician

Letter 3 - Model Hospital-Issued Notice of Noncoverage, Continued Stay-Swing Bed Only - (Attending Physician Concurs) (Patient Changes from Acute to NF Level of Care)

Hospital Letterhead

_____

Date of Notice

_____

Name of Patient or Representative

_____

Address

_____

City, State, Zip Code

_____

Admission Date

_____

Health Insurance Claim (HIC) Number

_____

Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

This notice is to inform you that we have reviewed the medical services you have received for (specify services or condition) from (date of admission) through (date of last day reviewed). Your attending physician has been advised and has concurred that beginning (specify date of first noncovered acute care day) further (specify services to be furnished or condition to be treated) (specify is/are medically unnecessary) or (could be furnished safely in another setting). This determination was based upon our understanding and interpretation of available Medicare coverage policies and guidelines.

Upon receipt of this notice, the items and services you received will not be covered under Medicare. The care that you need now is not hospital or skilled nursing care and Medicare does not pay for it.

If you decide to stay in the hospital, you are financially liable for all costs of the care you receive except for those services for which you are eligible under Part B, beginning on (specify date).[1]/ If you leave the hospital on (specify date), you will not be liable for costs of care except for payment of deductible, coinsurance, or any convenience services or items normally not covered by Medicare. You should discuss other arrangements with your attending physician for any further health care you may require.

[1]/ For PPS hospitals and short term/acute care hospitals in waivered States, insert the date of the third day following the date of receipt of the hospital notice.

However, this notice is not an official Medicare determination. The (name of QIO) is the quality improvement organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of (name of State) and to make that determination.

- If you disagree with our conclusion:
  - Request immediately, or at any point in the stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO at the address listed below.
- If you do not request an immediate review:
  - You may still request QIO review within 30 days after you receive this notice. Request this QIO review at the address listed below.
- QIO Review Results:
  - The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization, and will inform you of your reconsideration rights.
  - IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., it determines that your care is covered by Medicare), you will be refunded any amount collected by the hospital except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.
  - IF THE QIO AGREES WITH THE HOSPITAL: You are responsible for payment for all services beginning on (specify date)[1]/
- QIO Address:

_____
(QIO Name)

_____
(Address)

_____
(Telephone Number)

Sincerely,

_____
Chairperson of Utilization Review
Committee, Medical Staff, etc

---

[1]/ See footnote 1 on preceding page.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from the (name of hospital) at (time) on (date). I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____	_____	_____
(Signature of beneficiary or person acting on behalf of beneficiary)	(Time)	(Date)

cc: QIO

Attending Physician

Letter 4 - Model Hospital-Issued Notice of Noncoverage Continued Stay-Swing Bed Only (Attending Physician Concurs) (Patient Changes from Acute to NF Level of Care)

Hospital Letterhead

_____

Date of Notice

_____ _____

Name of Patient or Representative Admission Date

_____ _____

Address Health Insurance Claim (HIC) Number

_____ _____

City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

This notice is to inform you that we have reviewed the medical services you have received for (specify services or condition) from (date of admission) through (date of last day reviewed). Your attending physician has been advised and has concurred that beginning (specify date of first noncovered acute care day), you no longer need an acute level of care. You will begin to receive the type of hospital services which are furnished in a skilled nursing facility (SNF) beginning (specify date of first SNF swing- bed day). This is known as SNF swing-bed services. Medicare will pay for your SNF swing-bed services (if you have not used up all your SNF benefit days in the benefit period).

However, this notice is not an official Medicare determination. The (name of QIO) is the quality improvement organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of (name of State) and to make that determination.

- If you disagree with our conclusion and want an immediate review:
    - Request immediately, or at any point in the stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO at the address listed below.
- If you do not request an immediate review:
    - You may still request QIO review within 30 days after you receive this notice. Request this QIO review at the address listed below.

- QIO Review Results:
    - The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization, and will inform you of your reconsideration rights.
    - IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., it determines that your care is covered by Medicare), you will continue to receive acute care services covered under Medicare. You will continue to be responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.
    - IF THE QIO AGREES WITH THE HOSPITAL: you will continue to receive SNF swing bed services paid under Medicare. You will continue to be responsible for payment of any applicable amounts for deductible, coinsurance, or convenience services or items normally not covered by Medicare.
- QIO Address:

_____

(QIO Name)

_____

(Address)

_____

(Telephone Number)

Sincerely,

_____

Chairperson of Utilization Review

Committee, Medical Staff, etc

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from the (name of hospital) at (time) on (date). I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____	_____	_____
(Signature of beneficiary or person acting on behalf of beneficiary)	(Time)	(Date)

cc: QIO

Attending Physician

Letter 5 - Model Hospital-Issued Notice of Noncoverage Continued Stay (QIO Concurs)

Hospital Letterhead

_____

Date of Notice

_____ _____

Name of Patient or Representative Admission Date

_____ _____

Address Health Insurance Claim (HIC) Number

_____

_____ Attending Physician's Name

City, State, Zip Code

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

We have reviewed the medical services you have received for (specify services or condition) from (date of admission) through (date of last day reviewed) and has determined that further hospitalization is not necessary. This determination is based upon our understanding and interpretation of available Medicare coverage policies and guidelines.

The (name of QIO) is the quality improvement organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of (name of State). The (name of the QIO) has concurred with our decision that beginning (specify date of first noncovered day) further (specify services to be furnished or condition to be treated) (specify is/are medically unnecessary) or (could be safely furnished in another setting). You will also receive a notice from (name of QIO) confirming the review decision.

We have advised your attending physician of the denial of further inpatient hospital care. You should discuss other arrangements with your attending physician for any further health care you may require.

If you decide to stay in the hospital, you will be responsible for payment for all services provided to you by this hospital, except for those services for which you are eligible to receive payment under Part B, beginning (specify date).[1]/

For specialty hospital and PPS-exempt units, insert the date specified by the QIO. The beneficiary's (or representative's) liability begins on the day following the date of receipt of the notice.

_____

[1]/ Insert: The date following the day of receipt of the hospital notice.

- If you disagree with this decision:
    - You may request by telephone or in writing an expedited reconsideration of the QIO's determination. An expedited reconsideration will be performed if you make your request while in the hospital. You should make this request immediately through us or to the QIO at the address listed below..
- If you do not request an expedited reconsideration:
    - You may still request a reconsideration. Instructions on how to request this reconsideration will be given to you in a notice sent by (name of QIO).
- QIO Reconsideration Results:
    - The QIO will send to you a formal reconsideration determination of the medical necessity and appropriateness of your hospitalization and will inform you of your appeal rights.
    - IF THE QIO OVERTURNS ITS DECISION (i.e., it determines that your care is covered by Medicare), you will be refunded any amount collected except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.
    - IF THE QIO UPHOLDS ITS DECISION (i.e., it reaffirms that your care is not covered by Medicare), you are responsible for payment beginning (specify date).
- QIO Address:

_____

(QIO Name)

_____

(Address)

_____

(Telephone Number)

Sincerely,

_____

Chairperson of Utilization Review

Committee, Medical Staff, etc

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from the (name of hospital) at (time) on (date). I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____	_____	_____
(Signature of beneficiary or person acting on behalf of beneficiary)	(Time)	(Date)

cc: QIO

Attending Physician

Letter 6 - Model Hospital-Issued Notice of Noncoverage Continued Stay - Swing Bed Only (QIO Concurs) (Patient Changes from Acute to NF Level of Care)

Hospital Letterhead

_____

Date of Notice

_____ _____

Name of Patient or Representative Admission Date

_____ _____

Address Health Insurance Claim (HIC) Number

_____ _____

Attending Physician's Name

City, State, Zip Code

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

We have reviewed the medical services you have received for (specify services or condition) from (date of admission) through (date of last day reviewed) and has determined that further hospitalization paid under Medicare is not necessary. This determination is based upon the our understanding and interpretation of available Medicare coverage policies and guidelines.

The (name of QIO) is the quality improvement organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of (Name of State). The (name of QIO) has concurred with our decision that beginning (specify date of noncovered acute care day) further (specify services to be furnished or condition to be treated) (specify is/are) medically unnecessary or could be safely furnished in another setting. You will also receive a notice from (name of QIO) confirming the review decision.

We have advised your attending physician of the denial of further acute hospital care. Upon receipt of this notice, the items and services which you receive will no longer be covered under Medicare. The care that you need now is not hospital or skilled nursing care and Medicare does not pay for it.

You are financially liable for all costs of the care you receive, except for those services for which you are eligible under Part B, beginning on (specify date).[1]/ You should discuss other arrangements with your attending physician for any further health care you may require.

- If you disagree with this decision and want an expedited reconsideration:
  - ° You may request by telephone or in writing an expedited reconsideration of the QIO's determination. An expedited reconsideration will be performed if you make your request while in the hospital. You should make this request immediately through us or to the QIO at the address listed below..
- If you do not request an expedited reconsideration:
  - ° You may still request a reconsideration. Instructions on how to request this reconsideration will be given to you in a notice sent by (name of QIO).
- QIO Reconsideration Results:
  - ° The QIO will send to you a formal reconsideration determination of the medical necessity and appropriateness of your hospitalization and will inform you of your appeal rights.
  - ° IF THE QIO OVERTURNS ITS DECISION (i.e., it determines that you require acute care), you will be refunded any amount collected except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.
  - ° IF THE QIO UPHOLDS ITS DECISION (i.e., it reaffirms that your care is not covered by Medicare), you are responsible for payment beginning (specify date). If you leave the hospital on (specify date)[1]/, you will not be liable for costs of care except for payment of any applicable deductible, coinsurance, and convenience services or items normally not covered by Medicare.

---

[1]/ Insert: the date following the day of receipt of the QIO and hospital notice.

Page 3 - Hospital-Issued Notice of Noncoverage

- QIO Address:

_____

(QIO Name)

_____

(Address)

_____

(Telephone Number)

Sincerely,

_____

Chairperson of Utilization Review

Committee, Medical Staff, etc

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from the (name of hospital) at (time) on (date). I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____

(Signature of beneficiary or person acting on behalf of beneficiary) (Time) (Date)

cc: QIO

Attending Physician

Letter 7 - Model Hospital-Issued Notice of Noncoverage Continued Stay - Swing Bed Only (QIO Concurs) (Patient Changes from Acute to SNF Level of Care)

Hospital Letterhead

_____

Date of Notice

_____ _____

Name of Patient or Representative Admission Date

_____ _____

Address Health Insurance Claim (HIC) Number

_____ _____

Attending Physician's Name

City, State, Zip Code

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

This notice is to inform you that we have reviewed the medical services you have received for (specify services or condition) from (date of admission) through (date of last day reviewed) and has determined that acute care services are not necessary. This determination is based upon our understanding and interpretation of available Medicare coverage policies and guidelines.

The (name of QIO) is the quality improvement organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of (Name of State). The (name of QIO) has concurred with our decision that beginning (specify date of first noncovered acute care day) you no longer require an acute level of care. You will begin to receive the type of hospital services which are rendered in a skilled nursing facility (SNF) beginning (specify date of first SNF swing-bed day). This is known as SNF swing-bed services. The Medicare program will pay for your SNF swing-bed services (if you have not used up all your SNF benefit days (100) in the benefit period).

- If you disagree with this decision and want an expedited reconsideration:
    - You may request by telephone or in writing an expedited reconsideration of the QIO's determination. An expedited reconsideration will be performed if you

make your request while in the hospital. You should make this request immediately through us or to the QIO at the address listed below.

Page 2 - Hospital-Issued Notice of Noncoverage

- If you do not request an expedited reconsideration:
    - You may still request a reconsideration. Instructions on how to request this reconsideration will be given to you in a notice sent by (name of QIO).

- QIO Reconsideration Results:
    - The QIO will send to you a formal reconsideration determination of the medical necessity and appropriateness of your hospitalization and will inform you of your appeal rights.
    - IF THE QIO OVERTURNS ITS DECISION (i.e., it determines that your care is covered by Medicare), you will be refunded any amount collected except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.
    - IF THE QIO UPHOLDS ITS DECISION (i.e., it reaffirms that you do not require acute care), you will continue to receive SNF swing-bed services paid under Medicare. You will be responsible for payment of any applicable deductible, coinsurance, and convenience services or items normally not covered by Medicare.

- QIO Address:

_____

(QIO Name)

_____

(Address)

_____

(Telephone Number)

Sincerely,

_____

Chairperson of Utilization Review

Committee, Medical Staff, etc

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from the (name of hospital) at (time) on (date). I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____

(Signature of beneficiary or person acting on behalf of beneficiary) (Time) (Date)

cc: QIO

Attending Physician

Letter 8 - Model Hospital-Issued Notice of Noncoverage Continued Stay - Swing Bed Only (Patient Changes from SNF to NF or Custodial Care)

Hospital Letterhead

_____

Date of Notice

_____ _____

Name of Patient or Representative Admission Date

_____ _____

Address Health Insurance Claim (HIC) Number

_____

_____ Attending Physician's Name

City, State, Zip Code

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

We have reviewed the medical services you have received for (specify services or condition) from (date of admission) through (date of last day reviewed) and has determined that further hospitalization paid under the Medicare program is not necessary. This determination is based upon our understanding and interpretation of available Medicare coverage policies and guidelines.

We have advised your attending physician of the denial of further skilled nursing care. Upon receipt of this notice, the items and services which you receive will no longer be covered under the Medicare program. The care that you need now is not skilled nursing care, and Medicare does not pay for it.

You are financially liable for all costs of the care you receive, except for those services for which you are eligible under Part B, beginning on (specify date).[1]/ You should discuss other arrangements with your attending physician for any further health care you may require.

This notice is not an official Medicare determination. The (name of QIO) is the quality improvement organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of (name of State) and to make that determination.

_____

[1]/ Insert: the date of the day following receipt of the hospital notice.

- If you disagree with our conclusion and want an immediate review:
  - Request immediately, or at any point in the stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO at the address listed below.
- If you do not request an immediate review:
  - You may still request QIO review within 30 days after you receive this notice. Request this QIO review at the address listed below.
- QIO Review Results:
  - The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization, and will inform you of your reconsideration rights.
  - IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., it determines that your care is covered by Medicare), you will be refunded any amount collected by the hospital except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.
  - IF THE QIO AGREES WITH THE HOSPITAL: you are responsible for payment of all services beginning on (specify date).[1]/
- QIO Address:

_____

(QIO Name)

_____

(Address)

_____

(Telephone Number)

Sincerely,

_____

Chairperson of Utilization Review

Committee, Medical Staff, etc

_____

[1]/ See footnote 1 on preceding page.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from the (name of hospital) at (time) on (date). I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____

(Signature of beneficiary or person acting on behalf of beneficiary) (Time) (Date)

cc: QIO

Attending Physician

Letter 9 - Model Hospital-Issued Notice of Noncoverage Direct Preadmission/Admission to NF Swing Bed

Hospital Letterhead

_____

Date of Notice

_____ _____

Name of Patient or Representative Admission Date

_____ _____

Address Health Insurance Claim (HIC) Number

_____ _____

City, State, Zip Code Attending Physician's Name

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

The purpose of this notice is to inform you that we find that your admission for (specify service or condition) is not covered under Medicare because the services to be performed (specify are not considered skilled care or constitute custodial care). This determination was based upon (our understanding and interpretation of available Medicare coverage policies and guidelines. You should discuss other arrangements with your attending physician for any further health care you may require. If you decide to (be admitted to/remain in) the hospital, you will be financially responsible for [1]/.

This notice, however, is not an official Medicare determination. The (name of QIO) is the quality improvement organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of (name of State) and to make that determination.

_____

[1]/ For preadmission notices, insert: "all customary charges for services furnished during the stay, except for those services for which you are eligible to receive payment under Part B."

For admission notices issued not later than 3:00 P.M. on the date of admission (i.e., before 3:00 P.M.), insert: "customary charges for all services furnished after receipt of the hospital notice, except for those services for which you are eligible to receive payment under Part B." (If these requirements are not met, insert the liability phrase below.)

For admission notices issued after 3:00 P.M. on the day of admission, insert: "customary charges for all services furnished on the days following the day of receipt of this notice, except for those services for which you are eligible to receive payment under Part B."

- If you disagree with our conclusion and want an immediate review (Select as appropriate)

  Preadmission:

  - Request immediately, but no later than 3 calendar days after receipt of this notice, or, if admitted, at any point in the stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO by telephone or in writing to the address listed below.

  Admission:

  - Request immediately, or at any point during your stay, an immediate review of the facts in your case. You may make this request through us or directly to the QIO by telephone or in writing to the address listed below.

- If you do not wish an immediate review:

  - You may still request a review within 30 calendar days from the date of receipt of this notice by telephoning or writing to the address specified below.

- Results of the QIO Review:

  - The QIO will send you a formal determination of the medical necessity and appropriateness of your hospitalization, and will inform you of your reconsideration and appeal rights.

  - IF THE QIO DISAGREES WITH THE HOSPITAL (i.e., the QIO determines that your care is covered), you will be refunded any amount collected except for any applicable amounts for deductible, coinsurance, and convenience services or items normally not covered by Medicare.

  - IF THE QIO AGREES WITH THE HOSPITAL, you are responsible for payment for all services beginning on (specify date).[1]/ If you leave the hospital on (specify date)[1]/, you will not be liable for costs for care, except for payment of any applicable deductible, coinsurance, and convenience services or items normally not covered by Medicare.

---

[1]/ See footnote 1 on preceding page.

- QIO Address:

_____

(QIO Name)

_____

(Address)

_____

(Telephone Number)

Sincerely,

_____

Chairperson of Utilization Review

Committee, Medical Staff, etc

_____

Chairperson of Utilization Review

Committee, Medical Staff, etc

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

This is to acknowledge that I received this notice of noncoverage of services from the (name of hospital) at (time) on (date). I understand that my signature below does not indicate that I agree with the notice, only that I have received a copy of the notice.

_____ _____ _____

(Signature of beneficiary or person acting on behalf of beneficiary) (Time) (Date)

cc: QIO

Attending Physician

Letter 10 - Model Hospital Notice to Beneficiary of QIO Review of Need for Continued Hospitalization

Hospital Letterhead

_____

Date of Notice

_____ _____

Name of Patient or Representative Admission Date

_____ _____

Address Health Insurance Claim (HIC) Number

_____

_____ Attending Physician's Name

City, State, Zip Code

YOUR IMMEDIATE ATTENTION IS REQUIRED

Dear _____:

We have has determined that you no longer require an acute (hospital inpatient) level of care. Because your doctor disagreed with this decision we are asking the quality improvement organization (Name of QIO) to review your case.

(Name of QIO) will contact you to solicit your views about your case and the care you need.

You do not need to take any action until you hear from the quality improvement organization.

Sincerely,

_____

Chairperson of Utilization Review

Committee, Medical Staff, etc

140 - Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)

(Rev. 1, 10-01-03)

PM-A-01-110 (CR 1851)

Section 4421 of the Balanced Budget Act (BBA) of 1997 (Public Law 105-33), as amended by §125 of the Balanced Budget Refinement Act (BBRA) of 1999 (Public Law 106-113, Appendix F) and §305 of the Benefits Improvement and Protection Act of 2000 (BIPA), authorizes the implementation of a per discharge prospective payment system (PPS), through new §1886(j) of the Act, for inpatient rehabilitation hospitals and rehabilitation units referred to as inpatient rehabilitation facilities (IRFs).

IRF PPS is effective for cost reporting periods beginning on or after January 1, 2002. IRF PPS payment rates include all costs of furnishing covered IRF services (routine, ancillary, and capital-related costs) other than costs associated with operating approved educational activities as defined in 42 CFR 413.85 and 413.86, bad debts, and other costs not covered under the PPS.

140.1 - Medicare IRF Classification Requirements

(Rev. 1, 10-01-03)

In general, the criteria for a facility to be classified as an IRF remains unchanged from the requirements used to classify entities as exempt from the acute care hospital PPS. In order to be paid under the IRF PPS, a facility first must meet the conditions for payment under 42 CFR 412.604 of the regulations (established in the final rule). In addition, an entity must meet the requirements under 42 CFR 412.23(b) which in part states that a facility must "show that during its most recent 12-month cost reporting period, it served an inpatient population of whom at least 75 percent required intensive rehabilitative services for the treatment of one or more of the following conditions: stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of femur (hip fracture), brain injury, polyarthritis (including rheumatoid arthritis), neurological disorders (including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease), and burns."

Hospitals that are not paid under the IRF PPS, but are paid under special payment provisions are: Veteran's Administration Hospitals, hospitals that are reimbursed under state cost control systems approved under 42 CFR Part 403, and hospitals that are reimbursed in accordance with demonstration projects authorized under §402(a) of Public Law 90-248 (42 U.S.C. 1395b-1) or §222(a) of Public Law 92-603 (42 U.S.C. 1395b-1). Payment to foreign hospitals will be made in accordance with the provisions set forth in 42 CFR 413.74 of the regulation.

140.2 - Payment Provisions Under IRF PPS

(Rev. 1, 10-01-03)

A-03-008

Section 1886 of the BBA provides the basis for establishing the Federal payment rates applied under PPS to IRFs. The PPS incorporates per discharge federal rates based on average IRF costs in a base year updated for inflation to the first effective period of the system.

IRF PPS providers are not subject to the 3-day payment widow (72-hour rule) for pre-admission services, but are subject to the 1-day payment window (24-hour rule) for pre-admission services.

Beneficiary liability will operate the same as under the current Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) payment system. Even if Medicare payments are below cost of care for a patient under prospective payment, the patient cannot be billed for the difference in any case.

140.2.1 - Payment Adjustment Factors and Rates

(Rev. 1, 10-01-03)

The BBA sets forth the methodology for establishing the payment rates as well as the data on which they are based. In addition, this section prescribes adjustments to such rates based on geographic variation and case-mix and other factors the Secretary deems necessary to ensure that payment most accurately reflects cost.

The BBA specifies that payments during fiscal years 2001 and 2002 must be established in a manner that results in the amount of total payments, including any adjustments, being equal to 98 percent of the amount of payments that would have been made during those fiscal years (for operating and capital costs) had the IRF PPS not been enacted. As a result of the implementation of BIPA, a change has been made to eliminate the payment amount of 98 percent of the FY 2002 expenditures. Under §305 of the BIPA 2000, §1886(j)(3)(b) of the Act is amended to increase the amount of payment to 100 percent of FY 2002 expenditures.

For the initial period of PPS, beginning on or after January 1, 2002, all payment rates and associated rules were published in the "Federal Register" on August 7, 2001. For each succeeding fiscal year, the rates will be published in the "Federal Register" on or before August 1 of the year preceding the affected fiscal year.

140.2.2 - Case-Mix Groups

(Rev. 1, 10-01-03)

In general, a case will be grouped into a Case-Mix Group (CMG) based on the clinical characteristics of the Medicare beneficiary. Rehabilitation Impairment Categories (RICs), functional measurements, age, and comorbidities were used to develop the CMGs. Specifically, RICs are used to group cases that are similar in clinical characteristics and resource use. The RICs are formed using codes from the International Classification of Diseases 9th Revision (ICD-9s). In addition to the RICs, the CMGs are further partitioned using functional measures of motor and cognitive scores. Age improves the explanatory power of the CMGs if some groups are split based on this variable. Lastly, comorbidites were found to substantially increase the average cost of specific CMGs. The comorbidities are arrayed in three categories (or tiers) based on whether the costs are considered high, medium, or low. If a case has more than one comorbidity, the CMG payment rate will be based on the comorbidity that results in the highest payment.

140.2.3 - Case-Level Adjustments

(Rev. 1, 10-01-03)

Payment is based on the CMGs described above, as well as possible adjustments specific to the case and the facility characteristics. For case level adjustments, more than one case level adjustment may apply to the same case. For ease of understanding, the case level discussion is presented below in the same order that is used to assess whether or not they apply. For example, a case may be classified as a transfer, but may also receive additional payments because it meets the definition of an outlier case.

Interrupted stays are defined as those cases in which a Medicare beneficiary is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days. The 3 consecutive calendar days begin with the day of the discharge from the IRF and ends on midnight of the third day. The length of stay for these cases will be determined by the total length of the IRF stay including the days prior to the interruption and the days after the interruption. One CMG payment will be made for interrupted stay cases and the payment will be based on the initial assessment. For example, if a Medicare beneficiary is discharged on February 1, 2001, and is readmitted on February 3, the case would be considered an interrupted stay and only one CMG payment will be made based on the initial assessment. However, if the Medicare beneficiary was readmitted on February 4, then it would not be considered an interrupted stay. A separate DRG payment will not be made to the acute care hospital when the beneficiary is discharged and returns to the same IRF on the same day. However, a DRG payment can be made if the beneficiary does not return to the same IRF on the same day as they were discharged. If a case is determined to be an interrupted stay, other adjustments may apply to this payment amount. For example, the case still may meet the definition of a transfer case described below.

For the IRF PPS, transfer cases are defined as those in which a Medicare beneficiary is transferred to either another rehabilitation facility, a long term care hospital, an inpatient hospital, or a nursing home that accepts payment under either the Medicare program and/or the Medicaid program AND the length of stay of the case is less than the average length of stay for a given CMG. The transfer policy consists of a per diem payment amount calculated by dividing the per discharge CMG payment rate by the average length of stay for the CMG. Medicare will pay transfer cases a per diem amount and include an additional half day payment for the first day. Transfer payments will be calculated by first adding the length of stay of the case to 0.5 (to account for the addition of the half day payment for the first day) and then multiplying the result by the CMG per diem amount.

The IRF PPS also includes a payment adjustment for certain cases, such as short-stay cases (for cases that do not meet the definition of a transfer case). A separate CMG payment (5001) will be made for cases with a length of stay of 3 days or less, without consideration of the clinical characteristics of the patient. Further cases that expire with a length of stay of 3 days or less, will also be classified to CMG 5001.

Separate CMGs will also be made for cases that expire with a length of stay greater than 3 days. To improve the explanatory power of the groups, four additional CMGs were created to account for cases that expire. CMG 5101 is used for short-stay, orthopedic, expired cases. This CMG includes those cases that would otherwise be grouped to RICs 07, 08, and 09 and the length of the stay is greater than 3 days, but less than or equal to 13 days. CMG 5102 will be used for orthopedic expired cases where the length of stay is greater than or equal to 14 days. CMG 5103 will be used for short-stay, non-orthopedic, expired cases. This CMG includes those cases that would not be grouped to the orthopedic RICs and the length of the stay is greater than 3 days, but less than or equal to 15 days. CMG 5104 will be used for non-orthopedic expired cases where the length of stay is greater than or equal to16 days.

140.2.4 - Facility Level Adjustments

(Rev. 1, 10-01-03)

Facility-level adjustments apply to all cases and are based on the individual IRF characteristics. The facility-level adjustments include an area wage adjustment, an adjustment for facility's located in rural areas, and an adjustment for treating low-income patients. Outlier payments will also be discussed in this section. Although outlier payments are considered to be a case-level adjustment, a case can be determined to qualify for these additional payments only after all other facility-level adjustments are computed. Thus, for ease of understanding the discussion of these facility-level and outlier adjustments are presented in the same order that is used to assess their applicability.

To adjust payments for area wage differences, CMS first identified the labor-related portion of the prospective payment rates. The labor-related portion is 72.395 percent and

the non-labor related portion is 27.605 percent. The labor-related unadjusted Federal payment is multiplied by a wage index value to account for area wage differences. CMS is using the inpatient acute care hospital wage data to compute the wage indices. The wage data excludes the wages for services provided by teaching physicians, interns and residents, and nonphysician anesthetists under Medicare part B, because these services are not covered under the IRF PPS. The wage index that applies to the IRF PPS payment rates excludes 100 percent of wages for teaching physicians, residents, and nonphysician anesthetists. IRFs are divided into labor market areas. As with other CMS payment systems, urban areas are defined as a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area, as defined by the Executive Office of Management and Budget. For the purposes of computing the wage index for IRFs, the wage index values for urban and rural areas are determined without regard to geographic reclassification under §1886(d)(8) or (d)(10) of the Act.

Payments are adjusted for facilities located in rural areas. A facility is considered to be a rural IRF if they are located in a non-MSA area.

Additional payments are made for treating low-income patients (LIP). There are two parts in computing this adjustment. The first, is the calculation of the disproportionate share variable (DSH). This is computed by:

$$\text{DSH} = \frac{\text{SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non-Medicare Days}}{\text{Total Medicare Days}}$$

Once the DSH is calculated, this percentage is used to determine the LIP adjustment as specified in the IRF PPS final rule.

Additional payments are made for those cases that are high cost outliers. A case will be considered to be an outlier if the estimated cost of the case exceeds an adjusted threshold amount. The estimated cost of the case is calculated by multiplying the charge by the facility's overall cost-to-charge ratio obtained from the latest settled cost report. If the estimated cost of the case is greater than the sum of the adjusted payment amount and the adjusted threshold amount, then the case is considered an outlier and additional payments are added to the adjusted payment amount. The outlier payment is 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the facility-level adjusted CMG payment and the threshold amount multiplied by the facility-level adjustments as described above).

140.2.4.1 - LIP Adjustment: The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year 2002 for IRFs Paid Under the PPS

(Rev. 39, 12-08-03)

See Business Requirements at http://www.medicaid.com/manuals/pm_trans/R39CP.pdf

The SSI/Medicare beneficiary data for the IRF PPS is available to FIs electronically. This data is used to identify the disproportionate share percentage for all IRFs in the FI provider specific file so that FIs use the most current data in paying bills. The data contains the name of the facility, provider number, SSI days, covered Medicare days, and the ratio of Medicare Part A patient days attributable to SSI recipients. FIs will use this information to update their provider specific file.

The file is available on the CMS Mainframe under the file name:

K143.@BFN2699.REHAB02.SSI.FILE1

The SSI file is also available on the Internet at the following Web address: www.cms.hhs.gov/medicare/irfpps.asp

FIs use this data to determine an initial PPS payment amount and, if applicable, to determine a final outlier payment amount for IRFs with cost reporting periods beginning on or after October 1, 2003 and before October 1, 2004. Since the disproportionate share percentage is based on a facility's cost reporting period, FIs make a final determination of the amount of this percentage to compute the final LIP adjustment at the year-end settlement of the facility's cost report. Specifically, the FY 2002 SSI data is used for settlement purposes for facilities with cost reporting periods beginning on or after January 1, 2002 and before October 1, 2003. The final LIP adjustment is used to retrospectively adjust the initial PPS payment amount.

A - Clarification of Allowable Medicaid Days in Calculating the Disproportionate Share Variable

PM - A-99-62 (Excerpts referenced in PM A-01-131)

Background

Under §1886(d)(5)(F) of the Act, the Medicare disproportionate share patient percentage is made up of two computations. The first computation includes patient days that were furnished to patients who, during a given month, were entitled to both Medicare Part A and Supplemental Security Income (SSI) (excluding State supplementation). This number is divided by the number of covered patient days utilized by patients under Medicare Part A for that same period. The second computation includes patient days associated with beneficiaries who were eligible for medical assistance (Medicaid) under a State plan approved under Title XIX but who were not entitled to Medicare Part A. (See

42 CFR 412.106(b)(4).) This number is divided by the total number of patient days for that same period.

Included Days

In calculating the number of Medicaid days, the hospital must determine whether the patient was eligible for Medicaid under a State plan approved under Title XIX on the day of service. If the patient was so eligible, the day counts in the Medicare disproportionate share adjustment calculation. The statutory formula for "Medicaid days" reflects several key concepts. First, the focus is on the patient's eligibility for Medicaid benefits as determined by the State, not the hospital's "eligibility" for some form of Medicaid payment. Second, the focus is on the patient's eligibility for medical assistance under an approved Title XIX State plan, not the patient's eligibility for general assistance under a State-only program. Third, the focus is on eligibility for medical assistance under an approved Title XIX State plan, not medical assistance under a State-only program or other program. Thus, for a day to be counted, the patient must be eligible on that day for medical assistance benefits under the Federal-State cooperative program known as Medicaid (under an approved Title XIX State plan). In other words, for purposes of the Medicare disproportionate share adjustment calculation, the term "Medicaid days" refers to days on which the patient is eligible for medical assistance benefits under an approved Title XIX State plan. The term "Medicaid days" does not refer to all days that have some relation to the Medicaid program, through a matching payment or otherwise; if a patient is not eligible for medical assistance benefits under an approved Title XIX State plan, the patient day cannot become a "Medicaid day" simply by virtue of some other association with the Medicaid program.

Medicaid days, for purposes of the Medicare disproportionate share adjustment calculation, include all days during which a patient is eligible, under a State plan approved under Title XIX, for Medicaid benefits, even if Medicaid did not make payment for any services. Thus, Medicaid days include, but are not limited to, days that are determined to be medically necessary but for which payment is denied by Medicaid because the provider did not bill timely, days that are beyond the number of days for which a State will pay, days that are utilized by a Medicaid beneficiary prior to an admission approval but for which a valid enrollment is determined within the prescribed period, and days for which payment is made by a third party. In addition, we recognize in the calculation days that are utilized by a Medicaid beneficiary who is eligible for Medicaid under a State plan approved under Title XIX through a managed care organization (MCO) or health maintenance organization (HMO). However, in accordance with 42 CFR 412.106(b)(4), a day does not count in the Medicare disproportionate share adjustment calculation if the patient was entitled to both Medicare Part A and Medicaid on that day. Therefore, once the eligibility of the patient for Medicaid under a State plan approved under Title XIX has been verified, the FI must determine whether any of the days are dual entitlement days and, to the extent that they are, subtract them from the other days in the calculation.

Excluded Days

Many States operate programs that include both State-only and Federal-State eligibility groups in an integrated program. For example, some States provide medical assistance to beneficiaries of State-funded income support programs. These beneficiaries, however, are not eligible for Medicaid under a State plan approved under Title XIX, and, therefore, days utilized by these beneficiaries do not count in the Medicare disproportionate share adjustment calculation. If a hospital is unable to distinguish between Medicaid beneficiaries and other medical assistance beneficiaries, then it must contact the State for assistance in doing so.

In addition, if a given patient day affects the level of Medicaid DSH payments to the hospital but the patient is not eligible for Medicaid under a State plan approved under Title XIX on that day, the day is not included in the Medicare DSH calculation.

It should be noted that the types of days discussed above are not necessarily the only types of excluded days. See the chart below, which summarizes some, but not necessarily all, of the types of days to be excluded from (or included in) the Medicare DSH adjustment calculation.

To provide consistency in both components of the calculation, any days that are added to the Medicaid day count must also be added to the total day count, to the extent that they have not been previously so added.

Regardless of the type of allowable Medicaid day, the hospital bears the burden of proof and must verify with the State that the patient was eligible under one of the allowable categories during each day of the patient's stay. The hospital is responsible for and must provide adequate documentation to substantiate the number of Medicaid days claimed. Days for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid cannot be counted.

Types of Days Included/Excluded in the Medicare DSH Adjustment Calculation

Type of Day	Description	Eligible Title XIX Day
General Assistance Patient Days	Days for patients covered under a State-only (or county-only) general assistance program (whether or not any payment is available for health care services under the program). These patients are not Medicaid-eligible under the State plan	No
Other State-Only Health Program Patient Days	Days for patients covered under a State-only health program. These patients are not Medicaid-eligible under the State plan	No
Charity Care Patient Days	Days for patients not eligible for Medicaid or any other third-party payer, and claimed as uncompensated care by a hospital. These patients are not Medicaid-eligible under the State plan.	No
Actual 1902(r)(2) and 1931(b) Days	Days for patients eligible under a State plan based on a 1902(r)(2) or 1931(b) election. These patients are Medicaid-eligible under the Title XIX State plan under the authority	Yes

Type of Day	Description	Eligible Title XIX Day
	of these provisions, which is exercised by the State in the context of the approved State plan.	
Medicaid Optional Targeted Low-Income Children (CHIP-related) Days	Days for patients who are Title XIX-eligible and who meet the definition of "optional targeted low-income children" under §1905(u)(2). The difference between these children and other Title XIX children is the enhanced FMAP rate available to the State. These children are fully Medicaid-eligible under the State plan.	Yes
Separate CHIP Days	Days for patients who are eligible for benefits under a non-Medicaid State program furnishing child health assistance to targeted low-income children. These children are, by definition, not Medicaid-eligible under a State plan.	No.
1915(c) Eligible Patient (the "217" group) Days	Days for patients in the eligibility group under the State plan for individuals under a Home and Community Based Services waiver. This group includes individuals who would be Medicaid-eligible if they were in a medical institution. Under this special eligibility group, they are Medicaid-eligible under the State plan.	Yes
Retroactive Eligible Days	Days for patients not enrolled in the Medicaid program at the time of service, but found retroactively eligible for Medicaid benefits for the days at issue. These patients are Medicaid-eligible under the State plan.	Yes
Medicaid Managed Care Organization Days	Days for patients who are eligible for Medicaid under a State plan when the payment to the hospital is made by an MCO for the service. An MCO is the financing mechanism for Medicaid benefits, and payment for the service through the MCO does not affect eligibility	Yes
Medicaid DSH Days	Days for patients who are not eligible for Medicaid benefits, but are considered in the calculation of Medicaid DSH payments by the State. These patients are not Medicaid-eligible. Sometimes Medicaid State plans specify that Medicaid DSH payments are based upon a hospital's amount of charity care or general assistance days. This, however, is not "payment" for those days, and does not mean that the patient is eligible for Medicaid benefits or can be counted as such in the Medicare formula.	No

140.2.5 - Phase-In Implementation

(Rev. 1, 10-01-03)

Under the BBA, the Federal fiscal year in which a facility's cost reporting period begins, determines which transition period percentages apply. The first transition period percentages are applicable for cost reporting periods beginning during Federal fiscal year 2001. The second transition period percentages are applicable to cost reporting periods beginning during Federal fiscal year 2002, that is, periods beginning on or after October 1, 2001, and before October 1, 2002. For cost reporting periods beginning during Federal fiscal year 2003 and after, payment is based on 100 percent of the adjusted Federal prospective payment.

Since CMS is implementing the IRF PPS for discharges that occur during the IRF's cost reporting period that begins on or after January 1, 2002, IRFs are phased directly into the second transition period, where payment will be based on 66 2/3 percent of the PPS payment and 33 1/3 percent of the TEFRA payment. A facility will continue to be paid under the TEFRA (reasonable cost-based) system for its entire cost reporting period beginning prior to January 1, 2002.

In addition, §305 of the BIPA 2000 states facilities may elect to be paid 100 percent PPS payment, rather than payment based on the transition method. If a facility chooses not to be paid under the transition method, they must notify their FI no later than 30 days prior to its first cost reporting period for which the IRF PPS applies to the facility. The request to make the election must be made in writing to the Medicare FI for the facility. The FI must receive the request on or before the 30th day before the applicable cost reporting period begins, regardless of any postmarks or anticipated delivery dates. Requests received, postmarked, or delivered by other means after the 30th day before the cost reporting period begins will not be approved. If the 30th day before the cost reporting period falls on a day that the postal service or other delivery sources are not open for business, the facility is responsible for allowing sufficient time for delivery of the request before the deadline. If a facility's request is not received or not approved, payment will be based on the transition method.

140.2.6 - Outlier Payments: Cost-to-Charge Ratios

(Rev, 263, Issued 07-30-04, Effective: 10-01-04, Implementation: 10-04-04

This section describes the appropriate data sources for computing an overall Medicare facility-specific cost-to-charge ratio (CCR) for the purpose of determining outlier payments under the IRF PPS. For discharges beginning on or after October 1, 2003, FIs will use a CCR from the most recent tentative settled cost report or the most recent settled cost report (whichever is the later period). FIs will use the cost report and the associated data in determining a facility's overall Medicare cost-to-charge ratio specific to freestanding IRFs of for IRFs that are distinct part units of acute care hospitals.

The Medicare cost reporting forms contain information on both Medicare inpatient costs and charges. In addition, Medicare charges should be contained in the provider statistical and reimbursement (PS&R) report associated with a specific cost reporting period. If the overall Medicare cost-to-charge ratio appears to be substantially out-of-line with similar facilities, the FI should ensure that the underlying costs and charges are properly reported.

Effective October 1, 2003 an IRF will be assigned the appropriate national average CCR that falls above three standard deviations from the national mean (upper threshold). We will not use a lower threshold and an IRF will receive their actual CCR, no matter how low their ratio falls.

For discharges occurring on or after October 1, 2003 and before October 1, 2004, the upper threshold is 1.461 and the national cost-to-charge ratios are 0.597 for rural IRFs and 0.554 for urban IRFs. For discharges occurring on or after October 1, 2004, and before October 1, 2005, the upper threshold is 1.461, and the national cost-to-charge ratios are 0.636 for rural IRFs and 0.531 for urban IRFs.

The IRF PPS covers operating and capital-related costs and excludes medical education and nurse anesthetist costs paid for on a reasonable cost basis. Therefore, total Medicare charges for IRFs will consist of the sum of the inpatient routine charges and the sum of inpatient ancillary charges (including capital). Total Medicare costs will consist of the sum of inpatient routine costs (net of private room differential and swingbed) plus the sum of ancillary costs plus capital-related pass-through costs only.

The provider specific file contains a field for the operating cost-to-charge ratio (Field 25; file position 102-105) and for the capital cost-to-charge ratio (Field 42; file position 203-206). Because the cost-to-charge ratio computed for the IRF PPS includes routine, ancillary, and capital costs, the cost-to-charge ratio for freestanding IRFs, units, and new providers described below will be entered on the provider specific file only in field 25; file position 102-105. Field 42; file position 203-206 of the provider specific file must be zero-filled.

A - Calculating Medicare Cost-To-Charge Ratios for Freestanding IRFs

For freestanding IRFs, Medicare charges will be obtained from Worksheet D-4, Column 2, lines 25 through 30 plus line 103 from the cost report (where possible, these charges should be confirmed with the PS&R data). For freestanding IRFs, total Medicare costs will be obtained from Worksheet D-1, Part II, line 49 minus (Worksheet D, Part III, col. 8, lines 25 through 30 plus Worksheet D, Part IV, col., line 101). Divide the Medicare costs by the Medicare charges to compute the cost-to-charge ratio.

B - Calculating Medicare Cost-To-Charge Ratios for IRF Distinct Part Units

For IRF distinct part units, total Medicare inpatient routine and ancillary charges will be obtained from the PS&R report associated with the latest settled cost report. [If PS&R data is not available, estimate Medicare routine charges by dividing Medicare routine costs on Worksheet D-1, Part II, line 41, by the result of Worksheet C, Part I, line 31, column 3 divided by line 31, column 6. Add this amount to Medicare ancillary charges on Worksheet D-4, column 2, line 103 to arrive at total Medicare charges.] To calculate the total Medicare costs for distinct part units, data will be obtained from Worksheet D-1, Part II, line 49 minus (Worksheet D, Part III, col. 8, line 31 plus Worksheet D, Part IV, col. 7, line 101). All references to Worksheets and specific line numbers should correspond with the subprovider identified as the IRF unit, i.e., the letter "T" is in the third position of the Medicare provider number. Divide the total Medicare costs by the total Medicare charges to compute the cost-to-charge ratio.

C - Calculating Medicare Cost-To-Charge Ratios for New IRFs

As stated in the final rule, new facilities may receive outlier payments even though they will not have the historical cost report information needed to compute the estimated cost that determines if a case is an outlier. Therefore, a national cost-to-charge-ratio based on the facility location of either urban or rural will be used. Specifically, for FY 2005, CMS has estimated a national cost-to-charge ratio of 0.636 for rural IRFs and 0.531 for urban IRFs. Unless otherwise notified, FIs use these national ratios until the facility's actual cost-to-charge ratio can be computed using the first tentative settled or final settled cost report data which will then be used for the subsequent cost report period.

The CMS will continue to set forth the upper threshold (i.e., 3 standard deviations above the national geometric mean CCR) and the national CCRs applicable to IRFs in each year's annual notice of prospective payment rates published in the Federal Register.

D - Use of More Recent Data for Determining CCRs

In order to arrive at a CCR to be used in the PSF based on tentative settlement data, the intermediary should review previous adjustments used (if any) in the tentative settlement and take into consideration the impact of prior audit adjustments on prior period CCR to determine if they had an impact on the CCR. If these tentative settlement adjustments have no impact on the CCR, or if no adjustments were made, the tentative settled CCR will equal the CCR from the IRF's as-filed cost report. If the adjustments made at tentative settlement would have an impact on the CCR, the intermediary should compute a new CCR based on the tentative settlement. (Note: If the tentative settlement adjustments result in a difference in the CCR from the as filed cost report of 20% or less, then no adjustment to the CCR at tentative settlement is necessary.)

Following the initial update of the CCR for all IRFs for discharges on or after October 1, 2003, FIs should continue to update an IRF's CCR each time a more recent cost report is tentatively settled. Revised CCRs must be entered into the PSF not later than 45 days after the date of the tentative settlement or final settlement used in calculating the CCRs. Subject to the approval of CMS, CCRs may be revised more often if a change in a hospital's operations occurs which materially affects a hospital's cots or charges. Revised CCRs will be applied prospectively to all IRF PPS claims processed after the update.

The CMS may direct FIs to use an alternative CCR to the CCR from the later of the latest settled cost report or latest tentative settled cost report, if CMS believes this will result in a more accurate CCR. In addition, if the FI finds evidence that indicates that using data from the latest settled or tentatively settled cost report would not result in the most accurate CCR, the FI should contact CMS to seek approval to use a CCR based on alternative data. Also, a facility will have the opportunity to request that a different CCR be applied in the event it believes the CCR being applied is inaccurate. The IRF is required to present substantial evidence supporting its request. Such evidence should include documentation regarding its costs and charges that demonstrate its claim that an alternative ratio is more accurate. The regional office must approve any such request after evaluation by the fiscal intermediary of the evidence presented by the IRF.

E - Reconciling Outlier Payments for IRFs

For discharges occurring in cost reporting periods beginning on or after October 1, 2003, FI s are to reconcile IRF PPS outlier payments at the time of cost report final settlement if:

1) Actual CCR is found to be plus or minus 10 percentage points from the CCR used during that time period to make outlier payments, and

2) Outlier payments exceed $500,000 in that cost reporting period.

The return codes from the PRICER software may be used to identify the cases for which outlier payments were made in a cost reporting period. These criteria for the IRF PPS will be reevaluated periodically to assess whether they should be revised.

In the event that these criteria do not identify facilities that are being overpaid (or underpaid) significantly for outliers, then, based on an analysis of the facility's most recent cost and charge data that indicates that the CCR for those facilities are significantly inaccurate, FIs also have the administrative discretion to reconcile cost reports of those IRFs. However, FIs must seek approval from their regional office in the event they intend to reconcile outlier payments for an IRF that does not meet the above-specified criteria. The CMS will be issuing separate instructions detailing procedures to follow regarding this reconciliation process and the application of the adjustment for the time value of money.

F - Notification to Facilities Under the IRF PPS

FIs are to notify a facility whenever they make a change to its CCR. When a CCR is changed as a result of a tentative settlement or a final settlement, the change to the CCR should be included in the notice that is issued to each provider after a tentative or final settlement is completed.

140.3 - Billing Requirements Under IRF PPS

(Rev. 1, 10-01-03)

IRF PPS payment is contingent on the requirement that IRFs complete a patient assessment upon admission and discharge for Medicare patients. The final rule contains detailed information regarding the assessment schedule for the patient assessment instrument (PAI) with respect to transmission requirements, encoding dates, and other pertinent information. Further, we will provide an item-by-item guide, which will include detailed instructions regarding the manner in which each item on the assessment instrument needs to be completed.

Effective with cost reporting periods beginning on or after January 1, 2002, IRFs are required to report billing data with a new revenue code and a Health Insurance PPS (HIPPS) Rate Code on Form 1450 (or electronic equivalent) for all Part A inpatient

claims (Type of Bill 11X) to their FIs. The new revenue code, 0024, is used in conjunction with the HIPPS Rate Code to identify the CMG group classification for the beneficiary. In addition to all entries previously required on a Part A claim, the following additional instructions must be followed to accurately price and reimburse a claim under PPS. These claims must be submitted on Type of Bill 11X. The last four digits of the provider number for rehabilitation hospitals is from 3025 to 3099, and for rehabilitation units the third digit will be a T.

- The Revenue code, Form Locator (FL) 42, Record Type (RT) 60, field 5), (SV201), must contain revenue code 0024. This code indicates that this claim is being paid under the PPS. This revenue code can appear on a claim only once.

- The following Patient Status codes are applicable under the transfer policy for IRF PPS: 02, 03, 61, 62, 63, and 64.

NOTE: IRFs that transfer a beneficiary to a nursing home that accepts payment under Medicare and/or Medicaid should use PS 03, discharged/transferred to a SNF. IRFs that transfer a beneficiary to a nursing facility that does not accept Medicare or Medicaid, should code PS 04, discharged/transferred to an ICF, until such time that a new PS code is established to differentiate between nursing facilities that do not accept Medicare and/or Medicaid and those that do. PS 04 does not constitute a transfer under the IRF PPS policy.

- For typical cases, the HCPCS/Rates, FL44, (RT60, field 6), (SV202-2), must contain a five digit HIPPS Rate/CMG Code (AXXYY-DXXYY). The first position of the code is an A,B,C, or D. The HIPPS rate code beginning with A in front of the CMG is defined as without comorbidity. The HIPPS rate code containing a B in front of the CMG is defined as with comorbidity for Tier 1. The HIPPS rate code containing a C in front of the CMG is defined as with comorbidity for Tier 2. The HIPPS rate code containing a D in front of the CMG is defined as with comorbidity for Tier 3. The (XX) in the HIPPS rate code is the Rehabilitation Impairment Category (RIC). The (YY) in the HIPPS rate code is the sequential numbering system within the RIC.

Covered Charges, FL47, (RT60, field 10), (SV203), should contain zero covered charges when the revenue code is 0024. For accommodation revenue codes (010x-021x), covered charges must equal the rate times the units. The IRF Pricer will calculate and return the payment amount for the line item with revenue code 0024. Non-outlier payments will not be made based on the total charges shown in Revenue Code 0001.

- IRF providers will submit one admit through discharge claim for the stay. Final PPS payment is based upon the discharge bill.

- Should the patient's stay overlap the time in which the PPS applies to the facility, PPS payment will still be based on discharge. If the facility submitted an interim bill, a debit/credit adjustment must be made prior to PPS payment. If the facility

submits multiple interim bills, the provider will need to submit cancels and then rebill once the cancels are accepted.

- IRFs can submit adjustment bills (even to correct the CMG), but late charge bills will not be allowed (Type of bill 115).

- If a beneficiary has 1 day of Medicare coverage during their IRF stay, an entire CMG payment will be made.

- IRFs will be paid under the IRF PPS beginning on the first day of their cost reporting period that begins on or after January 1, 2002.

For interim bills, if the stay is greater than 60 days, the interim bill should include the lowest level of the HIPPS code from the admission assessment. The final claim will be adjusted to reflect data from the discharge assessment.

When coding PPS bills for ancillary services associated with a Part A inpatient stay, the traditional revenue codes will continue to be shown in FL 42, e.g., 0250 - Pharmacy, 042x - Physical Therapy, in conjunction with the appropriate entries in Service Units, FL46 and Total Charges, FL47.

- IRFs are required to report the number of units in FL 46 based on the procedure or service.

- IRFs are required to report the actual charge for each line item, in Total Charges, FL 47.

If a beneficiary's Part A benefits exhaust during the stay, code an occurrence code A3-C3 (RT 40, field 8-21), 2300 loop HI code BH). If benefits are exhausted prior to the stay, submit a no pay claim, which will be coded by the FI with no pay code B. Report any services that can be billed under the Part B benefit using 12X TOB.

Note: For more information on outlier payments when benefits are exhausted, please see §20.7.4. Although this references an expired instruction specific to inpatient hospital PPS billing, the information presented provides important general information. Should this situation occur in an IRF, IRF providers may apply this same type of logic and an IRF PC Pricer will be made available for assistance.

140.3.1 - Shared Systems and CWF Edits

(Rev. 1, 10-01-03)

A-03-065

- To insure that revenue code 0024 is not reported more than once on bill type 11X;

- To compare applicable inpatient claims with post-acute claims that will allow erroneous claims to be reviewed and appropriate adjustments to be made on an ongoing basis to the discharging hospital's inpatient claim.

- To check the incoming claims admission date to the history discharge date for the same provider except when patient status code is 30 (CWF);

- To check the incoming claim's discharge date to the history admission date for the same provider (CWF);

- To reject subsequent claims with the same PPS provider on the same day (CWF);

- Ensure accurate coding of patient status codes by checking the incoming claim's admission date to the history discharge date (For transfers to HHAs, the HH stay can begin within 3 days of an IP discharge. A SNF stay can begin within 14 days of an IP discharge);

    - CWF accepts the incoming claim and sends an informational unsolicited response to the FI on the history claim if the patient status code does not match the incoming provider number

    - The FI cancels the history claim to the provider

- To check incoming claim's discharge date to the history admission date to ensure the appropriate use of the patient status code on the incoming claim (For transfers to HHAs, the HH stay can begin within 3 days of an IP discharge. A SNF stay can begin within 14 days of an IP discharge);

- CWF rejects the incoming claim if the patient status code does not match the provider number;

- FI returns the incoming claim to the provider for correction of the patient status code.

- To insure that revenue code 0024 is only on claims submitted by IRF providers. Bills submitted incorrectly will be returned to the provider.

- To insure that a valid HIPPS/CMG rate code is always present with revenue code 0024;

- Units entered on the 0024 must be accepted, but are not required.

- To insure that revenue code total charges line 0001 must equal the sum of the individual total charges lines;

- To insure that the length of stay in the statement covers period, from and through dates equals the total days for accommodations revenue codes 010x-021x, including revenue code 018x (leave of absence)/interrupted stay,

- To insure that Occurrence Span Code 74 FL36, (RT40, fields 22,24,26), 2300 loop HI code BI), is present on the claim if there is an interrupted stay $\leq$ 3 days. If the interruption is greater than 3 days, the bill should be considered a discharge. If the patient returns to the IRF by midnight of the 3rd day, the bill continues under the same CMG. CWF will need to edit to ensure that if another IRF bill comes in during the interrupted stay, it is rejected, as it should be associated with the original CMG; and

- If HIPPS rate code is 5101, 5102, 5103, or 5104 patient status must be 20 (Expired)/

- The accommodation revenue code 018x, (RT 50, field 5), (SV201), (leave of absence) will continue to be used in the current manner including the appropriate UB92 occurrence span code, 74 (RT 40, field 22-27) and date range.

140.3.2 - IRF PPS Pricer Software

(Rev. 1, 10-01-03)

The CMS has developed an IRF Pricer Program that calculates the Medicare payment rate. Pricer will use a variety of inputs listed below to calculate the payment rate.

A - Inputs to Pricer

- Provider Specific File data

- Bill Data includes:

    - Provider number:

    - Patient Status:

    - Payment Modification Flag (if condition code is 66, set flag "Y" otherwise use "N.");

    - Covered Charges;

    - Discharge Date;

    - HIPPS/CMG Rate Code;

    - Length of Stay (LOS);

    - Covered Days;
    - Lifetime Reserve Days (LTR)

B - Data Returned From Pricer

Pricer returns the following information:

- PPS Return Code
- MSA
- Wage Index
- Average LOS
- Relative Weight
- Total Payment Amount
- PPS Federal Payment Amount
- Facility Specific Payment Amount
- Outlier Payment Amount
- Low-Income Payment (LIP) Amount
- LOS
- Regular Days Used
- LTR Days Used
- Transfer Percentage
- Facility Specific Rate pre-blend
- Standard Payment Amount
- PPS federal amount pre-blend
- Facility costs
- Outlier threshold
- Submitted HIPPS/CMG code

- PPS Pricer CMG code
- Calculation version code

The Pricer is available electronically to the Shared Systems.

140.3.3 - Remittance Advices

(Rev. 1, 10-01-03)

A new remittance advice remark code is used to notify an IRF when the CMG code was changed: N100 code corrected during adjudication.

FIs must notify IRF facilities of the new code and its definition prior to initial use. Existing reason and remark codes are used in remittance advice transactions to explain other adjustments made to the claim during adjudication.

Providers receiving version 3051.4A.01 of the Electronic Remittance Advice (ERA) will receive the CMG code under which payment is made in the service level procedure code field, identified with qualifier HC. If the CMG is modified during adjudication, the paid under CMG (rather than the submitted CMG), will be reported at the service level. Providers receiving version 4010 of the ERA will have the CMG reported in the same location, but with qualifier ZZ. Providers that receive earlier versions of the ERA, or who receive only paper RAs, will not receive service level details.

Existing Medicare Summary Notices and Notices of Utilization for beneficiaries are appropriate for IRF PPS claims.

140.3.4 - Payment Adjustment for Late Transmission of Patient Assessment Data

(Rev. 1, 10-01-03)

In accordance with the regulations, Medicare (Part A fee-for-service) patient assessment data must be transmitted to the CMS National Assessment Collection Database by the 17th calendar day from the date of the patient's discharge. Under 412.614(d)(2), if the actual transmission date is later than 10 calendar days from the mandated transmission date, the patient assessment data is considered late and the IRF receives a payment rate that is 25 percent less than the payment rate associated with the case-mix group (CMG). Therefore, if the IRF transmits the patient assessment data 28 calendar days or more from the date of discharge, with the discharge date itself starting the counting sequence, the penalty is applied.

On Revenue Code line 0024, Field Locator 45 (or electronic equivalent), Service Date, when entered by the provider or CMS adjustment process, will equal the date on which the final assessment was transmitted to the CMS National Assessment Collection Database. This field is optional. Providers may, but are not required to, include this date

on the bill if they expect that the assessment transmission will be 28 calendar days or more from the date of discharge thereby incurring the 25percent late assessment penalty. If the provider does not complete this field and the assessment is received 28 calendar days or more from the date of discharge, CMS will utilize a post-payment review process to identify claims subject to the late penalty and institute an adjustment process to correct payment. Complete details of the CMS post-payment review process will be determined at a later date. We anticipate that this process will account for changes in the primary source of payment, after the patient is discharged, that may be a legitimate basis for the late transmission of Medicare patient assessment data.

The following modifications were made to the IRF Pricer to account for the future implementation of this payment adjustment:

Under the inputs to Pricer, the "payment modification flag" has been changed to "special payment indicator." This is an alpha-numeric field with valid entries of 0 - 3 currently.

The shared systems will set the payment modification flag to:

1 = if the claim has Condition Code 66 entered

2 = if the assessment date is present on the revenue code line with 0024 and the assessment date is 28 calendar days or more from the date of discharge on this claim

3 = both 1 and 2 above apply, or

0 = Default value

Under Pricer outputs, Pricer will now return a "penalty amount" field. When applicable, the amount in this field will equal 25 percent of the total payment amount computed by Pricer. The total payment amount field will be then be reduced by the penalty amount so that the final total payment amount output by Pricer will be 75 percent of the CMG payment due the provider. For providers receiving a blend using their facility specific rate, the penalty does not apply to this part of the payment.

Return codes 10 - 17 will be added. They will identify claims where there was a penalty and they will mirror return codes 00 - 07 with the phrase "with penalty" added.

150 - Long Term Care Hospitals (LTCHs) PPS

(Rev. 1, 10-01-03)

PM A-02-093

150.1 - Background

(Rev. 1, 10-01-03)

LTCHs are certified under Medicare as short-term acutecare hospitals that have been excluded from the acute care hospital inpatient prospective payment system (PPS) under §1886(d)(1)(B)(iv) of the Act and, for Medicare payment purposes, are generally defined as having an average inpatient length of stay of greater than 25 days. This PPS replaced the previous reasonable cost-based payment system for LTCHs.

150.2 - Statutory Requirements

(Rev. 1, 10-01-03)

The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), as amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), required that a budget neutral, per discharge PPS for LTCHs based on diagnosis-related groups (DRGs) be implemented for cost reporting periods beginning on or after October 1, 2002.

The CMS satisfied the statutory implementation requirement by establishing October 1, 2002 as the effective date of the LTCH PPS with systems changes to follow. Payments for LTCH services furnished for cost reporting periods beginning on or after October 1, 2002 are based on the policies set forth in the August 30, 2002 final rule (67 FR 55954).

150.3 - Affected Medicare Providers

(Rev. 1, 10-01-03)

LTCHs are certified under Medicare as short-term acutecare hospitals and, for Medicare payment purposes, are generally defined as having an average inpatient length of stay of greater than 25 days. LTCHs are identified by the last four digits of the Medicare provider number, which range between "2000" and "2299."

Veterans Administration Hospitals, hospitals that are reimbursed under state cost control systems approved under 42 CFR Part 403, and hospitals that are reimbursed in accordance with demonstration projects authorized under §402(a) of Public Law 90-248 (42 U.S.C. 1395b-1) or §222(a) of Public Law 92-603 (42 U.S.C. 1395b-1) are not included in the LTCH PPS. (See 42 CFR §412.22(c).) Payment to foreign hospitals will be made in accordance with the provisions set forth in 42 CFR 413.74. Currently, two of

the four Maryland LTCHs included on CMS' OSCAR database are presently paid in accordance with demonstration projects (i.e., the Maryland "Waiver") and therefore not subject to payments under the LTCH PPS: Levindale Hebrew Geriatric Center (#212005) and Deaton Hospital and Medical Center (now know as University Specialty Hospital, #212007).

150.4 - Revision of the Qualification Criterion for LTCHs

(Rev. 208, 06-18-04)

Under the LTCH PPS, the greater than 25-day average length of stay *(ALOS)* calculation is based only on a hospital's Medicare inpatients, counting total medically necessary days, not only covered days. For cost reporting periods beginning on or after October 1, 2002, LTCHs are required to meet this revised criteria in order to qualify as LTCHs for Medicare payment purposes.

The average Medicare length of stay is calculated by dividing the total number of covered and noncovered days of care provided to Medicare patients, by the Medicare discharges occurring during that period. *If the days of a stay involve days of care furnished during two or more separate cost reporting periods, that is, an admission during one cost reporting period and a discharge during a future cost reporting period, the total number of days of the stay are considered to have occurred during the cost reporting period during which the patient was discharged. For cost reporting periods beginning on or after July 1, 2004, if a hospital fails to meet the ALOS requirement under this provision, the FI will determine the ALOS for cost reporting periods beginning on or after July 1, 2004 but before July 1, 2005 by dividing the applicable total days for Medicare inpatients during the cost reporting period when they occur, by the number of discharges occurring during the same cost reporting period*

If the FI determines that the LTCH does not qualify, FIs are to follow the procedures already established in the Medicare General Information, Eligibility, and Entitlement Manual (CMS Pub. 100-01). The new manual can be found at http://cms.hhs.gov/manuals/cmsindex.asp.

The CMS requires on-going monitoring of LTCH compliance with the above requirements as well as notification by FIs regarding this compliance.

150.5 - Payment Provisions Under LTCH PPS

(Rev. 1, 10-01-03)

Section 123 of Public Law 106-113(BBRA), as amended by §307 of Public Law 106-554(BIPA), authorizes the establishment of Federal payment rates under PPS for LTCHs. The BIPA confers broad authority on the Secretary to determine what payment system adjustments should be included in the LTCH PPS, both on a facility level and on a case-level, to ensure that payment most accurately reflects cost.

CMS has established a transition to full payments under the LTCH PPS: a 5-year phase-in during which a decreasing percentage of payments will based upon what payments would have been under the reasonable cost-based system. LTCHs may also elect to receive payment based on 100 percent of the "Federal payment rate." New LTCHs are to be paid based fully on 100 percent of the Federal rate (i.e. hospitals for which the first cost reporting period as an LTCH began on or after October 1, 2002). (See §150.10.1.)

150.5.1 - Budget Neutrality

(Rev. 1, 10-01-03)

The BBRA requires that total payments under the PPS must equal the amount that would have been paid if the PPS had not been implemented.

150.5.2 - Budget Neutrality Offset

(Rev. 1, 10-01-03)

A reduction factor to all Medicare payments during the transition to account for the monetary effect of the 5-year transition from the present cost-based payment system and the LTCH PPS, and the policy to permit LTCHs to elect payment solely under the PPS rather than based on the blend during the transition. (See §150.10.1.)

If a LTCH is paid under the transition blend methodology, the budget neutrality offset will be applied to both the TEFRA Rate Percentage and the Federal Rate percentage.

The budget neutrality offset equals 1 minus the ratio of the estimated TEFRA reasonable cost-based payments that would have been made had the LTCH PPS not been implemented to the projected total Medicare program payments that would be made under the transition methodology and the option to elect payment based on the 100 percent of the Federal rate.

The per discharge Federal rates under the PPS are based on average LTCH costs in a base year updated for inflation to the first effective period of the system.

The LTCH PPS is updated annually as is done with the inpatient, IRF, and SNF/Swing bed PPS systems.

150.6 - Beneficiary Liability

(Rev. 1, 10-01-03)

Beneficiary liability will operate the same as under the former TEFRA cost-based payment system, i.e., if Medicare payments are below the cost of care for a patient under prospective payment, the patient cannot be billed for the difference.

As under the former TEFRA cost-based payment system, beneficiaries (or their Medigap insurers or other private insurers, such as an employer-sponsored plan, as applicable) are responsible for all noncovered days, where Medicare has not made a full LTC-DRG payment.

For more detailed information regarding lifetime reserve days, refer to the Medicare Benefit Policy Manual, Chapter 5.

150.7 - Patient Classification System

(Rev. 1, 10-01-03)

The BBRA required the use of diagnostic-related groups (DRGs) for patient classification purposes in the PPS for LTCHs. In general, a case is grouped based on the clinical characteristics of the Medicare beneficiary.

The patient classification system groupings are called LTC-DRGs, which are based on the existing CMS DRGs used under the acute care hospital inpatient PPS. Patient discharges are grouped using ICD-9- CM codes based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient.

The same GROUPER software developed by 3M for the acute care hospital inpatient PPS, is used but with LTCH-specific relative weights reflecting the resources used to treat the medically complex LTCH patients).

150.8 - Relative Weights

(Rev. 1, 10-01-03)

Payment weights assigning a specific value representing the relative resource use of each LTC DRG are determined by the hospital-specific relative value method. This methodology normalizes charges within each hospital and then compares them across hospitals. Relative weights are updated annually October 1 using the most recent available claims data. Relative weights and the geometric average length of stay are in the Pricer program.

150.9 - Payment Rate

(Rev. 1, 10-01-03)

Payments to LTCHs under the LTCH PPS are based on a single standard Federal rate for both the inpatient operating and capital-related costs (including routine and ancillary services), but not certain pass through costs (i.e., bad debts, direct medical education, new technologies, and blood clotting factors). This single standard Federal rate is updated annually by the excluded hospital with capital market basket index. The formula for an unadjusted LTCH PPS prospective payment is as follows:

- Federal Prospective Payment = LTC-DRG Relative Weight * Standard Federal Rate Case-Level Adjustments

Effective July 1, 2003, the annual update to the standard Federal rate is based on the "LTCH PPS rate year" of July 1 through June 30, rather than the Federal fiscal year (October 1 through September 30

150.9.1 - Case-Level Adjustments

(Rev. 1, 10-01-03)

Payments are based on the LTC-DRG described as well as possible adjustments specific to the case. Because LTCHs are distinguished from other inpatient hospital settings by an average length of stay of greater than 25 days, it was necessary to establish payment categories for certain cases that have stays of considerably less than the average length of stay. The following case-level adjustments are applied to cases that, based on length of stay at the LTCH, receive significantly less than the full course of treatment for a specific LTC-DRG.

150.9.1.1 - Short-Stay Outliers

(Rev. 1, 10-01-03)

Generally, a short-stay outlier is a case that has a length of stay between 1 day and up to and including 5/6 of the average length of stay for the LTC-DRG to which the case is grouped. A short-stay outlier is paid the least of:

- 120 percent of the cost of the case (determined using the facility-specific cost to charge ratio and covered charges from the bill);

- 120 percent of the LTC-DRG specific per diem payment (determined using the LTCDRG relative weight, the average length of stay of the LTC-DRG, and the length of stay of the case); or

- The full LTC-DRG payment.

To compute 120% of cost:

- Charges x CCR = Cost ($13,870.33) x (0.8114) = $11,254.39

- 120% of cost = $11,254.39 x 1.2 = $13,505.27

To compute 120% of the specific LTC-DRG per diem:

- Full LTC-DRG payment / ALOS LTC-DRG x LOS of the case x 1.2

  Full LTC-DRG payment:

$34,956.15 (FY 2003 standard Federal rate)

x 0.72885 (labor %)

$25,477.79 (labor share)

x 1.0301 (1/5th wage index value for FY 2003)

$26,244.67 (wage adjusted labor share)

+ 9,478.36 (non-labor share=$34,956 x 0.27115)

$35,723.03 (adjusted standard Federal rate)

x 1.4103 (LTC-DRG 113 relative weight)

$50,380.19 (full LTC-DRG payment

Per Diem = $50,380.19 / 36.9 (ALOS LTC-DRG 113) = $1365.32 per day

If LOS of case is 10 days, then 120% of per diem = $1365.32 per day x 10 days x 1.2 = $16,383.80.

In this example, the case is paid 120% of cost ($13,505.27) since it is less than $120% of the specific LTC-DRG per diem ($16,383.80) and the full LTC-DRG payment ($50,380.19).

For discharges occurring on or after August 8, 2003, short-stay outlier payments are to be reconciled upon cost report settlement to account for differences between the estimated cost-to-charge-ratio and the actual cost-to-charge ratio for the period during which the discharge occurs. For further information, refer to the June 9, 2003 High Cost Outlier final rule (68 FR 34506 – 34513).

Short Stay Outlier Policy for LTCHs qualifying under §1886(d)(1)(B)(II)

A "subsection (II)" hospital:

- Was excluded as a LTCH in 1986
- Has an average inpatient LOS of greater than 20 days, and
- Demonstrates that 80 percent of its annual Medicare inpatient discharges in the 12-month reporting period ending FFY 1997 have a principal finding of neoplastic disease.

For a "subsection (II)" hospital there is a special short-stay outlier policy effective for the remainder of the transition period (i.e., discharges occurring on or after July 1, 2003 through December 31, 2006), where the lesser of 120 percent of cost or120 percent of the

per diem LTC-DRG in the existing short-stay outlier policy is replaced with the follow percentages:

- Effective for discharges occurring on or after July 1, 2003 through the first year of transition 195%;
- Effective for discharges during the second year of the transition, 193%;
- Effective for discharges during the third year of the transition, 165%;
- Effective for discharges during the fourth year of the transition, 136%; and
- Effective for discharges for the last year and thereafter, the percentage will return to 120%.

150.9.1.2 - Interrupted Stays

(Rev. 208, 06-18-04)

Beginning on July 1, 2004, there are two interruption of stay policies in effect under the LTCH PPS.

A 3-day or less interruption of stay is a stay at a LTCH during which beneficiary is discharged from the LTCH to an acute care hospital, IRF, SNF, or home and readmitted to the same LTCH within 3-days of the discharge. The 3-day or less period begins with the date of discharge from the LTCH and ends not later than midnight of the third day.

Medicare payment for any test, procedure, or care provided on an outpatient basis or for any inpatient treatment during the "interruption" would be the responsibility of the LTCH "under arrangements" with one limited exception: for RY 2005 (July 1, 2004 through June 30, 2005) if treatment at an inpatient acute care hospital would be grouped to a surgical DRG, a separate Medicare payment would be made under the IPPS for that care. Any tests or procedures, that were administered to the patient during that period of time of interruption, other than inpatient surgical care at an acute care hospital, will be considered to be part of that single episode of LTCH care and bundled into the payment to the LTCH. The LTCH will be required to pay any other providers without additional Medicare program payment liability.

If no additional Medicare services are delivered during the3-day or less interruption (e.g., the patient is home and doesn't receive any outpatient or inpatient services at an acute care hospital or IRF or care at a SNF) prior to readmission to the LTCH, the number of days away from the LTCH will not be included in the total length of stay for that beneficiary stay. If care is delivered on any day during the interruption, however, that the LTCH pays for "under arrangements," all the days of the interruption are included in the total length of stay for that beneficiary stay. Therefore, if a patient receives services on only one of the days of the interruption but is away from the LTCH

for 3 days, all 3 days will be deemed a part of the total episode of care and counted towards the length of stay for that patient stay. If an interruption of stay exceeds 3-days, the original interrupted stay policy, below, governs payment.

- *The original interrupted stay policy is now defined as "a greater than 3-day interruption of stay" and is a stay* in which a LTCH patient that is admitted upon discharge to an inpatient acute care hospital, an inpatient rehabilitation facility (IRF), a skilled nursing facility (SNF), or swing bed and returns to the same LTCH within a specified period of time. The day count begins on the day of discharge from the LTCH, which is also the admission day to the other provider, and ends on the day of readmission to the LTCH.
    - *For an acute care hospital: between 4 and 9 consecutive days;*
        - For an IRF*: between 4 and 27 consecutive days;*
        - For a SNF*: between 4 and 45 consecutive days;* and
        - For a Swing Bed: *between 4 and 45 consecutive* days or less.

Note that although the greater than 3-day interruption of stay policy only governs when a patient is away from the LTCH for between 4 days and the applicable provider threshold, the day count for determining whether the threshold is met begins when the patient is discharged. So if a patient is discharged on 9/2/04, the 3-day or less interrupted stay policy will govern payment if the patient is readmitted to the LTCH on 9/2, 9/3, or 9/4. If the patient is readmitted to the LTCH on 9/5, payment will be paid to, for example, the acute care hospital which provided treatment, but the day count for determining whether the or not the stay is one interrupted stay or a whether the return to the LTCH is a separate admission starts on 9/2. For example, if the LTCH discharges a patient to an acute care hospital on 9/2/04, if they are readmitted to the LTCH by 9/10/04, this is an interrupted stay. If they are readmitted on 9/11/04, it counts as a separate admission. An interrupted stay case is treated as one discharge for the purposes of payment; only one LTCH PPS payment is made. (The bill generated by the original stay in the LTCH should be cancelled by the provider or they may do a debit/credit adjustment.)

Multiple interrupted stays should be entered as one claim but each interrupted stay should be evaluated individually for the rule regarding the appropriate number of days at the intervening facility.

If the length of stay at the "receiving" site of care exceeds the above- specified period of time, the return to the LTCH is a new admission. This means that the original discharge to that site is treated as a discharge for payment purposes.

For the percentage of payments that are to be made under the TEFRA system during the 5-year transition, the FI treats each segment of the interrupted stay as a separate discharge. (FIs are to follow the same procedure as provided under the IRF PPS in determining the amount of the payment under the blend that TEFRA would have paid.)

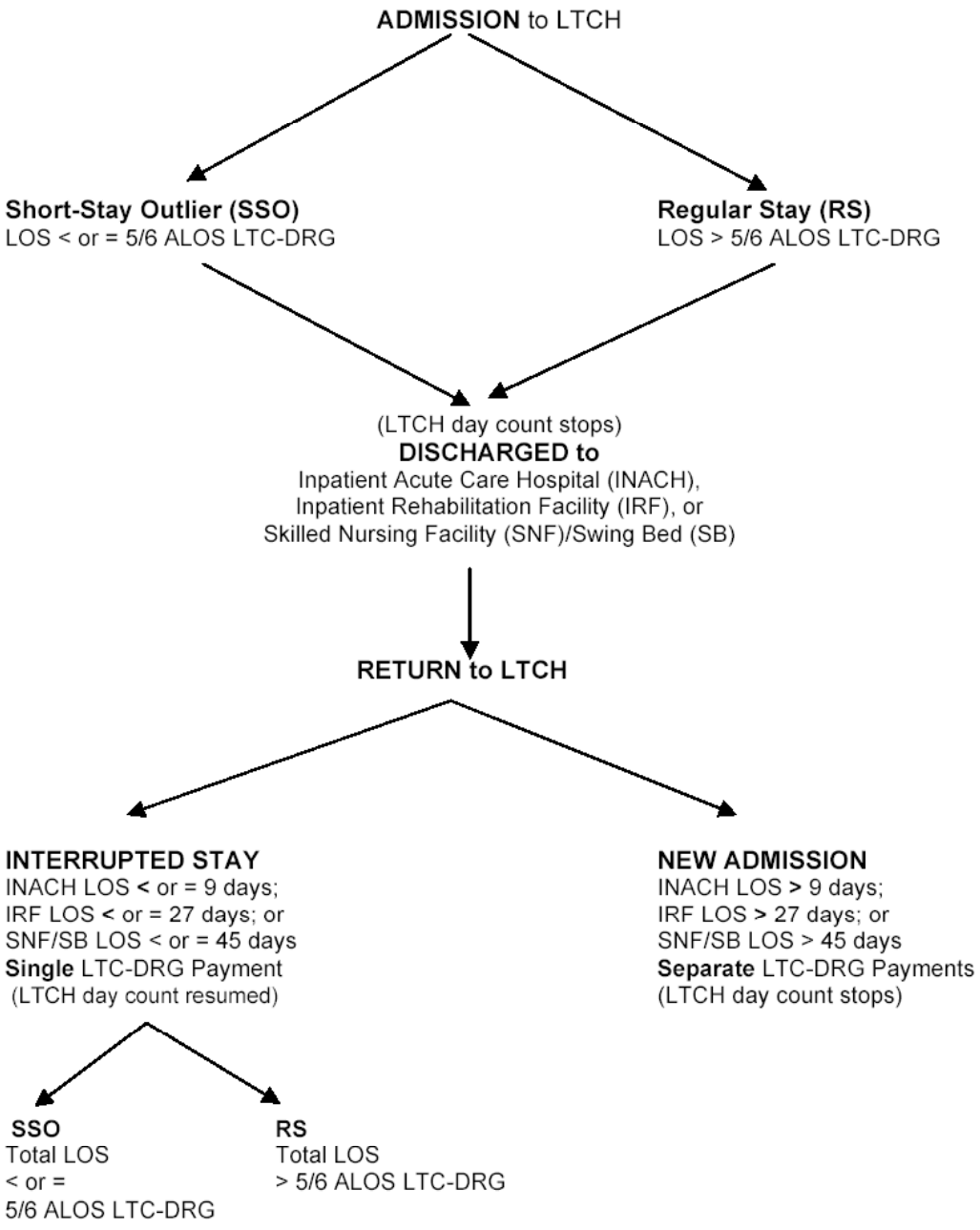
150.9.1.3 - Payments for Special Cases

(Rev. 208, 06-18-04)

- Payments for short-stay outliers are determined in the Pricer logic.
- Payments for interrupted stays are based on properly submitted bills by the LTCHs, which are described in billing instructions.

More than one case-level adjustment may apply to the same case. The following flow chart describes the order that is used to assess whether or not the adjustments apply. For example, a case may be a short-stay outlier and also be *governed by either the 3-day or less or greater than 3-day interruption of stay policy and therefore only generate 1 LTC-DRG payment to the LTCH.*

SHORT-STAY OUTLIERS AND INTERRUPTED STAYS



There are no special payment policies for transfer cases or deaths, i.e., if a patient in LTCH "A" is transferred to LTCH "B" each LTCH will receive a separate LTC-DRG payment based on the number of days the patient is in the respective LTC-DRG payment based on the number of days the patient is in the respective LTCH.

150.9.1.4 - Payment Policy for Co-Located Providers

(Rev. 1, 10-01-03)

Hospitals within hospitals, satellite facilities, and onsite SNFs:

LTCHs that are co-located with other Medicare providers (acute care hospitals, IRFs, SNFs) are subject to the interrupted stay policy (§150.9.1.2) but in addition, if such discharges and readmissions exceed 5 percent of the LTCH's total discharges during a cost reporting period, all such readmissions during that cost reporting period are to be paid as one discharge, regardless of the time spent at the intervening facility.

- One 5 percent calculation is applied to discharges to and readmissions from onsite acute care hospitals and a separate 5 percent calculation is made for the combined discharges to, and readmissions to, the LTCH from onsite IRFs, SNFs, and psychiatric facilities.)

- Prior to triggering either of the 5 percent thresholds, such cases are to be evaluated and paid under the interrupted stay policy. (Presently, there is no interrupted stay policy for psychiatric facilities, so in the case of a LTCH patient who is directly readmitted from a psychiatric facility, there will be two LTC-DRG payments unless, and until, the number of such readmissions (counted along with readmissions from an onsite IRF or SNF) reach the 5 percent threshold.)

LTCHs were required to notify their FIs about the providers with which they are co-located within 60 days of their first cost reporting period that began on or after October 1, 2002. A change in co-located status must be reported to the FIs within 60days of such a change. The implementation of the onsite policy is based on information maintained by FIs on other Medicare providers co-located with LTCHs. FIs notify the CMS RO of such arrangements.

Payments under this policy are determined at cost report settlement.

150.9.1.5 - High Cost Outlier Cases

(Rev. 1, 10-01-03)

Additional payments are made for those cases that are considered high cost outliers. A case falls into this category if the estimated cost of the case exceeds the outlier threshold (the LTC-DRG payment plus a fixed loss amount). (Short-stay outliers, described above, are also eligible for outlier payments if their costs exceed the outlier threshold. The applicable short-stay outlier payment is used to determine the outlier threshold for short-stay outlier cases.)

The fixed loss amount is determined annually on July 1 such that projected outlier payments are equal to 8 percent of total LTCH PPS payments.

If the estimated cost of the case is greater than the outlier threshold an additional payment is added to the LTC-DRG payment amount.

The outlier payment is 80 percent of the difference between the estimated cost of the case and the outlier threshold (the LTC-DRG payment plus a fixed loss amount).

The estimated cost of the case is calculated by multiplying the Medicare allowable charge on the claim by the LTCH's overall cost-to-charge ratio obtained from the latest settled cost report.

For discharges occurring on or after August 8, 2003, (high cost outlier payments may be reconciled upon cost report settlement to account for differences between the estimated cost-to-charge-ratio and the actual cost-to-charge ratio for the period during which the discharge occurs. For further information, refer to the June 9, 2003 High Cost Outlier final rule (68 FR 34506 – 34513).

150.10 - Facility-Level Adjustments

(Rev. 208, 06-18-04)

Facility-level adjustments are based on individual LTCH characteristics. The BIPA confers broad authority on the Secretary to include "appropriate adjustments to the long-term hospital payment system."

Variables examined include an area wage adjustment, adjustment for geographic reclassification, disproportionate share patient (DSH) percentage, and an adjustment for indirect medical education (IME).

- The system includes an area wage adjustment that is being phased in over 5 years.
- The wage adjustment is made by multiplying the labor-related share of the standard Federal rate by the applicable wage index value.
- A LTCH's wage index is based on the Metropolitan Statistical Area (MSA) or rural area in which the hospital is physically located, without regard to geographic reclassification under §§1886(d)(8) - (10) of the Act.
- The phase-in of the wage index adjustment is as follows:

Cost Reporting Periods Beginning During	Applicable Wage Index Value
FY 2003	1/5th of the value of the applicable pre-reclassification, no floor hospital inpatient wage index
FY 2004	2/5^{ths} of the value of the applicable pre-reclassification, no floor hospital inpatient wage index
FY 2005	3/5^{ths} of the value of the applicable pre-reclassification, no floor hospital inpatient wage index
FY 2006	4/5^{ths} of the value of the applicable pre-reclassification, no floor hospital inpatient wage index
FY 2007	Full value (5/5^{ths}) of the value of the applicable pre-reclassification, no floor hospital inpatient wage index

Based on analyses of patient charge data from FYs 2000 and 2001 MedPAR data and cost report data from FY 1998 and 1999 HCRIS data, there is no empirical evidence to support other adjustments. Therefore, for the present, there are no adjustments for DSH, IME, or geographic reclassification.

There is a cost-of-living adjustment (COLA) for LTCHs located in Alaska and Hawaii.

- The adjustment is made by multiplying the nonlabor-related portion of the unadjusted standard Federal rate by the applicable COLA factor from OPM based on the county that the LTCH is located (similar to the COLA under the acute care hospital inpatient PPS).

- *Annual updates for the LTCH PPS appear in **Federal Register** publications: for payment rates and associated adjustments, see the LTCH PPS final rule with an effective date of July 1. Annual updates of the LTC-DRGs are published in the IPPS final rule with an effective date of October 1.*

- The COLA factors effective *July 1, 2004* are the same as under the Acute Care Hospital Inpatient PPS and are as follows:

Area	**COLA**
Alaska:	
All Areas	1.25
Hawaii:	
Honolulu	1.25
Hawaii County	1.165
Kauai County	1.2325
Maui County	1.2375
Kalawao County	1.2375

150.10.1 - Phase-in Implementation

(Rev. 1, 10-01-03)

The PPS for LTCHs is to be phased-in over a five- year period from cost-based reimbursement to Federal prospective payment. During this transition period, payment is based on an increasing percentage of the LTCH prospective payment and a decreasing percentage of each LTCH's cost-based reimbursement rate for each discharge as follows:

Cost Reporting Periods Beginning On or After	LTCH PPS Federal Rate Percentage	TEFRA Rate Percentage
October 1, 2002, through September 30, 2003	20	80
October 1, 2003, through September 30, 2004	40	60
October 1, 2004, through September 30, 2005	60	40
October 1, 2005, through September 30, 2006	80	20
October 1, 2006	100	0

LTCHs can exercise a one-time irrevocable option to elect payment based on 100 percent of the Federal rate rather than transition from cost-based reimbursement to prospective payment. To exercise this option, for cost reporting periods beginning on or after October 1, 2002, and before December 1, 2002, the LTCH was to notify its FI of this election in writing, and it was to be received by the FI no later than November 1, 2002. To exercise this option, for cost reporting periods beginning on or after December 1, 2002, the LTCH must notify its FI in writing 30 days prior to the start of the LTCH's next cost reporting period.

Payments to new LTCHs, i.e., a hospital that has its first cost reporting period as a LTCH beginning on or after October 1, 2002, are made based on 100 percent of the standard Federal rate.

Note: under the BIPA, during cost reporting periods beginning during FY 2001, target amounts under TEFRA were increased by 25 percent. This increase will continue to be in effect for the TEFRA portion of transitions payments.

150.11 - Requirements for Provider Education and Training

(Rev. 1, 10-01-03)

Training resources are available for FI staff to use in training providers about the Long Term Care Hospital Prospective Payment System (LTCH PPS). The train-the-trainer process for LTCH PPS does not include in- person instruction for FIs. Instead, CMS provides various educational resources for FIs to learn about LTCH PPS.

The CMS provides the following LTCH PPS education resources for FIs:

- A training guide is available on http://www.cms.hhs.gov/medlearn/ltchpps.asp;
- A training video was mailed to FIs;
- A PowerPoint presentation for training providers is available on http://www.cms.hhs.gov/medlearn/ltchpps.asp; and
- An e-mail mailbox was established to address questions. Send questions to: LTCHPPS@cms.hhs.gov.

150.12 - Claims Processing and Billing

(Rev. 1, 10-01-03)

150.12.1 - Processing Bills Between October 1, 2002, and the Implementation Date

(Rev. 1, 10-01-03)

Claims submitted prior to implementation were processed under the current methodology. On or after January 1, 2003, submit mass adjust claims under the PPS payment methodology by April 30, 2003. The shared systems is creating a mass adjustment program.

Beginning October 16, 2003, all LTCHs are required to comply with the HIPAA Administrative Simplification Standards, unless they have obtained an extensionin compliance with the Administrative Compliance Act to submit claims in compliance with

the standards at 42 CFR 162.1002 and 45 CFR 162.1192 using the ICD-9-CM coding. All ICD-9-CM coding must be used for LTCH providers with cost reporting period beginning on or after October 1, 2002.

150.13 - Billing Requirements Under LTCH PPS

(Rev. 1, 10-01-03)

Billing LTCH PPS Services

Effective with cost reporting periods beginning on or after October 1, 2002, LTCHs are to incorporate the following so that FIs accurately price and pay a claim under the LTCH PPS. These claims must be submitted on Type of Bill 11X. The last four digits of the provider number for LTCHs are from 2000 to 2299.

This is a DRG- based payment system; therefore the LTCH DRG is determined by the grouping of ICD-9-CM codes based on the principal diagnosis, up to eight additional diagnoses, and up to six procedures performed during the stay, as well as age, sex, and discharge status of the patient on the claim. Grouper software will determine DRG assignment.

Each bill from a LTCH must contain the complete diagnosis and procedure coding for purposes of the GROUPER software. Normal adjustments will be allowed. LTCH providers submit one admit through discharge claim for the stay. Final PPS payment is based upon the discharge bill.

150.14 - Stays Prior to and Discharge After PPS Implementation Date

(Rev. 1, 10-01-03)

If the patient's stay begins prior to and ends on or after the provider's first fiscal year begin date under LTCH PPS, payment to the facility is based on LTCH PPS rates and rules. There is no split billing. If the facility submitted an interim bill, a debit/credit adjustment must be made prior to PPS payment. If the facility submits multiple interim bills, the provider needs to submit cancels for all bills and then rebill once the cancels are accepted.

150.15 - System Edits

(Rev. 208, 06-18-04)

The Shared systems and/or Common Working File (CWF) must ensure:

- That revenue code total charges line 0001 must equal the sum of the individual total charges lines;

- That the length of stay in the statement covers period, from and through dates equals the total days for accommodations revenue codes 010x-021x, including revenue code 018x (leave of absence)/interrupted stay;

- That Occurrence Span Code 74 FL36, (RT 40, fields 22,24,26), (2300 loop HI code BI), is present on the claim when there is an interrupted stay (the beneficiary has returned to the LTCH in a specified amount of time). *See section 150.9.1.2.*

If the interruption is greater than the specified number of days applicable to the specific provider, the bill is considered a discharge and two bills would exist if the beneficiary returns to the same LTCH, otherwise it is considered an interruption with one DRG payment associated. CWF will edit for both of these situations.

Payments under the onsite discharge and readmittance policy are to be reconciled at cost report settlement, at which time it is possible to determine the total number of such cases that have occurred during that cost reporting period.

The accommodation revenue code 018X (RT 50, field 5), (SV 201), (leave of absence) continues to be used in the current manner in terms of Occurrence Span code 74 (RT 40, field 22 - 27) and date range.

150.16 - Billing Ancillary Services Under LTCH PPS

(Rev. 1, 10-01-03)

When coding PPS bills for ancillary services associated with a Part A inpatient stay, the traditional revenue codes continue to be shown in FL 42, in conjunction with the appropriate entries in Service Units, FL46 and Total Charges, FL47.

- LTCHs are required to report the number of units in FL 46 based on the procedure or service.

- LTCHs are required to report the actual charge for each line item, in Total Charges, FL 47.

- In general the current policy applies for billing ancillary services and nothing changes with the implementation of this PPS.

150.17 - Benefits Exhausted

(Rev. 1, 10-01-03)

If a beneficiary's Part A benefits exhaust during the stay, provider’s code an Occurrence Code A3-C3 (RT 40, field 8-21), (2300 loop HI code BH). If benefits are exhausted prior to the stay, hospitals submit a no-pay claim that is to be coded by the FI with no pay code B.

LTCH PPS uses Occurrence Code 47 to indicate the first full day of cost outlier status and also uses Occurrence Span Code 70 for covered non-utilization periods beyond the short-stay outlier threshold. There is an exception if there are not enough regular days to reach the short-stay outlier threshold point. For the beneficiary to continue coverage, LTR days must be utilized for the remainder of the entire stay, as available. Similarly, for the beneficiary to continue coverage, if only LTR days are available, they must be used on a continuous basis throughout the entire stay, as available.

The following examples illustrate the short-stay outlier policy in relation to benefits exhausted:

150.17.1 – Assumptions for Use in Examples Below

(Rev. 1, 10-01-03)

1. Cost outlier threshold amount is $50,000

2. Threshold amount is reached on the 25th day

3. The DRG ALOS equals 12 days, therefore, the Short Stay Threshold equals 10 days

4. Billed charges are $3,000 per day for the first 12 days, $2,000 on the 13th day and $1,000 each day thereafter

5. Beneficiary elects to use any available LTR days

150.17.1.1 - Example 1: Coinsurance Days < Short Stay Outlier Threshold (30 Day Stay)

(Rev. 1, 10-01-03)

1a.

Date of service: 1/1/03 - 1/31/03

Medically necessary days: 30

Covered charges: $55,000

Benefits available: 9 coinsurance and 60 LTR

Covered days: 30

Noncovered days: 0

Coinsurance days used: 9

LTR days used: 21

Cost report days: 30

Reimbursement: Full DRG payment plus cost outlier based on $55,000 covered charges

1b.

Date of service: 1/1/03 - 1/31/03

Medically necessary days: 30

Covered charges: $27,000

Benefits available: 9 coinsurance and 0 LTR

Covered days: 9

Noncovered days: 21

Coinsurance days used: 9

LTR days used: 0

Cost report days: 9

OC A3: 1/09/03

Reimbursement: Short stay outlier

1c.

Date of service: 1/1/03 - 1/31/03

Medically necessary days: 30

Covered charges: $50,000

Benefits available: 9 coinsurance and 10 LTR

Covered days: 19

Noncovered days: 11

Coinsurance days used: 9

LTR days used: 10

Cost report days: 25

OC 47: 1/26/03

OC A3: 1/25/03

OSC 70: 1/20/03 - 1/25/03

Reimbursement: Full DRG payment

150.17.1.2 - Example 2: Coinsurance Days Greater Than or Equal to Short Stay Outlier Threshold (30 day stay)

(Rev. 1, 10-01-03)

2a.

Date of service: 1/1/03 - 1/31/03

Medically necessary days: 30

Covered charges: $55,000

Benefits available: 15 coinsurance and 60 LTR

Covered days: 20

Noncovered days: 10

Coinsurance days used: 15

LTR days used: 5

Cost report days: 30

OC 47: 1/26/03

OSC 70: 1/16/03 - 1/25/03

Reimbursement: Full DRG payment plus cost outlier based on $55,000 covered charges

2b.

Date of service: 1/1/03 - 1/31/03

Medically necessary days: 30

Covered charges: $53,000

Benefits available: 15 coinsurance and 3 LTR

Covered days: 18

Noncovered days: 12

Coinsurance days used: 15

LTR days used: 3

Cost report days: 28

OC 47: 1/26/03

OC A3: 1/28/03

OSC 70: 1/16/03 - 1/25/03

Reimbursement: Full DRG payment plus cost outlier based on $53,000 covered charges

2c.

Date of service: 1/1/03 - 1/31/03

Medically necessary days: 30

Covered charges: $50,000

Benefits available: 15 coinsurance and 0 LTR

Covered days: 15

Noncovered days: 15

Coinsurance days used: 15

LTR days used:0

Cost report days: 25

OC 47: 1/26/03

OC A3: 1/25/03

OSC 70: 1/16/03 - 1/25/03

Reimbursement: Full DRG payment

150.17.1.3 - Example 3: Coinsurance Days Greater Than or Equal to Short Stay Outlier Threshold (20 day stay)

(Rev. 1, 10-01-03)

Date of service: 1/1/03 - 1/21/03

Medically necessary days: 20

Covered charges: $45,000

Benefits available: 15 coinsurance and 0 LTR

Covered days: 15

Noncovered days: 5

Coinsurance days used: 15

LTR days used: 0

Cost report days: 20

OSC 70: 1/16/03 - 1/20/03

Reimbursement: Full DRG payment

150.17.1.4 - Example 4: Only LTR Days < Short Stay Outlier Threshold (30 day stay)

(Rev. 1, 10-01-03)

Date of service: 1/1/03 - 1/31/03

Medically necessary days: 30

Covered charges: $27,000

Benefits available: 9 LTR

Covered days: 9

Noncovered days: 21

Coinsurance days used: 0

LTR days used: 9

Cost report days: 9

OC A3: 1/09/03

Reimbursement: Short stay outlier payment

150.17.1.5 - Example 5: Only LTR Greater Than or Equal to Short Stay Outlier Threshold (30 day stay)

5a.

Date of service: 1/1/03 - 1/31/03

Medically necessary days: 30

Covered charges: $50,000

Benefits available: 12 LTR

Covered days: 12

Noncovered days: 18

Coinsurance days used: 0

LTR days used: 12

Cost report days: 25

OC 47: 1/26/03

OC A3: 1/25/03

OSC 70: 1/13/03 - 1/25/03

Reimbursement: Full DRG payment

5b.

Date of service: 1/1/03 - 1/31/03

Medically necessary days: 30

Covered charges: $55,000

Benefits available: 60 LTR

Covered days: 30

Noncovered days: 0

Coinsurance days used: 0

LTR days used: 30

Cost report days: 30

Reimbursement: Full DRG payment plus cost outlier based on $55,000 covered charges

5c.

Date of service: 1/1/03 - 1/31/03

Medically necessary days: 30

Covered charges: $53,000

Benefits available: 28 LTR

Covered days: 28

Noncovered days: 2

Coinsurance days used: 0

LTR days used: 28

Cost report days: 28

OC 47: 1/26/03

OC A3: 1/28/03

Reimbursement: Full DRG payment plus cost outlier based on $53,000 covered charges

150.18 - Provider Interim Payment (PIP)

(Rev. 1, 10-01-03)

PIP applies to LTCH PPS. Outlier payments in regards to PIP are handled the way they currently are under other inpatient PPS systems.

150.19 - Interim Billing

(Rev. 1, 10-01-03)

Interim bills are allowed every 60 days. If the facility submits multiple interim bills, the provider must cancel and rebill once the cancels are accepted.

150.20 – FI Benefit Payment Report (IBPR)

(Rev. 1, 10-01-03)

The IBPR report changes to reflect the payments for LTCHs going to PPS free-standing hospitals.

150.21 - Remittance Advices (RAs)

(Rev. 1, 10-01-03)

Reason and remark codes already in existence for inpatient hospital PPS apply under this PPS.

150.22 - Medicare Summary Notices (MSNs)

(Rev. 1, 10-01-03)

Use existing notices for inpatient hospital PPS for LTCH PPS.

150.23 - LTCH Pricer Software

(Rev. 1, 10-01-03)

The CMS developed a LTCH Pricer program that calculates the Medicare payment rate.

Pricer software is electronically supplied to the Shared systems. Pricer pays a short-stay outlier if the stay is between 1 day and up to and including 5/6 of the average length of stay for the LTC-DRG.

- Pricer incorporates the five-year phase-in period for those providers that choose to be paid on the blended rate.

150.23.1 - Inputs/Outputs to Pricer

(Rev. 1, 10-01-03)

Inputs

- Provider Specific File Data (to be updated in§§3656.3 and 3850 of the MIM); Fields-3,4,5,6,7,8,9,10,12,13,14,19 (five year blend or may choose 100%), 21,22,25 (although this field refers to the operating cost/charge ratio, for LTCH, entered here will be a combined operating and capital cost/charge ratio). See the section "Determining the Cost-to-Charge Ratio" below for determining the cost/charge ratio.

- The facility-specific rate (Field 21) will be determined using the same methodology that would be used to determine the interim payment per discharge under the TEFRA system if the LTCH PPS were not being implemented.

- Bill Data
    - Provider #
    - Patient Status
    - Covered Charges
    - Discharge Date
    - Length of Stay (LOS)
    - Covered Days
    - Lifetime Reserve Days (LTR)
    - DRG (from Grouper)

Outputs

- PPS Return Code
- MSA
- Wage Index
- Average LOS
- Relative Weight

- Final Payment Amount
- DRG Adjusted Payment Amount
- Federal Payment Amount
- Outlier Payment Amount
- Payment Amount
- Facility Costs
- LOS
- Regular Days Used
- LTR Days Used
- Blend Year, 1-5
- Outlier Threshold
- DRG
- COLA
- Calculation Version Code
- National Labor Percent
- National Non-Labor Percent
- Standard Federal Rate
- Budget Neutral Rate
- New Facility-specific Rate

150.24 - Determining the Cost-to-Charge Ratio

(Rev. 1, 10-01-03)

This section describes the appropriate data sources for computing an overall Medicare hospital specific cost-to-charge ratio for the purpose of determining short-stay outlier payments at §412.529 and high cost outlier payments at §412.525(a) under the LTCH PPS.

- For discharges occurring before August 8, 2003, FIs are to use the latest available settled cost report and associated data in determining each LTCH's overall Medicare cost-to-charge ratio. Updated cost-to-charge ratios should be calculated each time a subsequent cost report settlement is made. No retroactive adjustments are to be made to outlier payments upon cost report settlement.

- For discharges occurring on or after August 8, 2003, FIs may use an alternative cost-to-charge ratio, as directed by CMS, which more accurately reflects recent substantial increases/decreases in a hospital's charges. LTCHs may also request that FIs use a different (higher or lower) cost-to-charge ratio based on substantial evidence and approval by the respective CMS Regional Office.

- For discharges occurring on or after October 1, 2003, FIs calculate a LTCH's cost-to-charge ratio from the latest settled or tentatively settled cost report, whichever is later. Updated cost-to-charge ratios are to be calculated each time a subsequent cost report is settled or tentatively settled.

For discharges occurring on or after August 8, 2003, (high cost and short-stay) outlier payments may be reconciled upon cost report settlement to account for differences between the estimated cost-to-charge-ratio and the actual cost-to-charge ratio for the period during which the discharge occurs. For further information, refer to the June 9, 2003 High Cost Outlier final rule (68 FR 34506 – 34513).

The LTCH PPS covers operating and capital-related costs and excludes the costs of bad debts, medical education, nurse anesthetist, and blood clotting factors, which are paid for on a reasonable cost basis.

- Total Medicare charges for LTCHs will consist of the sum of inpatient routine charges and the sum of inpatient ancillary charges (including capital).

- Total Medicare costs will consist of the sum of inpatient routine costs (net of private room differential and swing-bed) plus the sum of ancillary costs plus capital-related pass-through costs only.

- For LTCHs, overall Medicare cost-to-charge ratios will be based on the latest settled cost report data unless such data are either unavailable or outside the ranges noted below.

The Medicare cost reporting forms contain information on both Medicare inpatient costs and charges. In addition, Medicare charges should be contained in the provider statistical and reimbursement (PS&R) report associated with a specific cost reporting period. If the overall Medicare cost-to-charge ratio cannot be calculated (i.e., "new" LTCHs) or is not reasonable, the appropriate urban or rural statewide operating and capital average calculated annually by CMS under the Hospital Impatient PPS and published in the Federal Register is to be used. For FY 2004, the statewide average operating and capital

cost-to-charge ratios can be found in Tables). For "new" LTCHs, use the Hospital Inpatient PPS statewide averages until the LTCH's actual cost-to-charge ratio can be computed using the first settled cost report data; then the actual ratios can be used for the subsequent cost reporting period.

To ensure that the distribution of outlier payments remains equitable, a LTCH's overall Medicare cost-to-charge ratio is considered not to be reasonable if:

- For discharges occurring before August 8, 2003, the value exceeds the combined (operating plus capital) upper (ceiling) and lower (floor) cost-to-charge ratio thresholds calculated annually by CMS under the Hospital Inpatient PPS and published in the Federal Register. For FY 2003, the combined operating and capital upper limit is 1.421 (1.258 plus 0.163) and the combined operating and capital lower limit is 0.206 (0.194 plus 0.012) (see August 1, 2002, 67 FR 50125).

- For discharges occurring on or after August 8, 2003, the value exceeds the combined (operating plus capital) upper (ceiling) cost-to-charge ratio threshold calculated annually by CMS under the Hospital Inpatient PPS and published in the Federal Register. For FY 2003, the combined (operating and capital) cost-to-charge ratio ceiling is 1.421 (1.258 plus 0.163; see August 1, 2002, 67 FR 50125). For FY 2004, the combined (operating and capital) cost-to-charge ratio ceiling is 1.366 (1.203 plus 0.163; see August 1, 2003, 68 FR 45478).

If the overall Medicare cost-to-charge ratio appears not to be reasonable, the FI should ensure that the underlying costs and charges are properly reported prior to assigning the appropriate combined statewide average.

The provider specific file contains a field for the operating cost-to-charge ratio (Field 25; file position 102-105) and for the capital cost-to-charge ratio (Field 42; file position 203-206). Because the cost-to-charge ratio computed for the LTCH PPS includes routine, ancillary, and capital costs, the cost-to-charge ratio for LTCHs is to be entered in the provider specific file only in Field 25; file position 102-105. Field 42; file position 203-206 of the provider specific file must be zero-filled.

Under the LTCH PPS, an overall Medicare cost-to-charge ratio is calculated as follows:

- Medicare charges are obtained from Worksheet D-4, Column 2, lines 25 through 30 plus line 103 from the cost report (where possible, these charges should be confirmed with the PS&R data).

- Total Medicare costs are obtained from Worksheet D-1, Part II, line 49 minus (Worksheet D, Part III, col. 8, lines 25 through 30 plus Worksheet D, Part IV, col. 7, line 101).

- Divide the Medicare costs by the Medicare charges to compute an overall Medicare cost-to-charge ratio.

160 – Necessary Changes to Implement Special Add-On Payments for New Technologies

(Rev. 1, 10-01-03)

A-02-124

160.1 - Special Add-On Payments For New Technologies

(Rev. 1, 10-01-03)

Section 533(b) of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (BIPA) amended section 1886(d)(5) of the Act to add subparagraphs (K) and (L) and establish a process of identifying and ensuring adequate payment for new medical services and technologies under Medicare. In the September 7, 200l, final rule (66 FR 46902), CMS established that cases using approved new technology would be appropriate candidates for an additional payment when: the technology represents an advance in medical technology that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries; the payment for such cases can be demonstrated to be inadequately paid otherwise under the diagnosis-related group (DRG) system; and data reflecting the costs of the technology would be unavailable to use to recalibrate the DRG weights.

Under 42 CFR 412.88 of the regulations, an add-on payment is made for discharges involving approved new technologies, if the total covered costs of the discharge exceed the DRG payment for the case (including adjustments for indirect medical education (IME) and disproportionate share hospitals (DSH) but excluding outlier payments). PRICER calculates the total covered costs for this purpose by applying the cost-to-charge ratio (that is used for inpatient outlier purposes) to the total covered costs of the discharge. Payment for eligible cases is equal to:

- The full DRG payment (see example 1 that follows); plus
- The lesser of

    1. 50 percent of the costs of the new medical service or technology (see example 2); or

    2. 50 percent of the amount by which the total covered costs (as determined above) of the case exceed the DRG payment (see example 3); plus

- Any applicable outlier payments if the costs of the case exceed the DRG, plus adjustments for IME and DSH, and any approved new technology payment for the case plus the fixed loss outlier threshold. The costs of the new technology are included in the determination of whether a case qualifies for outliers.

This instruction implements the above payment mechanism into the claims processing systems.

Below are three illustrative examples of this policy for cases involving an eligible technology estimated to cost $3,000 in a DRG that pays $20,000.

Example One

Applying the hospital's cost-to-charge ratio to the total covered charges for the case, it is determined the total cost for the case is $19,000. Medicare would pay $20,000, the full DRG payment. Even though the case involved a new technology eligible for add-on payments, the total covered costs of the case did not exceed the DRG payment, therefore, no additional payment is made.

Example Two:

Applying the hospital's cost-to-charge ratio to the total covered charges for the case, it is determined the total cost for the case is $25,000. Because, in this case, 50 percent of the costs of the new medical service or technology is less than 50 percent of the amount by which the total covered costs (as determined above) of the case exceed the DRG payment, Medicare would pay 50 percent of the costs of the new technology (in addition to the DRG payment). Therefore, for this case, Medicare would pay $21,500 (the DRG payment of $20,000 plus one-half of $3,000, the estimated cost of the new technology).

Example Three:

Applying the hospital's cost-to-charge ratio to the total covered charges for the case, it is determined the total cost for the case is $22,000. Medicare would pay one-half of the amount by which the costs of the case exceed the DRG payment, up to the estimated cost of the new technology. Therefore, for this case, Medicare would pay $21,000 (the DRG payment of $20,000 plus one-half of the costs above that amount).

160.1.1 - Identifying Claims Eligible for the Add-On Payment for New Technology

(Rev. 1, 10-01-03)

Technologies eligible for add-on payments are identified based on the applicable codes from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). Claims submitted with an ICD-9-CM code indicating that a new technology was involved in the treatment of the patient is then eligible for add-on payments as described above.

The system maintainers pass (if present) the "principal" and up to five "other procedure" codes to PRICER. If an eligible code is present, PRICER calculates an add-on payment if appropriate.

This adds six new fields (7 positions each) to the end of the claim data record sent to PRICER by the system maintainer.

Additionally, the National Uniform Billing Committee has approved value code 77 (FL 39-41 of the CMS-1450 or electronic equivalent) for FI use only, defined as "New Technology Add-On Payment." This value code must be passed to CWF and the PS&R. The amount shown in this value code must be paid to PIP providers on a claim-by-claim basis the same as outlier payments are paid to PIP providers.

160.1.2 - Remittance Advice Impact

(Rev. 1, 10-01-03)

In order to process this special add-on payment for new technologies, and report in the Remittance Advice (electronic and paper), contractors

- Use reason code 94 with group code OA in the CAS segment
- Use code ZL in the AMT segment.
- Report Code ZL in the Flat File for reporting with X12 code CS in the composite data element of the 835 PLB segment.

For PIP payment, the contractor includes only the add-on payment on a claim-by-claim basis.

Addendum A - Provider Specific File

(Rev. 152, 04-30-04)

A-03-058 (for CCR development)

	File Position	Format	Title	Description
1	1-8	X(8)	National Provider Identifier (NPI)	Alpha-numeric 8 character Identifier (NPI) Provider number.
2	9-10	X(2)	NPI Filler	Blank.
3	11-16	X(6)	Provider Oscar No.	Alpha-numeric 6 character provider number. Cross check to Item 10, provider type. Positions 3 and 4 of:

Provider #	Type (see field 10)
00-08	Blanks, 00, 07-11, 13-17, 21-22
12	18
13	23,37
20-22	02
30	04
33	05
40-44	03
50-64	32-34, 38
15-17	35
70-84, 90-99	36

Codes for special units S, T, U, V, W, U and Z are in the third position of the provider number and should be type 06 (hospital distinct parts).

	File Position	Format	Title	Description
4	17-24	9(8)	Effective Date	Must be numeric, CCYYMMDD. This is the effective date of the provider's first PPS period, or for subsequent PPS periods, the effective date of a change to the PROV file. If a termination date is present for this record, the effective date must be equal to or less than the termination date. Month 01-12, day 01-31, year greater than 82 but not greater than current year.
5	25-32	9(8)	Fiscal Year Beginning Date	Must be numeric, CCYYMMDD Day: 01-31, Month: 01-12 Year: Greater than 81, but not greater than current year. Must be updated annually to show the current year for providers receiving a blended payment based on their FY begin date. Must be equal to or less than the effective date (Field #4 above).
6	33-40	9(8)	Report Date	Must be numeric, CCYYMMDD. Date file created/run date of the PROV report for submittal to CMS CO.
7	41-48	9(8)	Termination Date	Must be numeric, CCYYMMDD. Termination Date in this context is the date on which the reporting FI ceased servicing the provider. Must be zeros or contain a termination date. Must be equal to or greater than the effective date. If the provider is terminated or transferred to another FI, a termination date is placed in the file to reflect the last date the provider was serviced by the outgoing FI. Likewise, if the provider identification number changes, the FI must place a termination date in the PROV file transmitted to CO for the old provider identification number.
8	49	X	Waiver Indicator	Provider waived from PPS? Must be Y

	File Position	Format	Title	Description
				(yes) or N (no). Y = means waived (Provider is not under PPS). N = means not waived (Provider is under PPS).
9	50-54	9(5)	Intermediary Number	Assigned intermediary number.
10	55-56	X(2)	Provider Type	This identifies providers that require special handling. The FI enters the appropriate code: Must be blank or 00, 02-08, 13-18, 21-23, or 32-38. 00 or blanks = Short Term Facility 02 Long Term 03 Psychiatric 04 Rehabilitation Facility 05 Pediatric 06 Hospital Distinct Parts 07 Rural Referral Center 08 Indian Health Service 13 Cancer Facility 14 Medicare Dependent Hospital (During cost reporting periods that began on or after 4-1-90.) 15 Medicare Dependent Hospital/Referral Center (during cost reporting periods that began on or after 4-1-90. Invalid 10/1/94 through 90-30-97. See §20.6B.) 16 Rebased Sole Community Hospital 17 Rebased Sole Community Hospital/Referral Center 18 Medical Assistance Facility 21 Essential Access Community Hospital (EACH) 22 Essential Access Community

	File Position	Format	Title	Description
				Hospital/Referral Center 23 Rural Primary Care Hospital 32 Nursing Home Case Mix Quality Demonstration Project - Phase II (SNF only) 33 Nursing Home Case Mix Quality Demonstration Project - Phase III Step 1 (SNF only) 34 Reserved 35 Hospice 36 Home Health Agency 37 Critical Access Hospital 38 Skilled Nursing Facility (SNF) - For Non demo PPS SNF's - eff. for cost reporting periods beginning on or after 7/1/98.
11	57	9	Current Census Division	Must be numeric (1-9). The Census division to which the facility belongs for payment purposes. When a facility is reclassified for the standardized amount, FIs must change the census division to reflect the new standardized amount location. Valid codes are: 1 New England 2 Middle Atlantic 3 South Atlantic 4 East North Central 5 East South Central 6 West North Central 7 West South Central 8 Mountain 9 Pacific
	NOTE: When a facility is reclassified for purposes of the standard amount, the FI changes the census division to reflect the new standardized amount location.			
12	58	X	Change Code Wage Index Reclassification	Enter "Y" if hospital's wage index location has been reclassified for the year. Enter "N" if it has not been reclassified for the

	File Position	Format	Title	Description
				year. Adjust annually.
13	59-62	X(4)	Actual Geographic Location - MSA	Enter the appropriate code for the MSA 0040-9965, or the rural area, (blank) (blank) 2 digit numeric State code such as _ _36 for Ohio, where the facility is physically located.
14	63-66	X(4)	Wage Index Location - MSA	Enter the appropriate code for the MSA, 0040-9965, or the rural area, (blank) (blank) (2 digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the actual location MSA (field 13), if not reclassified. Pricer will automatically default to the actual location MSA if this field is left blank.
15	67-70	X(4)	Standardized Amount MSA Location	Enter the appropriate code for the MSA, 0040-9965, or the rural area, (blank) (blank) (2 digit numeric State code) such as _ _ 3 6 for Ohio, to which a hospital has been reclassified for standardized amount. Leave blank or enter the actual location MSA (field 13) if not reclassified. Pricer will automatically default to the actual location MSA if this field is left blank
16	71-72	X(2)	Sole Community or Medicare Dependent Hospital – Base Year	Leave blank if not a sole community hospital (SCH) or a Medicare dependent hospital (MDH) effective with cost reporting periods that begin on or after April 1, 1990. If an SCH or an MDH, show the base year for the operating hospital specific rate, the higher of either 82 or 87. See §20.6. Must be completed for any SCH or MDH that operated in 82 or 87, even if the hospital will be paid at the Federal rate.

	File Position	Format	Title	Description
17	73	X	Change Code for for Lugar reclassification	Enter an "L" if the MSA has been reclassified for wage index purposes under §1886(d)(8)(B) of the Act. These are also known as Lugar reclassifications, and apply to ASC-approved services provided on an outpatient basis when a hospital qualifies for payment under an alternate wage index MSA. Leave blank for hospitals if there has not been a Lugar reclassification.
18	74	X	Temporary Relief Indicator	Enter a 'Y' if this provider qualifies for a payment update under the temporary relief provision, otherwise leave blank.
19	75	X	Federal PPS Blend Indicator	HHA: Enter the code for the appropriate percentage payment to be made on HH PPS RAPs. Must be present for all HHA providers, effective on or after 10/01/2000 0 = Pay standard percentages 1 = Pay zero percent All IRFs are 100% Federal for cost reporting periods beginning on or after 10/01/2002. LTCH: Enter the appropriate code for the blend ratio between federal and facility rates. Effective for all LTCH providers with cost reporting periods beginning on or after 10/01/2002.

	Federal %	Facility%
1	20	80
2	40	60
3	60	40
4	80	20
5	100	00

	File Position	Format	Title	Description
20	76-89	X(5)	Filler	Blank.
21	81-87	9(5)V9(2)	Case Mix Adjusted Cost Per Discharge/PPS Facility Specific Rate	For PPS hospitals and waiver state non-excluded hospitals, enter the base year cost per discharge divided by the case mix index. Enter zero for new providers. See §20.1 for sole community and Medicare-dependent hospitals on or after 04/01/90. For inpatient PPS hospitals, verify if figure is greater than $10,000. For LTCH, verify if figure is greater than $35,000.
22	88-91	9V9(3)	Cost of Living Adjustment (COLA)	Enter the COLA. All hospitals except Alaska and Hawaii use 1.000.\
23	92-96	9V9(4)	Intern/Beds Ratio	Enter the provider's intern/resident to bed ratio. Calculate this by dividing the provider's full time equivalent residents by the number of available beds (as calculated in positions 97-101). Do not include residents in anesthesiology who are employed to replace anesthetists or those assigned to PPS excluded units. Base the count upon the average number of full-time equivalent residents assigned to the hospital during the fiscal year. Correct cases where there is reason to believe that the count is substantially in error for a particular facility. The FI is responsible for reviewing hospital records and making necessary changes in the count at the end of the cost reporting period. Enter zero for nonteaching hospitals.
24	97-101	9(5)	Bed Size	Enter the number of adult hospital beds and pediatric beds available for lodging inpatient. Must be greater than zero. (See the Provider Reimbursement Manual, §2405.3G.)

	File Position	Format	Title	Description
25	102-105	9V9(3)	Operating Cost to Charge Ratio	Derived from the latest settled cost report and corresponding charge data from the billing file. Compute this amount by dividing the Medicare operating costs by the Medicare covered charges. Obtain Medicare operating costs from the Medicare cost repot form CMS-2552-96, Supplemental Worksheet D-1, Part II, Line 53. Obtain Medicare covered charges from the FI billing file, i.e., PS&R record. For hospitals for which the FI is unable to compute a reasonable cost-to-charge ratio, they use the appropriate urban or rural statewide average cost-to-charge ratio calculated annually by CMS and published in the "Federal Register." These average ratios are used to calculate cost outlier payments for those hospitals where you compute cost-to-charge ratios that are not within the limits published in the "Federal Register." For LTCH and IRF PPS, a combined operating and capital cost-to-charge ratio is entered here. See below for a discussion of the use of more recent data for determining CCRs.
26	106-110	9V9(4)	Case Mix Index	The case mix index is used to compute positions 81-87 (field 21). Zero fill for all others. In most cases, this is the case mix index that has been calculated and published by CMS for each hospital (based on 1981 cost and billing data) reflecting the relative cost of that hospital's mix of cases compared to the national average mix.
27	111-114	V9(4)	Supplemental Security Income Ratio	Enter the SSI ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.

	File Position	Format	Title	Description
28	115-118	V9(4)	Medicaid Ratio	Enter the Medicaid ratio used to determine if the hospital qualifies for a disproportionate share adjustment and to determine the size of the capital and operating DSH adjustments.
29	119	X	Provider PPS Period	This field is obsolete as of 4/1/91. Leave Blank for periods on or after 4/1/91
30	120-125	9V9(5)	Special Provider Update Factor	Zero fill for all hospitals after FY91. This Field is obsolete as of FY92.
31	126-129	V9(4)	Operating DSH	Disproportionate share adjustment Percentage. Pricer calculates the Operating DSH effective 10/1/91 and bypasses this field. Zero fill for all hospitals 10/1/91 and later.
32	130-137	9(8)	Fiscal Year End	This field is no longer used. If present, must be CCYYMMDD
33	138	X(1)	Special Payment Indicator	Code indicates the type of special payment provision that applies. Blank = not applicable Y = reclassified 1 = special wage index indicator 2 = both special wage index indicator and reclassified
34	139	X(1)	Hospital Quality Indicator	Code indicats hospital meets criteria to receive higher payment per MMA quality standards. 1 = hospital quality standards have been met
35	140-144	X(5)	Actual Geographic Location Core-Based	Enter the appropriate code for the CBSA 00001-89999, or the rural area, (blank (blank) (blank) 2 digit numeric State code such as _ _ _ 36 for Ohio, where the

	File Position	Format	Title	Description
			Statistical Area (CBSA)	facility is physically located.
36	145-149	X(5)	Wage Index Location CBSA	Enter the appropriate code for the CBSA, 00001-89999, or the rural area, (blank)(blank) (blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified due to its prevailing wage rates. Leave blank or enter the actual location CBSA (field 35), if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank.
37	150-154	X(5)	Standardized Amount Location CBSA	Enter the appropriate code for the CBSA, 00001-89999 or the rural area, (blank) (blank)(blank) (2 digit numeric State code) such as _ _ _ 3 6 for Ohio, to which a hospital has been reclassified. Leave blank or enter the actual location CBSA (field 35) if not reclassified. Pricer will automatically default to the actual location CBSA if this field is left blank
38	155-160	9(2)V9(4)	Special Wage Index	Enter the special wage index that certain providers may be assigned. Enter zeroes unless field 33 = "1" or "2"
39	161-166	9(4)V99	Pass Through Amount for Capital	Per diem amount based on the interim payments to the hospital. Ust be zero if location 185 = A, B, or C (See the Provider Reimbursement Manual, §2405.2). Used for PPS hospitals prior to their cost reporting period beginning in FY 92, new hospitals during their first 2 years of operation FY 92 or later, and non-PPS hospitals or units. Zero fill if this does not apply.
40	167-172	9(4)V99	Pass Through Amount for	Per diem amount based on the interim payments to the hospital (See the Provider,

	File Position	Format	Title	Description
			Direct Medical Education	Reimbursement Manual, §2405.2.). Zero fill if this does not apply.
41	173-178	9(4)V99	Pass Through Amount for Organ Acquisition	Per diem amount based on the interim payments to the hospital. Include standard acquisition amounts for kidney, heart, and liver transplants. Do not include acquisition costs for bone marrow transplants. (See the Provider Reimbursement Manual, §2405.2.) Zero fill if this does not apply.
42	179-184	9(4)V99	Total Pass Through Amount, Including Miscellaneous	Per diem amount based on the interim payments to the hospital (See the Provider Reimbursement Manual §2405.2.) Must be at least equal to the three pass through amounts listed above. The following are included in total pass through amount in addition to the above pass through amounts. Certified Registered Nurse Anesthetists (CRNAs) are paid as part of Miscellaneous Pass Through for rural hospitals that perform fewer than 500 surgeries per year, and Nursing and Allied Health Professional Education when conducted by a provider in an approved program. Do not include amounts paid for Indirect Medical Education, Hemophilia Clotting Factors, or DSH adjustments. Zero fill if this does not apply.
43	185	X	Capital PPS Payment Code	Type of capital payment methodology for hospitals: A = Hold Harmless – cost payment for old capital B = Hold Harmless – 100% Federal rate C = Fully prospective blended rate Must be present unless a "Y" is entered in

	File Position	Format	Title	Description
				location 49 (position 207), or 08 is entered in location 55-56 or a termination date is present in location 41-48.
44	186-191	9(4)V99	Hospital Specific Capital Rate	Enter the hospital's allowable adjusted base year inpatient capital costs per discharge. This field is not used as of 10/1/02.
45	192-197	9(4)V99	Old Capital Hold Harmless Rate	Enter the hospital's allowable inpatient "old" capital costs per discharge incurred for assets acquired before December 31, 1990, for capital PPS. Update annually.
46	198-202	9V9(4)	New Capital-Hold Harmless Ratio	Enter the ratio of the hospital's allowable inpatient costs for new capital to the hospital's total allowable inpatient capital costs. Update annually.
47	203-206	9V999	Capital Cost-to-Charge Ratio	Derived from the latest cost report and corresponding charge data from the billing file. For hospitals for which the FI is unable to compute a reasonable cost-to-charge ratio, it uses the appropriate statewide average cost-to-charge ratio calculated annually by CMS and published in the "Federal Register." A provider may submit evidence to justify a capital cost-to-charge ratio that lies outside a 3 standard deviation band. The FI uses the hospital's ratio rather than the statewide average if it agrees the hospital's rate is justified. See below for a detailed description of the methodology to be used to determine the CCR for Acute Care Hospital Inpatient and LTCH Prospective Payment Systems.
48	207	X	New Hospital	Enter "Y" for the first 2 years that a new hospital is in operation. Leave blank if hospital is not within first 2 years of operation.
49	208-212	9V9(4)	Capital Indirect	Enter the ratio of residents/interns to the

	File Position	Format	Title	Description
			Medical Education Ratio	hospital's average daily census. Calculate by dividing the hospital's full-time equivalent total of residents during the fiscal year by the hospital's total inpatient days. See §20.4.1 above.) Zero fill for a non-teaching hospital.
50	213-218	9(4)V99	Capital Exception Payment Rate	The per discharge exception payment to which a hospital is entitled. (See §20.4.7 above.)
51	219-240	X(22)	Filler	Blank.

Methodology for Determining Payment for Outliers Under the Acute Care Hospital Inpatient and LTCH Prospective Payment Systems

Use of More Recent Data for Determining CCRs

A. Changing CCRs For Hospitals Subject to the IPPS

Under 42 CFR 412.84(i)(1), if more recent charge data indicate that a hospital's charges have been increasing at an excessive rate (relative to the rate of increase among other hospitals), as explained below, CMS may direct the FI to change the hospital's operating and capital CCRs to reflect the high charge increases evidenced by the later data. A hospital may also request that its FI use a different (higher or lower) CCR based on substantial evidence presented by the hospital. Before a change based on a hospital's request can become effective, the CMS Regional Office must approve the change.

FIs are to perform data analysis to identify those hospitals that appear to have disproportionately benefited from the time lag in updating the CCRs using the latest settled cost reports. These are hospitals:

1. With FY 2003 operating outlier payments of at least 10 percent of total operating diagnosis-related group (DRG) payments plus operating outlier payments;

2. Whose operating outlier payments relative to total operating DRG payments increased by at least 20 percent from either FY 2001 to FY 2002, or FY 2002 to FY 2003; and

3. Whose average charges per case increased by at least 15 percent both from FY 2000 to FY 2001, and from FY 2001 to FY 2002.

FIs are also to perform data analysis to identify hospitals that received operating outlier payments in excess of 100 percent of total operating DRG payments for FY 2003 (outlier payments divided by DRG payments).

Effective for discharges occurring on or after August 8, 2003, for hospitals that are identified through the above data analysis, FIs are to use an alternative CCR rather than one based on the latest settled cost report (such as a CCR based on data from the latest tentative settled cost report or more recent data) to identify and pay for outliers under the IPPS. By July 25, 2003, for each of the hospitals identified, FIs should calculate a capital and operating CCR using the alternative data and submit this ratio to CMS (to the attention of Michael Treitel, e-mail at mtreitel@cms.hhs.gov). CMS will notify FIs whether to use these ratios or an alternative ratio. For all IPPS claims processed on or after August 8, 2003, until more accurate data becomes available, FIs are to use this approved alternative ratio.

B. Use of Alternative Data in Determining CCRs For Hospitals Subject to the IPPS and For Hospitals Subject to the LTCH PPS

Under 42 CFR 412.84(i)(1) of the IPPS and 42 CFR 412.525(a)(4)(ii), 42 CFR 412.529(c)(5)(ii) of the LTCH PPS, CMS may direct FIs to use an alternative CCR to the CCRs from the later of the latest settled cost report or latest tentative settled cost report), if CMS believes this will result in a more accurate CCR. In addition, if the FI finds evidence that indicates that using data from the latest settled or tentatively settled cost report would not result in the most accurate CCR, then the FI should contact CMS to seek approval to use a CCR based on alternative data.

Also, a hospital may request that a different CCR be applied in the event it believes the CCR being applied is inaccurate. The hospital is required to present substantial evidence supporting its request. Such evidence should include documentation regarding its costs and charges that demonstrate its claim that an alternative ratio is more accurate. The CMS Regional Office must approve any such request after evaluation by the fiscal intermediary of the evidence presented by the hospital.

C. Ongoing CCR Updates Using CCRs From Tentative Settlements For Hospitals Subject to the IPPS and For Hospitals Subject to the LTCH PPS

For discharges beginning on or after October 1, 2003, FIs use CCRs from the latest settled cost report or from the latest tentative settled cost report (whichever is from the later period) to determine a hospital's operating and capital CCRs. By October 1, 2003, for all hospitals that are paid under the IPPS or LTCH PPS, FIs must have updated CCRs on the Provider Specific File (PSF) to reflect CCRs from the most recent tentative settlements or final settled cost reports, (whichever is the later period). These updated CCRs are used to process claims with discharge dates on or after October 1, 2003. The CCR on the PSF must be updated when that cost report is settled or when a cost report for a subsequent cost reporting period is tentatively settled, whichever is the latest cost reporting period.

In order to arrive at CCRs to be used in the PSF based on tentative settlement data, the FI should review previous adjustments used (if any) in the tentative settlement and take into consideration the impact of prior audit adjustments on prior period CCRs to determine if they had an impact on the CCRs. If these tentative settlement adjustments have no impact on the CCRs, or if no adjustments were made, the tentative settled CCRs will equal the CCRs from the hospital's as-filed cost report. If the adjustments made at tentative settlement would have an impact on the CCRs, the FI should compute new CCRs based on the tentative settlement. (Note: If the tentative settlement adjustments result in a difference in the CCR from the as filed cost report of 20 percent or less, then no adjustment to the CCR at tentative settlement is necessary.)

Following the initial update of CCRs for all hospitals for discharges on or after October 1, 2003, FIs should continue to update a hospital's operating and capital CCRs each time a more recent cost report is tentatively settled. Revised CCRs must be entered into the PSF not later than 45 days after the date of the tentative settlement or final settlement used in calculating the CCRs. Subject to the approval of CMS, CCRs may be revised more often if a change in a hospital's operations occurs which materially affects a hospital's costs or charges. Revised CCRs will be applied prospectively to all IPPS and LTCH PPS claims processed after the update.

II. Statewide Average for Hospitals Subject to the IPPS and for Hospitals Subject to the LTCH PPS

Prior to August 8, 2003, hospitals were assigned a statewide average CCR if their actual operating or capital CCR fell outside 3 standard deviations from the respective national geometric mean CCR.

Effective August 8, 2003, a hospital is longer be assigned the statewide average CCR when the hospital has a CCR that falls below 3 standard deviations from the national mean. Hospitals receive their actual CCRs, no matter how low their ratios fall.

The statewide average CCRs may still apply in those instances in which a hospital's operating or capital CCRs exceed the upper threshold. In addition, hospitals that have not yet filed their first Medicare cost report may still receive the statewide average CCRs. CMS will continue to set forth the upper threshold (i.e., 3 standard deviations above the national geometric mean CCR) and the statewide CCRs applicable to IPPS hospitals and LTCHs in each year's annual notice of prospective payment rates published in the "Federal Register."

III. Reconciling Outlier Payments For Hospitals Subject to the IPPS and For Hospitals Subject to the LTCH PPS

For the hospitals under the IPPS for which the FI applied alternative CCRs for discharges occurring on or after August 8, 2003 (that were identified through the above 3-step data analysis), and, for discharges occurring in cost reporting periods beginning on or after

October 1, 2003 for all other IPPS hospitals, FIs reconcile outlier payments at the time of cost report final settlement if:

1. Actual operating or capital CCRs are found to be plus or minus 10 percentage points from the CCRs used during that time period to make outlier payments, and

2. Total outlier payments in that cost reporting period exceed $500,000.

Consistent with the June 9, 2003 Federal Register (68 FR 34504) in which CMS indicated that it intended to issue program instructions that would provide specific criteria for identifying those hospitals subject to reconciliation for the remainder of FY 2003 and for FY 2004, these criteria allow FIs to focus their limited resources on only those hospitals that appear to have disproportionately benefited from the time lag in updating their CCRs. Similarly, for hospitals subject to the LTCH PPS, for discharges occurring in cost reporting periods beginning on or after October 1, 2003, reconciliations should be made if:

1. Actual operating CCRs are found to be plus or minus 10 percentage points from the CCRs used during that cost reporting period to make outlier payments, and

2. High cost outlier payments made under 412.525 and short stay outlier payments made under 42 CFR 412.529 combined exceed $500,000 in that cost reporting period.

The return codes from the PRICER software may be used to identify the cases for which high cost outlier and/or short stay outlier payments were made in a cost reporting period.

If the above criteria for IPPS hospitals and LTCHs do not identify additional hospitals that are being similarly overpaid (or underpaid) significantly for outliers, then, based on an analysis of the hospital's most recent cost and charge data that indicates that CCRs for those hospitals are significantly inaccurate, FIs have the administrative discretion to reconcile cost reports of those additional IPPS hospitals and LTCHs. However, FIs must seek approval from their CMS Regional Office in the event they intend to reconcile outlier payments for an IPPS hospital or a LTCH that does not meet the above-specified criteria.

IV. Notification to Hospitals under the IPPS and the LTCH PPS

FIs are to notify a hospital whenever they make a change to its CCR. When a CCR is changed as a result of a tentative settlement or a final settlement, the change to the CCR should be included in the notice that is issued to each provider after a tentative or final settlement is completed.