Medicare
Intermediary Manual
Part 3 - Claims Process

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

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CHANGE REQUEST 1626

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3610.19 – 3611.2 (Cont.)	6-117 - 6-120.2 (6 pp.)	6-117 - 6-120.1 (5 pp.)

NEW REVISED MATERIAL--EFFECTIVE DATE: October 1, 2001
IMPLEMENTATION: October 1, 2001

Section 3610.21, Requirements for CAH Services and CAH Long-Term Care Service, gives a definition for a discharged patient for the purpose of ascertaining the 96 hour average rule for inpatients of a CAH.

3610.22, Payment for Services Furnished by a CAH, explains the procedure for paying a CAH for outpatient services rendered under the all-inclusive method of reimbursement. Under this election the payment will be the **sum** of the facility charges and professional charges. The professional charges will be 115 percent of physician fee schedule.

Payments for clinical diagnostic laboratory tests should be reimbursed on a reasonable cost basis with no patient liability.

3610.23, Payment for Post-Hospital SNF Care Furnished by a CAH, SNF level services provided by a CAH are exempt from SNF PPS.

These instructions should be implemented within your current operating budget.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previous published in the manual and is only being reprinted.

b. For remittances reporting PIP payments, the Hemophilia Add On will be reported in the provider level adjustment PLB segment with the provider level adjustment reason "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.

c. 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**.--

a. For paper remittances reporting non-PIP payments involving Hemophilia Add On, add a "Hemophilia Add On" category to the end of the "Pass Thru Amounts" listings in the "Summary" section of the paper remittance. Enter the total of the Hemophilia Add On amounts due for the claims covered by this remittance next to the Hemophilia Add On heading.

b. Add the Remark Code 'MA103' (Hemophilia Add On) to the remittance advice under the REM column for those claims that qualify for Hemophilia Add On payments.

This will be the full extent of Hemophilia Add On reporting on paper remittance notices; providers wishing more detailed information must subscribe to the Medicare Part A specifications for the ANSI ASC X12 835, where additional information is available.

3610.19 Medicare Rural Hospital Flexibility Program.-

The Medicare Law allows establishment of a Medicare Rural Hospital Flexibility Program by any State that has submitted the necessary assurances and complies with the statutory requirements for designation of hospitals as Critical Access Hospitals (CAHs).

To be eligible as a CAH, a facility must be a currently participating Medicare hospital, a hospital that ceased operations on or after November 29, 1989, or a health clinic or health center that previously operated as a hospital before being downsized to a health clinic or health center. The facility must be located in a rural area of a State that has established a Medicare rural hospital flexibility program, and must be located more than a 35-mile drive from any other hospital or critical access hospital, or be certified by the State to be a "necessary provider". In mountainous terrain or in areas with only secondary roads available, the mileage criterion is 15 miles. In addition, the facility must make available 24 hour emergency care services, provide not more than 15 beds for acute (hospital-level) inpatient care, and maintain a length of stay, as determined on an annual average basis, of no longer than 96 hours.

An exception to the 15-bed requirement is made for swing-bed facilities, which are allowed to have up to 25 inpatient beds that can be used interchangeably for acute or SNF-level care, provided that not more than 15 beds are used at any one time for acute care. The facility is also required to meet the conditions of participation for CAHs (42 CFR Part 485, Subpart F). Designation by the State is not sufficient for CAH status. To participate and be paid as a CAH, a facility must be certified as a CAH by HCFA.

3610.20 Grandfathering Existing facilities.--As of October 1, 1997, no new EACH designations can be made. The EACHs designated by HCFA before October 1, 1997, will continue to be paid as sole community hospitals for as long as they comply with the terms, conditions, and limitations under which they were designated as EACHs.

3610.21 Requirements for CAH Services and CAH Long-term Care Services.--

A. Effective November 29, 1999, CAHs are no longer required to maintain documentation showing that individual stays longer than 96 hours were needed because of inclement weather or other emergency conditions, or submit a case-specific waiver of the 96-hour limit from a peer review organization (PRO) or equivalent entity. Thus, intermediaries are not required to obtain documentation showing that a PRO or equivalent entity has, on request, approved stays beyond 96 hours in specific cases. A CAH may provide acute inpatient care for a period that does not exceed, as determined on an annual average basis, 96 hours per patient. A patient is considered discharged when the admission's office records the discharge and (1) the patient has been discharged by the appropriate practitioner on the medical chart and (2) the patient is no longer receiving services. The patient would have to be out of the room and the room available for occupancy.

Calculate the CAH's length of stay based on patient census data. If a CAH exceeds the length of stay limit, send the report to the HCFA Regional Office and a copy to the State agency. The CAH will be required to develop and implement a corrective action plan acceptable to the HCFA Regional Office, or face termination of its Medicare provider agreement.

Items and services that a CAH provides to its inpatients are covered if they are items and services of a type that would be covered if furnished by a hospital to hospital inpatients.

B. A CAH may use its inpatient facilities to provide post-hospital SNF care and be paid for SNF-level services if it meets the following requirements.

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

2. The facility provides not more than 25 inpatient beds, and the number of beds used at any time for acute care inpatient services does not exceed 15 beds (any bed of a unit of the facility that is licensed as a distinct-part SNF is not counted under paragraph (1) of this section); and,

3. The facility has been granted swing-bed approval by HCFA.

C. A CAH that participated in Medicare as a rural primary care hospital (RPCH) on September 30, 1997, and on that date had in effect an approval from HCFA to use its inpatient facilities to provide post-hospital SNF care, may continue in that status under the same terms, conditions, and limitations that were applicable at the time those approvals were granted.

3610.22 Payment for Services Furnished by a CAH.--

A. Payment for Inpatient Services Furnished by a CAH.--Effective for cost reporting periods beginning after October 1, 1997, payment for inpatient services of a CAH is the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except the following principles do not apply: the lesser of costs or charges (LCC) rule, ceilings on hospital operating costs, and the reasonable compensation equivalent (RCE) limits for physician services to providers. Payment for inpatient CAH services is billed as a 11x type of bill and is subject to Part A deductible and coinsurance requirements.

B. Payment for Outpatient Services Furnished by a CAH.--For cost reporting periods beginning before October 1, 2000, a CAH will be paid for outpatient services under the method in item 1 below. For cost reporting periods beginning on or after October 1, 2001, the CAH will be paid under the method in item 1 below unless it elects to be paid under the method in item 2. If a CAH elects payment under item 2 (cost-based facility payment plus fee schedule for professional services) for a cost reporting period, that election is effective for all of the cost reporting period to which it applies. If the CAH wishes to be paid under the all inclusive method, that election should be made in writing by the CAH, which notifies you 60 days in advance of the beginning of the affected cost reporting period. If the CAH makes no election, it will be paid for outpatient services under the standard method in item 1.

All outpatient CAH services, other than pneumococcal pneumonia vaccines, influenza vaccines, administration of the vaccines, screening mammograms, and clinical diagnostic laboratory tests are subject to Part B deductible and coinsurance. Regardless of the payment method applicable for a period, payment for outpatient CAH services is not subject to the following payment principles: lesser of cost or charges, reasonable compensation equivalent (RCE) limits, any type of reduction to operating or capital costs under 42 CFR 413.124 or 413.30(j)(7), or blended payment rates for ASC, radiology, and other diagnostic services.

1. Standard method: Cost-based Facility Services, with Billing of Carrier for Professional Services.--Payment for outpatient CAH services under this method will be made for 80 percent of the reasonable cost of the CAH in furnishing those services, after application of the Part B deductible. Payment for professional medical services furnished in a CAH to CAH outpatients is made by the carrier on a fee schedule, charge, or other fee basis, as would apply if the services had been furnished in a hospital outpatient department. For purposes of CAH payment, professional medical services are defined as services provided by a physician or other practitioner, e.g., a physician assistant or nurse practitioner, that could be billed directly to a carrier under Part B of Medicare.

In general, payment for professional medical services, under the cost-based CAH payment plus professional services method should be made on the same basis as would apply if the services had been furnished in the outpatient department of a hospital.

Bill type 85X should be used for all outpatient services including ASC services. Referenced diagnostic services (nonpatients) will continue to be billed on a 14x type of bill.

2. All Inclusive Method: Cost-Based Facility Services Plus Fee Schedule for Professional Services.--Section 403(d) of the BBRA amended §834(g) to permit the CAH to elect this method of reimbursement for services and items furnished on or after July 1, 2001. A CAH may elect to be paid for outpatient services in any cost reporting period under this method. An election of this payment method, once made for a cost reporting period, remains in effect for all of that period and applies to all services furnished to outpatients during that period.

Payment to the CAH for each outpatient visit will be the sum of the following amounts:

(a) For facility services, not including physician or other practitioner, payment will be the reasonable costs of the services. On the HCFA-1450, (or electronic equivalent) the facility service(s) rendered to outpatients will be listed along with the appropriate revenue code. Pay the amount equal to the sum of 80 percent of its reasonable costs of its outpatient services after application of the Part B deductible; plus

(b) On a separate line, the professional services will be listed, along with appropriate HCPC code (physician or other practitioner). Pay 115 percent of whatever Medicare would pay of the physician fee schedule. (Multiply the fee schedule amount, after applicable deductions, by 1.15 percent.)

Outpatient services, including ASC services, rendered in an all inclusive method rate provider will be billed using the 85X type of bill. Revenue code 510 should be on the bill with visits indicated in the units field and the dollar amount in the charges field. If there is no amount for the revenue code 510, place an "0" in the charge field. Referenced diagnostic services (nonpatients) will continue to be billed on a 14X type of bill.

C. Payment for outpatient services of a CAH is subject to applicable Part B deductible and coinsurance amounts, as described in §3626.3, except as described in paragraphs D. and E.

D. Part B of Medicare pays 100 percent for pneumococcal pneumonia vaccines (PPV) and influenza virus vaccines and their administration. Payment is on a reasonable cost basis. Deductible and coinsurance do not apply. Part B of Medicare also covers the reasonable cost of hepatitis B vaccine and its administration. Deductible and coinsurance apply. Payment for screening mammography is not subject to applicable Part B deductible, but coinsurance does apply. Follow the instructions as described in §3660.10.

E. Regardless of the payment method that applies under paragraph B, make payments for clinical diagnostic laboratory tests furnished to CAH outpatients on or after November 29, 1999, on a reasonable cost basis with no beneficiary cost-sharing – no coinsurance, deductible, co-payment, or any other cost-sharing.

3610.23 Payment for Post-Hospital SNF Care Furnished by a CAH.—Under §203 of the Benefits Improvement and Protection Act (BIPA) of 2000, swing beds in CAHs are exempt from §1888(e)(7) of the Act (as enacted by §4432(a) of the Balanced Budget Act of 1997), which applies the SNF Prospective Payment System (PPS) to SNF services furnished by swing-bed hospitals generally. In addition, this provision establishes a new reimbursement system for CAHs that provides full reasonable cost payment for CAH swing-bed services. This provision is effective with cost reporting periods beginning on or after the date of the enactment of the BIPA 2000, December 21, 2000.

Currently, to calculate the swing bed cost carve out from routine services, Medicare substitutes the pre-determined regional rate as a proxy for total swing bed routine costs and then applies that same pre-determined rate to total swing bed days. Under the BIPA 200 provision, adjust the CAH swing bed rate effective with the first day of the provider's fiscal year beginning on/after December 21, 2000. Instead of using the pre-determined rate for SNF-like swing bed days, calculate an interim payment reflecting an estimate of each facility's routine cost in the current year. This interim payment rate will be calculated from the latest available cost reporting data. To reimburse a CAH for its swing bed services based services based on cost, it will be necessary to refer to the CAH's most recent cost report to track the number of SNF-like swing bed days, total patient days, and total routine costs. Presently, the cost report calculates total routine costs through worksheet D-1 of the Form HCFA-2552-96.

SNF-like swing bed routine costs should be calculated using existing procedures; i.e., multiplying the average statewide rate per patient day paid under the state Medicaid plan by the number of SNF-like swing bed days. The SNF-like swing bed costs should then be deducted from the hospital's total routine costs. Then, to calculate the SNF-like swing bed cost per day, the adjusted routine costs are divided by the sum of the total number of inpatient routine care days and total SNF-like swing bed days. This cost per day is then applied against the SNF-like swing bed days to arrive at the carve out for SNF swing bed costs. That same per diem is then applied against the Medicare swing bed days resulting in Medicare share of routine swing bed costs.

The cost report instructions will be modified on Worksheet D-1 to accommodate this change in payment procedures for CAHs.

The ancillary costs are apportioned to Medicare based on billed charges. The cost report currently calculates Medicare's share of ancillary costs through worksheet D-4 of the same cost reporting Form HCFA-2552-96. No change would be required to the cost report for calculating swing bed ancillary costs.

Settlement for CAHs for swing bed services will continue to be calculated on Worksheet E-2.

All CAH SNF bills should have a "z" in the third position of the provider number.

3610.24 Review of Form HCFA-1450 for the Inpatient.-- All items on HCFA-1450 are completed in accordance with §3604.

3611. HOSPITAL CAPITAL PAYMENTS UNDER PPS

The Omnibus Budget Reconciliation Act of 1987 established an effective date of October 1, 1991, for capital PPS. Capital PPS will pay hospitals a fixed amount for each Medicare admission upon completion of a 10-year transition period.

Hospitals and hospital distinct part units that are excluded from PPS for operating costs are also excluded from PPS for capital costs. They continue to be paid for capital-related costs on a reasonable cost basis.

Capital payments are based on the same DRG designations and weights, outlier guidelines, geographic classifications, wage indexes, and disproportionate share percentages that apply to PPS for operating costs. The indirect teaching adjustment is based on the ratio of residents to average daily census. The hospital split bill, adjustment bill, waiver of liability and remaining guidelines in §§3610.1 - 3610.14, also apply to capital PPS payments. Outlier thresholds and computation methods have been combined effective with FY 1993 for operating and capital costs.

Capital transfer cases are paid on a per diem basis analogous to the manner in which operating PPS payments are made for transfer cases.

Beneficiary deductible and coinsurance obligations do not apply to capital costs. Ancillary costs paid under Part B do not impact capital PPS payments. The 10-year transition period was established to protect hospitals that had incurred capital obligations in excess of the standardized national rate from major disruption. These high capital cost hospitals are known as "hold harmless" hospitals. The transition period also provides for phase-in of the national rate for those hospitals with capital obligations that are less than the national rate.

A combined payment is made for both operating costs and capital costs under PPS, but the value of the payment for each must be separately identified in the remittance advice for accounting purposes.

3611.1 Federal Rate.--The standard Federal capital payment for FY 1992 and later years is based on the projected national average Medicare capital costs per discharge for each of the fiscal years. The Federal rate is adjusted for each hospital's case mix, day and cost outliers and wage index location. A hospital qualifies for a capital DSH adjustment if it is located in a large urban or other urban area, has at least 100 beds, and has a disproportionate share (DSH) percentage greater than 0.

The Federal rate is adjusted annually to reflect changes in these factors.

An adjustment is also provided to the Federal rate for indirect costs of medical education of interns and residents. Calculate the adjustment by dividing the hospital's full-time equivalent total of interns and residents by the hospital's total patient days (line 8, column 6 of worksheet S3 of the HCFA Form 2552-89, minus the total of the lines 1B, 1C, 1D, and 7, divided by the number of days in the

cost reporting period.) Review the hospital's records and make any needed changes in the count at the end of the cost reporting period. Enter the indirect medical education adjustment ratio in positions 184-188 of the provider-specific file for use by PRICER.

3611.2 Hold Harmless Payments.--In FY 1992, hospitals with a hospital-specific rate for capital that is above the Federal PPS rate for the cost reporting period that ended in FY 1990 can receive the higher of:

- The hold harmless-old capital rate, which is 100 percent of the reasonable costs of old capital for sole community hospitals, or 85 percent of the reasonable costs associated with old capital for all other hospitals, plus a payment for new capital (see §3611.5 for the definitions of old and new capital); or

- The hold harmless - 100 percent Federal rate.

Adjust the hospital-specific rate in the cost report for the period ending in FY 1990 for case mix. Update the rate to FY 1992 levels using the projected increase in national average capital costs per discharge to initially determine whether a hospital should be paid under the hold harmless or the fully prospective methodology. The type of methodology is entered in the provider-specific file. (See §3656.3.)

Hospitals paid under the fully prospective methodology may change to the hold harmless methodology if justified by the addition of obligated capital and other changes in remaining old capital costs subsequent to the base period. This option is available through the later of a hospital's cost reporting period beginning in FY 94 or after obligated capital has been put in use. Hospitals must request an extension from you by the later of January 1, 1993, or within 180 days of the event causing the delay, if they will be unable to put an asset in use for inpatient care by October 1, 1996. The new hospital-specific rate reflects the disposal of old assets and the addition of obligated capital costs, but not new capital acquisitions. If the recalculated hospital-specific rate exceeds the Federal rate, the hospital will be paid under the hold harmless methodology. The payment methodology in effect for FY 94 (or after the obligated capital has been put in use, if later) determines the payment methodology applicable for the remainder of the transition period under either transition payment methodology.

Do not hold harmless a hospital for increased costs resulting from a lease arrangement entered into after December 31, 1990

If a hospital has such low Medicare utilization in its original capital base period that it is not required to file a cost report, its hospital-specific rate will be based on its old capital costs per discharge in the first 12-month cost reporting period for which a cost report is filed.

Convert a reasonable cost/hold harmless hospital to the 100 percent Federal payment rate when:

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

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