# Program Memorandum Intermediaries/Carriers

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

**Transmittal AB-01-140** **Date: SEPTEMBER 27, 2001**

**CHANGE REQUEST 1849**

**SUBJECT: Claims Processing Instructions for the Medicare Participating Centers of Excellence Demonstration and the Medicare Provider Partnership Demonstration**

This Program Memorandum (PM) contains clarifications and modifications to CR 1525, Transmittal AB-01-97, dated July 17, 2001. Unless explicitly stated in this PM, all provisions and requirements of CR 1525 remain unchanged. All section headings and references refer to CR 1525.

**PAYMENT PROCESSING REQUIREMENTS**

Under "Payment Processing Requirements, Overview", note the following underlined additions to the first paragraph:

A major focus during the initial phase of both of these demonstrations will be to develop and implement the administrative infrastructure to allow for efficient operations and the building of an automated global claims processing capability. There are several systems modifications proposed which are critical to automating the claims payment process under these demonstrations. A proposed flow chart is provided in Attachment II for reference. Note that the payment processing to be used under these demonstrations is *not* the same as that used in the "Medicare Participating Heart Bypass Center Demonstration", an earlier Medicare global payment demonstration.

Under "Payment Processing Requirements", Section I (A), Notice of Admission (NOA) - Hospital, note the following underlined modifications:

**A. Hospital -** Demonstration hospitals will be required to electronically notify the intermediary using Direct Data Entry (DDE) whenever a beneficiary to be covered under the demonstration(s) is admitted (or as soon thereafter as possible) or if the patient's demonstration status (i.e. covered or not covered under the demonstration) changes. The proposed standardized "Notice of Admission" (NOA) will take advantage of the same process used to elect hospice benefits, receive services by a religious non-medical health care facility, and "enroll" in the new coordinated care demonstration. Demonstration hospitals *must* report the demonstration number on all NOAs as well as all bills submitted. (There will be a separate demonstration number for Centers of Excellence and the Provider Partnership Demonstration.)

Under "Payment Processing Requirements", Section I (C), Notice of Admission (NOA) - Common Working File (CWF), note the following underlined modifications to the last paragraph after Item 4:

In all cases CWF will notify the FI of the action taken, and, in turn, the FI will notify the hospital that the change has been made. This requirement shall include the provision of remittance advices to hospitals showing all actions taken on NOA transmittals, similar to what is provided for traditional claims. Hospitals should not Have to look up each beneficiary individually, by HIC# , to determine whether the NOA related transaction was processed as requested.

Section III. titled "Part B Claims Processing" should be re-titled to be "Carrier Claims Processing"

Under "Payment Processing Requirements", Section III (C ), Part B Claims Processing *(to be re-titled "Carrier Claims Processing")* - Common Working File (CWF), note the following underlined modifications under items 5, 7 & 9:

**C. Common Working File**

5. If, however, there is no site of service provider ID on the claim but there is a discharge date on the NOA and the date of service is NOT the same as either the admission or the discharge date reflected on the NOA, then CWF will reject the claim back to the carrier with an error code and trailer which will indicate that this is a demonstration claim to be processed as a "no pay claim". The error code does not have to be unique to each demonstration although the trailer shall specify which demonstration is applicable.

7. If the site of service provider ID is filled in, CWF will check to determine whether the site of service on the claim matches the hospital on the NOA. If there is a match, CWF will "reject the claim back to the carrier" with an error code and trailer which will indicate that this is a demonstration claim (to be processed as a "no pay claim". The error code does not have to be unique to each demonstration although the trailer shall specify which demonstration is applicable.

9. If the date criteria are met and the site of services do not match but there is a discharge date on the NOA, then the CWF will check to determine if the date of service is on either the admission or discharge date--(i.e., not on one of the in-between inpatient dates). If the answer is "no", CWF will "reject the claim back to the carrier" with an error code and trailer which will indicate that this is a demonstration claim and to be processed as a "no pay claim". The error code does not have to be unique to each demonstration although the trailer shall specify which demonstration is applicable.

   When CWF returns a claim to the carrier which it has determined should be processed as a "no pay" claim under the rules of one of these demonstrations, CWF shall also provide a "trailer record" to the carrier indicating the hospital where the services were provided, the date of admission, and, if available, the date of discharge. This information shall come from the NOA auxiliary record which is stored by CWF, and shall be used by the carrier, in conjunction with data from the Part B claims, to prepare reports for the participating demonstration.

**SPECIAL CIRCUMSTANCES**

Under "Special Circumstances", Section III, Cost Reporting and Reconciliation for Hospital Payments, should be replaced by the following paragraph:

**III. Cost Reporting and Reconciliation for Hospital Payments**

It is intended that the cost reports and settlement for disproportionate share and indirect medical education be processed based on what the fiscal intermediary would have paid for Part A services in the absence of the demonstration. In processing claims, the FI must indicate on the processed claim record what portion of the global payment is attributable to Part A demonstration payment and the Part B demonstration payment. These amounts will be on the look up table provided to the FI by the project officer. Splitting out the payment will insure that the money comes out of the appropriate trust fund. However, the claim record must also show what would have been paid for Part A services in the absence of the demonstration, including all outlier payments. Separation of demonstration claims will not be required on the "Provider Statistics and Reimbursement (PSR)" reports although, if needed, the demonstration number will be on every claim for subsequent "back end" reporting purposes.

Under "Special Circumstances", Section IV, Direct Medical Education, Indirect Medical Education (IME) & Disproportionate Share (DSH), note the following underlined clarifications:

**IV. Direct Medical Education, Indirect Medical Education (IME) & Disproportionate Share (DSH)**

Direct medical education is paid as a pass through to the hospital and is not paid on an interim basis with each discharge. It should continue to be processed in this manner and should be unaffected by either demonstration.

It is also the intent that operational IME and operational DSH, which are paid on an interim basis with each claim, should continue to be paid as they would be in the absence of the demonstration. Interim operational IME & DSH payments which are calculated in the pricer module should continue to be added to the global DRG payment at the time the claim is processed. During the settlement and reconciliation process, all hospital days, including those for demonstration patients, should be included.

As noted below, payments for capital IME and capital DSH which are included in the traditional prospective capital payment should not be paid separately under the demonstrations. They will be included in the global payment. However, payments for capital IME and capital DSH will be included as part of the traditional cost report settlement process.

Under "Special Circumstances", Section V(B), Prospective Capital, note the following underlined clarifications:

**V. Capital Payments**

**B. Prospective Capital**

Prospective capital payments will be included in the global payment and should not be added to the claim at the time it is processed. However, that portion of prospective capital that is attributable to IME and DSH will be subject to final settlement based on the cost reports.

**SYSTEM SPECIFICATIONS**

Under "System Specifications", Section II, Hospital Requirements, omit H 1 and H 2 from CR 1525 and substitute the following, revised H 1 and H 2:

**H 1** To avoid inappropriate payments, a Notice of Admission (NOA) transaction will be used to admit and cancel admissions of beneficiaries in the demonstration. The NOA must be submitted for new admissions and to cancel an admission when it was originally entered in error or changed circumstances make the beneficiary ineligible for the demonstration. However, it will not be necessary to submit a separate NOA when a patient is discharged and the admission period ends. The discharge date from the final discharge bill will be put on the NOA by CWF thereby "revoking" it when the patient is discharged. If an error is made on an NOA, the hospital will be required to cancel the original NOA and submit a new NOA. Hospitals must submit the NOA using direct data entry (DDE) and receive verification that the election was received and accepted by CWF prior to billing for demonstration related services.

**H 2** Completion of the Notice of Admission by the Hospital - The following information is required to be submitted on the NOA:

FL 1. Provider Name, Address, and Telephone Number (Required). The minimum entry is the provider's name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine digit ZIP codes

are acceptable. Use the information to reconcile provider number discrepancies. Provider FAX numbers are also desirable.

FL 4. Type of Bill (Required). Enter the three-digit numeric type of bill code: 11A, or 11D as appropriate. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular enrollment. It is referred to as a "frequency" code.

3rd Digit - Frequency.

A - admission / election notice
D - cancellation

*Use of the type of bill code and frequency digits specified above was approved by the NUBC for use in these demonstrations on February 12, 2001.*

FL 12. Patient's Name (Required). Show the patient's name with the surname first, first name, and middle initial, if any.

FL 13. Patient's Address (Required). Show the patient's full mailing address including street name and number, post office box number or RFD, city, State, and ZIP code.

FL 14. Patient's Birth Date (Required). (If available.) Show date of birth numerically as CCYYMMDD. If the date of birth cannot be obtained after a reasonable effort, zero fill the field.

FL 15. Patient's Sex (Required). Show an "M" for male or an "F" for female.

FL 17. Admission Date (Required). Enter the admission date. Show the date numerically as CCYYMMDD.

FL 51. National Provider Identifier (Required). This is the six-digit number assigned by Medicare plus any additional characters assigned by the FI.

FL 58. Insured's Name (Required). Enter the beneficiary's name on line A if Medicare is the primary payer. *(If Medicare is not the primary payer, the beneficiary is ineligible for these demonstrations.)* Show the name as on the beneficiary's HI card.

FL 60. Certificate/Social Security Number and Health Insurance Claim/Identification Number (Required). Show the number as it appears on the patient's HI card, Social Security Award Certificate, utilization notice, MSN or EOMB, temporary eligibility notice, etc., or as reported by the SSO.

FL 63. Treatment Authorization Code field- Use this field to insert the appropriate demonstration number ("07" for Participating Centers of Excellence; "08" for Provider Partnerships).

A hospital representative will send an original, signed notice of admission election statement to the intermediary; a copy will be retained by the hospital for their own records.

Under "System Specifications", Section III, Intermediary Requirements, the fields and positions listed in I 3 and I 4 will be modified as indicated below by the underlined numbers. A new item I 16 is added as follows:

**I 3** Demonstration inpatient claims will be identified for CWF in field 83, positions 821 and 822. The demonstration special processing number is 07 for Centers of Excellence and 08 for Medicare Provider Partnership.

**I 4** For bills submitted to CWF, the FIs will report the negotiated payment amount less any deductible or coinsurance amounts applicable, i.e., the amount paid to the provider, in the reimbursement field of the claims record. The FIs will compute what the applicable inpatient payment would have been under the traditional Medicare fee-for-service program and other payment amounts in the value code area of the claims record as shown below. Note that the definition of the value codes listed below may not be the same as that used in previous Medicare demonstrations.

| Code | Title | Definition |
|---|---|---|
| Y1 | Part A Demonstration Payment | This is the portion of the payment designated as reimbursement for Part A services under the demonstration. This amount is instead of the traditional prospective DRG payment (operating and capital) as well as any outlier payments that might have been applicable in the absence of the demonstration. No deductible or coinsurance has been applied. Payments for operating IME and DSH which are processed in the traditional manner are also not included in this amount. |
| Y2 | Part B Demonstration Payment | This is the portion of the payment designated as reimbursement for Part B services under the demonstration. No deductible or coinsurance has been applied. |
| Y3 | Part B Coinsurance | This is the amount of Part B coinsurance applied by the intermediary to this claim. For demonstration claims this will be a fixed copayment unique to each hospital and DRG (or DRG/procedure group). |
| Y4 | Conventional Provider Payment Amount for Non-Demonstration Claims | This is the amount Medicare would have reimbursed the provider for Part A services if there had been no demonstration. This should include the prospective DRG payment (both capital as well as operational) as well as any outlier payment, which would be applicable. It does not include any pass through amounts such as that for direct medical education nor interim payments for operating IME and DSH. |

The actual payment to the hospital under the demonstration should be equal to the dollar amounts represented by: "Y1" + "Y2" + Operationl IME + Operational DSH minus the Part A deductible and any Part A coinsurance that might be applicable and minus "Y3", the Part B coinsurance.

**I 16** The global payment includes an adjustment for outliers. No separate payment for outliers should be processed. Payment should not be made based on Value Code "17". However, the amount that would have been paid for outliers must be calculated and recorded on the claim record in order to be available for reporting.

Under "System Specifications", Section IV, Carrier Requirements, the positions listed in C 13 will be modified as indicated below by the underlined numbers. A new requirement, C 20 will be added

**C 13** The demonstration ID number is 07 for the Centers of Excellence Demonstration and 08 for the Provider Partnership Demonstration. To facilitate CWF acceptance of these demonstration claims and their movement to the national claims history, enter the demonstration ID number on the HUBC, field 49, positions 272-273. Locations of the demonstration number on claims are as follows:

**C 20** When sending a site of service provider ID to CWF, carriers should submit the site of service provider ID to CWF on the HUBC, field 50b, positions 274-289.

**The *effective* date for this PM is January 1, 2002.**

**The *implementation date* for this PM is January 1, 2002.**

**These instructions should be implemented within your current operating budget. There are no extra funds allowed for processing claims under this demonstration.**

**This PM may be discarded December 31, 2005.**

**All contractors should address questions or issues surrounding implementation of these instructions to their regional office contact. The demonstration contact person for this PM is Jody Blatt at (410) 786-6921.**