Medicare Hospital Manual

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

Transmittal 778 **Date: OCTOBER 10, 2001**

REFER TO CHANGE REQUEST 1888

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
415.22 - 415.24	4-179 - 4-181 (3 pp.)	4-179 - 4-181 (3 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE:* July 1, 2001
***IMPLEMENTATION DATE:* November 5, 2001**

Section 415.21, CAH Services and CAH Long-term Care Services, these sentences were inadvertently omitted in Transmittal 772.

Section 415.22, Payment for Services Furnished by a CAH, is expanded to include the procedure for paying for outpatient services rendered under the all-inclusive method of payment. Also included are the revenue codes that must accompany the HCPC code of the physician/other practitioner service rendered in a CAH that elected the all-inclusive method of payment. These revenue codes are- 96x, 97x, or 98x.

NOTE: The number of visits does not have to be listed on the claim; therefore revenue code 510 is not a requirement unless there is a charge for a clinic visit.

If you chose the all-inclusive method of reimbursement for outpatient services, the implementation date is November 5, 2001. You may continue to bill as you are doing, (facility claims to the fiscal intermediaries, professional claims to your carrier), or you may choose to hold these types of claims until November 5, 2001. If you choose to continue to bill as you are, adjustments will be made where appropriate.

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

415.21 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 equity. 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 for it to be available for occupancy.

The CAH's length of stay will be calculated by their fiscal intermediary based on patient census data. If a CAH exceeds the length of stay limit, this information will be sent to the CMS Regional Office and a copy sent to the State agency. The CAH will be required to develop and implement a corrective action plan acceptable to the CMS 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 CMS;

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 CMS.

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 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.

415.22 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 that 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 subject to Part A deductible and coinsurance requirements. Inpatient services should be billed as an 11X type of bill.

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 July 1, 2000, 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 elective 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-type, 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 service, 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. Referenced diagnostic services will continue to be billed on a 14X type of bill.

2. Optional Method: Cost-Based Facility Services Plus Fee Schedule for Professional Services.--Section 202 of the Benefits Improvement and Protection Act of 2000 (BIPA 2000) permits the CAH to elect this method of reimbursement for cost reporting beginning 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 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 Form HCFA-1450, (or electronic equivalent) list the facility service(s) rendered to outpatients along with the appropriate revenue code. Payment will be the amount equal to the sum of 80 percent of its reasonable costs of its outpatient services after application of the Part B deductible and coinsurance.

(b) On a separate line, list the professional services, along with the appropriate HCPC code (physician or other practitioner) and one of the following revenue codes - 96x, 97x, or 98x. Payment will be 115 percent of the physician fee schedule, after applicable Part B deductible and coinsurance.

The Medicare Physician Fee Schedule (MPFS) supplementary file, established for use by the CORF, and the CORF Abstract File, will be used to pay for all the physician/professional services rendered in a CAH that elected the all-inclusive method. Your fiscal intermediary will pay 115 percent of whatever Medicare would

pay of the physician fee schedule. (The fee schedule amount, after applicable deductions, will be multiplied by 1.15 percent.) If there is a code listed on the bill that is not in either of files the appropriate carrier will be contacted.

Outpatient services, including ASC, rendered in an all-inclusive rate provider method should be billed using the 85X type of bill. Continue to bill referenced diagnostic services (non-patients) on bill type 14x.

C. Payment for outpatient services of a CAH is subject to applicable Part B deductible and coinsurance amounts.

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 for 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.

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

415.23 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 CAH's 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.

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

415.24 Review of Form HCFA-1450 for the Inpatient.--Complete all items on Form HCFA-1450 in accordance with §460.