



News Flash - The Medicare Billing Information for Rural Health Services: Information for Providers, Suppliers, and Physicians (Second Edition), which provides rural information pertaining to rural health facility types, coverage and payment policies, and rural provisions under the 2003 MMA and the Deficit Reduction Act of 2005 is now available in downloadable format at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/RuralChart.pdf> on the CMS website.

MLN Matters Number: MM5454 **Revised**

Related Change Request (CR) #: 5454

Related CR Release Date: April 27, 2007

Effective Date: October 1, 2007

Related CR Transmittal #: R53DEMO

Implementation Date: October 2, 2007

Note: This article was updated on August 27, 2012,, to reflect current Web addresses. All other information is the same.

Method of Payment for Extended Stay Services under the Frontier Extended Stay Clinic Demonstration, Authorized by Section 434 of the Medicare Modernization Act

Provider Types Affected

Clinics billing (or that wish to bill) Medicare fiscal intermediaries (FIs) or Part A/B Medicare Administrative Contractors (A/B MACs) for care provided to Medicare beneficiaries under the Frontier Extended Stay Clinic Demonstration

Provider Action Needed

Change Request 5454, from which this article is taken, provides Medicare fiscal intermediaries and A/B MACs the billing and systems instructions they need to pay clinics that provide authorized extended stays under the Frontier Extended Stay Clinic demonstration. The Centers for Medicare & Medicaid Services (CMS) will select no more than 6 clinics initially and that selection will occur during CY2007.

Please refer to the Background section, below, for more information.

Background

Section 434 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established "The Frontier Extended Stay Clinic (FESC)

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Demonstration Project” to test the feasibility of providing extended stay services to remote, frontier areas under Medicare payment and regulations. In fulfilling this requirement, CMS announced, in an August 29, 2006, news release, that it will provide, in the three-year FESC demonstration, added financial support to designated small health clinics that serve highly remote areas in Alaska and other states. (CMS news releases are available at <http://www.cms.gov/apps/media/> on the CMS website.)

These Frontier Extended Stay Clinics (FESCs) are designed to address the needs of 1) seriously or critically ill (or injured) patients who, due to adverse weather conditions or other reasons, cannot be transferred to acute care hospitals; or 2) patients who do not meet CMS inpatient hospital admission criteria and who need monitoring and observation for a limited period of time. Further, in order to qualify, FESCs must be located in communities which are 1) at least 75 miles away from the nearest acute care hospital or critical access hospital, or 2) inaccessible by public road.

As mentioned, under the FESC demonstration, participating clinics will be allowed to keep patients for extended stays in situations where weather or other circumstances prevent transfer, including extended stays up to 48 hours for patients who do not meet CMS inpatient hospital admission criteria but who need monitoring and observation. You should be aware, however, that there can be no more than 4 patients under this criterion at any one time at any single facility.

CMS will select no more than 6 clinics initially and that selection will occur during CY2007. Clinics will be identified by Rural Health Clinic and Federally Qualified Health Center provider numbers.

Change Request 5454, from which this article is taken, provides your Medicare fiscal intermediaries and A/B MACs with the billing and systems instructions they need to pay clinics participating under the FESC demonstration for the authorized extended stays.

These instructions follow:

- As mentioned above, clinics can provide services to:
 - Patients with emergency medical conditions who require an extended stay due to weather or other conditions that preclude transport to an acute care hospital; and
 - ill or injured patients who need an extended stay because a physician, nurse practitioner or physician assistant 1) determines that they do not meet Medicare inpatient hospital admission criteria, but do need monitoring and observation, and 2) determines that they can be discharged within 48 hours.

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- Clinics will be paid for extended stays in 4 hour increments after an initial 4 hour stay. Subject to a screening for medical necessity, Medicare payment will only occur for stays that equal or exceed 4 hours.
- It is important to note that the Medicare FI and/or A/B MAC will conduct a medical necessity screening and make Medicare payment under the demonstration only if the patient meets the following medical necessity requirements:
 - The patient's stay equals or exceeds 4 hours; and
 - The FI and/or A/B MAC determines under its medical review that the patient's condition has been evaluated by a physician, physician assistant, or nurse practitioner and is of sufficient risk to warrant continued observation in the clinic.
- The FI or A/B MAC will use an adaptation of the Section 290.4.3 of Chapter 4 of the *Medicare Claims Processing Manual* in conducting its medical necessity screening. Specifically, these instructions are summarized as follows:
 - All medical conditions are eligible.
 - Observation time begins when the patient is seen by the clinic staff and observation time must be documented on the medical record.
 - The beneficiary must be in the care of a physician, physician assistant, or nurse practitioner during the observation period, as determined in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician, physician assistant, or nurse practitioner.
 - The medical record must include documentation that the physician, physician assistant, or nurse practitioner explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.
- Code GXXXX will be used to indicate the length of stay for each Medicare patient from when he/she is admitted to the clinic, measured in 4-hour units of time. If the indicated length of stay is between 4 and 8 hours, the clinic receives payment for two units. If the GXXXX code indicates a stay between 8 and 12 hours, the clinic would receive payment for 3 units, etc.
- Providers should bill for the services using type of bill 71X, 73X, or 13X with revenue codes 516, 519, 0529, or 0510.
- When code GXXXX indicates less than 1 time unit, i.e., less than 4 hours, clinics will not receive any additional payment for the extended stay. However, in this situation, particular clinics (listed below) can bill and receive the customary encounter-based payment for a clinic visit:

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- Federally certified Rural Health Clinics will bill for the Rural Health Clinic encounter-based payment for a Medicare visit;
- Federally Qualified Health Centers will bill the Federally Qualified Health Center encounter-based clinic visit for Medicare;
- Indian Health Service owned and operated clinics will bill the Indian Health Service encounter-based clinic visit for Medicare; and
- Tribally owned and operated clinics electing to bill as Indian Health Service, tribally operated Indian Health Service facilities, and tribally owned and operated facilities will bill the customary encounter based clinic rate for Medicare.

CMS will identify a payment rate for a 4 hour stay unit and the rate may vary by type of provider. Total payment will be the payment rate multiplied by the number of extended stay units. Except for Indian Health Service and tribally owned and operated clinics, Medicare will impose a 20 percent coinsurance on the beneficiary for the extended stay services. However, there will be no deductible for extended stay services.

CMS will design a form, which each participating clinic will use to document weather conditions or other circumstances that prevent a transfer. Clinics will complete the form for each patient held for 48 hours or more, store it onsite at the clinic, and make it available to the FI, A/B MAC, and/or CMS for audit when requested. Either CMS, the FI, or the A/B MAC will audit these records at least once every six months and determine whether the clinic is in compliance with the 48 hour rule. If CMS determines that the clinic is not maintaining this rule, it has the right to suspend payments of greater than 48 hours to the clinic.

The clinic will report to CMS, the FI, or A/B MAC any time there are more than 4 Medicare patients in the clinic for more than 4 hours, and complete the form (above) documenting weather or other conditions that prevent transfer. Either CMS, the FI, or A/B MAC will audit these records at least once every quarter and determine whether the clinic is in compliance with the rule.

Additional Information

You can find the official instruction, CR 5454, issued to your FI or A/B MAC by visiting <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R53DEMO.pdf> on the CMS website

If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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