



News Flash – Did you know that your local Medicare contractor (carrier, fiscal intermediary, or Medicare Administrative Contractor (MAC)) is a valuable source of news and information regarding Medicare business in your specific practice location? Through their electronic mailing lists, your local contractor can quickly provide you with information pertinent to your geographic area, such as local coverage determinations, local provider education activities, etc. If you have not done so already, you should go to your local contractor website and sign up for their listserv or e-mailing list. Many contractors have links on their home page to take you to their registration page to subscribe to their listserv. If you do not see a link on the homepage, just search their site for “listserv” or “e-mail list” to find the registration page. If you do not know the Web address of your contractor’s homepage, it is available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

MLN Matters Number: MM6327

Related Change Request (CR) #: 6327

Related CR Release Date: February 13, 2009

Effective Date: March 13, 2009

Related CR Transmittal #: R1677CP and R102BP

Implementation Date: March 13, 2009

Note: This article was updated on December 17, 2012, to reflect current Web addresses. All other information remains unchanged.

Shipboard Services Billed to the Carrier and Services Not Provided Within the United States. Change Request (CR) 6327 rescinds and fully replaces CR 6217

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Medicare Administrative Contractors (MACs)) for billed shipboard services provided to Medicare beneficiaries.

Disclaimer

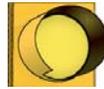
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Provider Action Needed



STOP – Impact to You

This article is based on Change Request (CR) 6327 which clarifies payment for shipboard services billed to Medicare contractors and services not provided within the United States.



CAUTION – What You Need to Know

CR 6327 revises the Medicare Claims Processing Manual and the Medicare Benefit Policy Manual to clarify that Medicare contractors will make payment for physician and ambulance services furnished in connection with a covered foreign hospitalization, including emergency physician and ambulance services furnished during the time period immediately preceding the covered foreign hospitalization. **CR 6327 rescinds and fully replaces CR 6217.**



GO – What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

Medicare law prohibits payment for items and services furnished outside the United States except for certain limited services (see the Social Security Act, Section 1814(f) at http://www.ssa.gov/OP_Home/ssact/title18/1814.htm and Section 1862(a)(4) at http://www.ssa.gov/OP_Home/ssact/title18/1862.htm on the Internet). The law specifies **the following are exceptions to the “foreign” exclusion:**

- Inpatient hospital services for treatment of an emergency in a foreign hospital that is closer to, or more accessible from, the place the emergency arose than the nearest U.S. hospital that is adequately equipped and available to deal with the emergency, provided either of the following conditions exist:
 - The emergency arose within the U.S, or
 - The emergency arose in Canada while the individual was traveling, by the most direct route and without unreasonable delay, between Alaska and another State;
- Inpatient hospital services at a foreign hospital that is closer to, or more accessible from, the individual’s residence within the U.S. than the nearest

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U.S. hospital that is adequately equipped and available to treat the individual's condition, whether or not an emergency exists;

- Physician and ambulance services in connection with a foreign inpatient hospital stay that is covered in accordance with (1) or (2) above.

Note: The term "United States" includes the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, American Samoa, and, for purposes of services rendered on a ship, the territorial waters adjoining the land areas of the United States.

The Medicare Claims Process Manual (Chapter 1, Section 10.1.4.7; see <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf> on the Centers for Medicare & Medicaid Services (CMS) website) currently states that:

- Services furnished by a physician or supplier in U.S. territorial waters must be furnished on board vessels of American registry, and
- The physician must be registered with the Coast Guard in order for Medicare to make payment.

However, that manual language is not consistent with Medicare law. Therefore, because Section 10.1.4.7 is not consistent with Medicare law, **CMS is clarifying Section 10.1.4.7 in order to make it consistent with current Medicare law by removing the language that states:**

- The vessels must be of American registry, and
- The physician must be registered with the Coast Guard.

CMS is also clarifying Chapter 1, Sections 10.1.4, and 10.1.4.1 and Chapter 3, Section 110.1 of the Medicare Claims Processing Manual and Chapter 16, Section 60 of the Medicare Benefit Policy Manual to show **that physician and ambulance services furnished in connection with a covered foreign hospitalization are covered**. The term "**and during a period of**" covered foreign hospitalization implies that only physician and ambulance services that are furnished during the period of the covered foreign hospitalization are covered (i.e., the period after the beneficiary has been admitted to the foreign hospital), when, in fact, the emergency physician and ambulance services **are covered** both:

- During the time period immediately before the beneficiary is actually admitted to the foreign hospital, and
- During the covered foreign hospitalization itself.

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You can find the revised chapters of two manuals referenced above as attachments to CR 6327.

Additional Information

The official instruction, CR 6327, was issued to your carrier, FI, and MAC via two transmittals. The first modifies the Medicare Claims Processing Manual and is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1677CP.pdf> and the second modifies the Medicare Benefit Policy Manual and that transmittal is at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R102BP.pdf> on the CMS website.

If you have any questions, please contact your carrier, FI, or 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.

News Flash - It's Not Too Late to Give and Get the Flu Shot! In the United States, the peak of flu season typically occurs anywhere from late December through March; however, flu season can last as late as May. Each office visit presents an opportunity for you to talk with your patients about the importance of getting an annual flu shot and a one time pneumococcal vaccination. Protect yourself, your patients, and your family and friends by getting and giving the flu shot. **Don't Get the Flu. Don't Give the Flu.** Remember - Influenza and pneumococcal vaccinations plus their administration are covered Part B benefits. Note that influenza and pneumococcal vaccines are NOT Part D covered drugs. Health care professionals and their staff can learn more about Medicare's Part B coverage of adult immunizations and related provider education resources, by reviewing Special Edition *MLN Matters* article SE0838 <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0838.pdf> on the CMS website.

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