



News Flash - The revised *Rural Health Clinic Fact Sheet* (April 2009), which provides information about Rural Health Clinic (RHC) services, Medicare certification as a RHC, RHC visits, RHC payments, cost reports, and annual reconciliation, is now available in downloadable format from the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RuralHlthClinfactsht.pdf> on the CMS website.

MLN Matters® Number: MM6452 **Revised**

Related Change Request (CR) #: 6452

Related CR Release Date: November 9, 2010

Effective Date: October 1, 2009

Related CR Transmittal #: R66DEMO

Implementation Date: October 1, 2009

Method of Payment for Extended Stay Services Under the Frontier Extended Stay Clinic (FESC) Demonstration, Authorized by Section 434 of the Medicare Modernization Act (MMA) - CR6452 provides additional information to CR 6057

Note: This article was updated on November 19, 2012, to reflect current Web addresses. This article was previously revised on November 15, 2010, to reflect a revised CR 6452 that was issued on November 9, 2010. The article was revised to reflect the revised payment methodology for the Indian Health Service and tribally owned clinics participating in the FESC demonstration. In addition, the CR release date, transmittal number, and the Web address for accessing CR 6452 have been revised.

Provider Types Affected

Specific Rural Health Clinics (RHC), Federally Qualified Health Centers (FQHC), or Tribally Owned clinics that are part of the FESC demonstration project and billing Medicare Fiscal Intermediaries (FIs) or Medicare Administrative Contractors (A/B MACs) for extended stay services rendered to Medicare beneficiaries in remote frontier areas.

Impact on Provider

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2007 American Medical Association.

This article is based on CR6452 and outlines the payment instructions and policy rules for the FESC demonstration project, which impacts a very limited number of providers as identified in this article.

Background

Section 434 of the MMA established the Frontier Extended Stay Clinic (FESC) Demonstration Project to test the feasibility of providing extended stay services to remote frontier areas under Medicare payment and regulations. A FESC must be located in a community which is:

1. At least 75 miles away from the nearest acute care hospital or critical access hospital; or
2. Is inaccessible by public road.

FESCs are designed to address the needs of seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred to acute care hospitals, or patients who do not meet CMS inpatient hospital admission criteria and who need monitoring and observation for a limited period of time.

Under rules established for the demonstration, clinics participating under the FESC demonstration will be allowed to keep patients for extended stays in situations where weather or other circumstances prevent transfer. Extended stays up to 48 hours are permitted for patients who do not meet the Centers for Medicare & Medicaid Services (CMS) inpatient hospital admission criteria but who need monitoring and observation for a limited period of time. According to the rules, there can be no more than four patients under this criterion at any one time at any single facility and the FESC demonstration will last for three years.

The following five clinics/tribal facilities are eligible for the demonstration

Clinic	Town	Clinic Type
Inter-island Medical Center	Friday Harbor, WA	RHC
Cross Road Medical Center	Glenallen, AK	FQHC
Iliuliuk Family & Health Services	Unalaska, AK	FQHC
Alicia Roberts Medical Center	Prince of Wales Island, AK	Tribal Facility
Haines Health Center	Haines, AK	Tribal Facility

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2007 American Medical Association.

A listed clinic must receive certification from CMS before it can bill for services to the MAC or FI. Certification signifies a clinic's adherence to the requirements for services, staffing, life safety codes and other factors.

Key Points

For each chosen clinic:

- The clinic will be paid for extended stays in four hour increments after an initial four hour stay. Medicare payment will only occur for stays that last at least four hours. For these stays, which equal or exceed four hours, demonstration payment will also apply to the first four hours of the stay.
- The clinic may provide services to:
 - Patients with an emergency medical condition who require an extended stay due to weather or other conditions that preclude transport to an acute care hospital.
 - Ill or injured patients who receive an extended stay because a physician, nurse practitioner or physician assistant determines that they do not meet Medicare inpatient hospital admission criteria but do need monitoring and observation, and determines that they can be discharged within 48 hours.
- The code G9140 will indicate the length of stay for each Medicare patient from the point of time that he/she is seen by the clinic. This code will measure four-hour units of time.
- The participating clinic will submit a patient documentation form, designed by CMS. This form will be submitted to the FI or AB/MAC for every Medicare patient whose stay in the clinic equals or exceeds 4 hours from the time he/she is originally seen by clinic staff. The form will include the patient's name, observation time verifying that the patient's stay equals or exceed 4 hours, diagnosis or condition, and documentation that the physician, physician assistant, or nurse practitioner explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.
- The clinic shall include documentation on this form of weather or other conditions that delay transfer of the patient, if relevant. The FI or AB/MAC will have no responsibility in assessing these weather (or other) conditions.
- The following conditions apply:
 - All medical conditions will be eligible;
 - Observation time must be documented on the medical record; and

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2007 American Medical Association.

- A beneficiary's time in observation begins when he/she is seen by the clinic staff.
- CMS and the FI or MAC will conduct a retrospective review of these extended stay documentation forms and determine from the information contained on these forms whether the clinic is abiding by the rule that patients have medical necessity for extended stays.
- If code G9140 indicates less than 1 time unit, i.e., less than 4 hours, the clinic will not receive any additional payment for an extended stay. That is, if G9140 shows less than 4 hours, a federally certified Rural Health Clinic will bill for the Rural Health Clinic encounter-based payment for the Medicare visit; a Federally Qualified Health Center will bill the Federally Qualified Health Center encounter-based clinic visit for Medicare; and, tribally owned and operated clinics electing to bill as Indian Health Service will bill the customary encounter rate for Medicare.
- If G9140 indicates 1 or more time unit, Medicare will make an enhanced payment. If at least 1 time unit, i.e., at least 4 hours, is indicated, the enhanced demonstration payment is also made for the first 4 hour period. For example, if the stay is 3 hours, then the clinic will get the customary clinic visit rate and no enhanced payment; if the stay achieves the 4 hour threshold, then the clinic will get the enhanced payment rate for the first 4 hour period, as well as for any further 4-hour periods. For stays of 4 or more hours, the clinic's customary encounter rate will not be made in addition to the enhanced payment for the extended stay.
- Code G9140 will indicate the number of units of time, based on 4-hour blocks, e.g., 1 unit represents 4 hours, 2 units represents 8 hours, etc. The clinic will receive an enhanced demonstration payment only if the patient's stay equals or exceeds 4 hours. For stays greater than 4 hours, the clinic, in submitting the number of units on the claim, will round down to the lower number of units for an incremental amount less than 2 hours, and will round up to the greater number of units for an incremental amount of time greater than or equal to 2 hours and less than 4 hours. For example:
 - Stay of 3 hours – payment is the customary clinic rate;
 - Stay of 5 hours - payment at 1 unit of time;
 - Stay of 7 hours - payment at 2 units of time;
 - Stay of 9 hours - payment at 2 units of time;
 - Stay of 11 hours – payment at 3 units of time;
 - Stay of 13 hours – payment of 3 units of time.
- The following conditions apply:

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2007 American Medical Association.

- The FI/MAC will impose a 20 percent coinsurance on Medicare beneficiaries receiving the extended stay services (i.e., services in the clinic beyond the first four hours.)
 - There will be no deductible for extended stay services.
- The revenue codes are 516, 519, 0529 and 0510 and the applicable bill types are 13X, 71X, and 73X.
- There is no deductible for extended stay services.
- Clinics may not bill for periods exceeding 48 hours (12 units), except when longer stays are required due to weather or transportation conditions.
- In situations when a clinic reports the G code greater than 12 time units, i.e., 48 hours, Medicare payment is contingent on weather and transportation conditions on the basis of reports submitted to CMS.
- This payment will be the rate of payment per time unit multiplied by the number of time units in the stay,(e.g. If 5 units are billed, the provider may be paid for 5 units.)
- CMS will conduct additional retrospective reviews of two circumstances pertaining to patient stays:
 - CMS will verify the weather conditions for stays longer than 12 time units by retrospectively assessing documentation provided by clinics. The clinic will provide this documentation for each patient on the same form described in section 4. Neither the FIs nor the A/B MACs will have responsibility in this verification process. 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. Neither the FI nor the A/B MAC has responsibility for monitoring these records.
 - The clinic will report to CMS at any time when there are more than 4 Medicare patients who are each in the clinic for more than 4 hours. If the clinic reports there are more than 4 patients at one time, CMS will determine from the forms documenting patient condition, observation time, and weather or other conditions that prevent transfer whether the clinic is in compliance with the rule. Neither the FI nor the A/B MAC has responsibility for monitoring these records.
- The FI and/or A/B MAC will pay claims on an automated basis and post payment reviews will be conducted as previously described.
- There is a four hour payment rate for each FESC selected for the demonstration. These rates are based on the 2007 Ambulatory Payment Classification for observation services, and they incorporate wage and cost-of-living adjustments. The four hour payment rates for the clinics for 2009 are:

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2007 American Medical Association.

Tribal Clinics	Alicia Roberts Medical Center (Prince of Wales Island, Alaska)	\$541.24
	Haines Health Center (Haines, Alaska)	\$541.24
Federally Qualified Health Centers	Cross Road Medical Center (Glenallen, Alaska)	\$541.24
	Iliuliuk Family and Health Services (Unalaska, Alaska)	\$541.24
Rural Health Clinics	Inter-island Medical Center (Friday Harbor, Washington)	\$479.74

For subsequent years of the demonstration, these payment amounts will be updated by the market basket adjustment, which is applicable to the outpatient prospective payment system.

Additional Information

To see the official instruction (CR6452) issued to your Medicare FI or A/B MAC visit <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R66DEMO.pdf> on the CMS website.

If you have questions, please contact your Medicare 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.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2007 American Medical Association.