CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 122	**Date: April 9, 2010**
	Change Request 6880

SUBJECT: Claims Submitted for Items or Services Furnished to Medicare Beneficiaries in State or Local Custody Under a Penal Authority and Examples of Application of Government Entity Exclusion. This CR rescinds and fully replaces CR 6544.

I. SUMMARY OF CHANGES: This transmittal has not changed from the CR 6544, Transmittal 110, issued on September 4, 2009. For updated billing and claims processing requirements associated with this CR, see Pub. 100-04, Transmittal 1944.

EFFECTIVE DATE: July 9, 2010
IMPLEMENTATION DATE: July 9, 2010

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	16/50.3.3/Examples of Application of Government Entity Exclusion

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-02	Transmittal: 122	Date: April 9, 2010	Change Request: 6880

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Effective Date: July 9, 2010

Implementation Date: July 9, 2010

I. GENERAL INFORMATION

A. Background: Under Section 1862(a)(2) of the Social Security Act ("the Act"), the Medicare program does not pay for services if the beneficiary has no legal obligation to pay for the services and no other person or organization has a legal obligation to provide or pay for that service. Also, under Section 1862(a)(3) of the Act, if services are paid for directly or indirectly by a governmental entity, Medicare does not pay for the services.

B. Policy: In the FY 2008 IPPS rule (72 FR 47409 and 47410), CMS clarified its regulations at 42 CFR §411.4(b) by stating that for purposes of Medicare payment, individuals who are in "custody" include, but are not limited to, individuals who are under arrest, incarcerated, imprisoned, escaped from confinement, under supervised release, on medical furlough, required to reside in mental health facilities, required to reside in halfway houses, required to live under home detention, or confined completely or partially in any way under a penal statute or rule.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6880.1	Medicare contractors/carriers shall not make payment for individuals or groups of individuals who are in "custody" under a penal statute or rule unless the exceptions outlined at Pub. 100-02, chapter 16, section 50.3.3 are met.	X	X	X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6880.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Fred Grabau 410-786-0206

Post-Implementation Contact(s): Fred Grabau 410-786-0206

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: ***For Medicare Administrative Contractors (MACs)*****:**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

50.3.3 - Examples of Application of Government Entity Exclusion

(Rev. 122, Issued: 04-09-10, Effective/Implementation Date: 07-09-10)

The following paragraphs explain the application of the governmental entity exclusion to various situations involving services rendered by governmental and non governmental facilities:

1. State Veterans Homes

Many State governments operate veterans homes and hospitals. These institutions are generally open only to veterans and certain dependents of veterans, and include domiciliary, hospital, infirmary, and/or nursing home type facilities. These institutions are financed primarily from State funds; in addition, most receive nominal per diem payments from the VA for domiciliary care, hospital care, or nursing home type care for each veteran who would also qualify for admission to a VA hospital or domiciliary.

When such a participating institution charges its residents and patients to the extent of their ability to pay, or seeks payment from available sources other than Medicare, benefits are payable for covered items and services furnished to Medicare beneficiaries. However, if it is the policy of the institution to admit and treat a veteran without charge simply because the individual is a veteran, or because the condition is service-connected, payment would be precluded under title XVIII.

Per diem amounts paid by the VA to State veterans homes on behalf of those patients who are otherwise eligible for care in a VA facility may be credited towards any deductible, coinsurance, or noncovered amounts required to be paid by the patient. However, if a State veterans home collects amounts from the VA in excess of the applicable deductible and coinsurance, the intermediary reduces the Medicare payment to the extent of such payments.

2. State and Local Psychiatric Hospitals

In general, payment may be made under Medicare for covered services furnished without charge by State or local psychiatric hospitals which serve the general community. (See §50.3.1.) However, payment may not be made for services furnished without charge to individuals who have been committed under a penal statute (e.g., defective delinquents, persons found not guilty by reason of insanity, and persons incompetent to stand trial). For Medicare purposes such individuals are "prisoners," as defined in subsection 3, and may have services paid by Medicare only under the exceptional circumstances described there.

A psychiatric hospital to which patients convicted of crimes are committed is considered to be serving the general community if State law also provides for voluntary admissions to the institution.

3. Prisoners

The regulation at 42 CFR §411.4(b) states:

"Individuals who are in custody include, but are not limited to, individuals who are under arrest, incarcerated, imprisoned, escaped from confinement, under supervised release, on medical furlough, required to reside in mental health facilities, required to reside in halfway houses, required to live under home detention, or confined completely or partially in any way under a penal statute or rule."

Moreover, 72 FR 47405 states further that the—

"…definition of "custody" is in accordance with how custody is defined by Federal courts for purposes of the habeas corpus protections of the Constitution. For example, the term "custody" is not limited solely to physical confinement. (Sanders v. Freeman, 221F.3d 846, 850-851 (6th Cir. 2000).) Individuals on parole, probation, bail, or supervised release may be "in custody."

42 CFR §411.4(b) goes on to describe the special conditions that must be met in order for Medicare to make payment for individuals who are in custody, 42 CFR §411.4(b) states:

"Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met:

1. State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody, and

2. The State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts."

The CMS presumes that a state or local government that has custody of a Medicare beneficiary under a penal statute has a financial obligation to pay for the cost of healthcare items and services unless the State can demonstrate to the intermediary's, *A/B MAC's, DME MAC's,* or carrier's satisfaction, in consultation with the RO, that:

- State or local law requires that individuals in custody repay the cost of the services.

- The State or local government entity enforces the requirement to pay by billing and seeking collection from all individuals in custody with the same legal status (e.g., not guilty by reason of insanity), whether insured or uninsured, and by pursuing collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts. This includes collection of any Medicare deductible and coinsurance amounts and the cost of items and services not covered by Medicare.

NOTE: The intermediary, *A/B MAC, DME MAC,* or carrier will require evidence that routine collection efforts include the filing of lawsuits to obtain liens against individuals' assets outside the prison and income derived from non-prison sources.

- The State or local entity documents its case with copies of regulations, manual instructions, directives, etc., spelling out the rules and procedures for billing and collecting amounts paid for prisoners' medical expenses. As a rule, the intermediary*, A/B MAC, DME MAC,* or carrier will inspect a representative sample of cases in which prisoners have been billed and payment pursued, randomly selected from both Medicare and non-Medicare eligible. The existence of cases in which the State or local entity did not actually pursue collection, even though there is no indication that the effort would have been unproductive, indicates that the requirement to pay is not enforced.

The CMS maintains a file of incarcerated beneficiaries, obtained from SSA, that is used to edit claims.

Providers and suppliers that render services or items to a prisoner or patient in a jurisdiction that meets the conditions described above indicate this fact with the use of a modifier (for carrier processed claims) or condition code (for intermediary processed claims). Otherwise the claims are denied.

4. Health Department Outpatient Clinics

Services rendered free of charge by State and local health department outpatient clinics are not covered unless the services are rendered because of the individual's indigence or as a means of controlling infectious diseases. Thus, services rendered by city-operated clinics for the poor and clinics for the detection and treatment of such illnesses as venereal disease and tuberculosis are **not** excluded from Medicare coverage.

5. Vocational Rehabilitation (VR) Agencies

Under the vocational rehabilitation (VR) programs of the various States, vocational training and services, including hospital and medical care, are provided to handicapped persons who qualify under State law. These programs are financed in part by a Federal matching fund program set up under the Vocational Rehabilitation Act.

When items or services are furnished by a State VR agency, title XVIII benefits are payable if the agency charges all clients for its services or makes services available without cost only to medically indigent individuals. If a rehabilitation agency has paid for items and services furnished by nonproviders (e.g., physicians' services and prosthetic appliances), it may claim the Part B payment due the beneficiary if the latter has authorized it to do so. The procedure is similar to that provided for State welfare agencies; the State vocational rehabilitation agency function is comparable to that of a State welfare agency in relation to a welfare recipient.