

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 59	Date: DECEMBER 12, 2008
	Change Request 6057

Subject: Method of Payment for Extended Stay Services Under the Frontier Extended Stay Clinic Demonstration, Authorized by Section 434 of the Medicare Modernization Act. This Change Request is a full replacement of CR 5454.

I. SUMMARY OF CHANGES: Payment Instructions and Policy Rules for Frontier Extended Stay Clinic Demonstration mandated by section 434 of the Medicare Modernization Act and recently approved by the Office of Management and Budget (OMB). This change request is a full replacement of CR 5454.

New / Revised Material

Effective Date: January 1, 2009

Implementation Date: January 12, 2009

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-Only One Per Row.

R/N/D	Chapter / Section / Subsection / Title
N/A	

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:

Funding for implementation activities will be provided to contractors through the regular budget process.

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.

IV. ATTACHMENTS:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-19	Transmittal: 59	Date: December 12, 2008	Change Request: 6057
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SUBJECT: Method of Payment for Extended Stay Services under the Frontier Extended Stay Clinic Demonstration, Authorized by Section 434 of the Medicare Modernization Act. This Change Request is a full replacement of CR 5454.

Effective Date: January 1, 2009

Implementation Date: January 12, 2009

I. GENERAL INFORMATION

A. Background: Section 434 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (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 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 4 patients under this criterion at any one time at any single facility.

According to Section 434, the FESC demonstration will last for three years.

The following six clinics are eligible for the demonstration:

<u>Clinic</u>	<u>Town</u>	<u>Provider Number</u>	<u>Clinic Type</u>	<u>FI or MAC</u>
Inter-island Medical Center	Friday Harbor, WA	503893	RHC	Riverbend
Powder River Medical Clinic	Broadus, MT	273803	RHC	Trailblazer (MAC)
Cross Road Medical Center	Glenallen, AK	021820	FQHC	NGS (legacy)
Iliuliuk Family & Health Services	Unalaska, AK	021823	FQHC	NGS (legacy)
<u>Tribal Facilities –</u>				
Alicia Roberts Medical Center	Prince of Wales Island, AK		TEZ066	Trailblazer (MAC)
Haines Health Center	Haines, AK		TEZ064	Trailblazer (MAC)

A listed clinic must received certification from CMS before it can bill for services to the Medicare Administrative Contractor (MAC) or fiscal intermediary (FI). Certification signifies a clinic’s adherence to the requirements for services, staffing, life safety codes and other factors. The project officer will notify the MAC (or FI) of each clinic’s certification.

B. Policy: For each chosen clinic:

1. The clinic shall be able to 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 last at least 4 hours. For these stays that equal or exceed 4 hours, demonstration payment will also apply to the first four hours of the stay.
2. The clinic may provide services to –
 - a) 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.
 - b) 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.
3. 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 4-hour units of time.
4. The FI and/or A/B MAC will conduct a medical necessity screening of each Medicare patient whose stay in the clinic equals or exceeds 4 hours from the time he/she is originally seen by the clinic staff. The FI and/or MAC will make a Medicare payment under the demonstration if and only if the patient meets the following medical necessity requirements:
 - i) the patient's stay equals or exceeds 4 hours; and
 - ii) the FI and/or 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.
5. The FI and/or A/B MAC will use the following instructions to conduct the medical necessity screening to determine whether the patient meets these requirements. These instructions have been adapted for this demonstration from Section 290.4.3, "Separate and Packaged Payment for Observation", of Chapter 4 of the Medicare Claims Processing Manual. The time a patient stays and receives services once he/she is seen by clinic staff is considered as observation.
 - a) Diagnosis Requirements
 - i) All medical conditions will be eligible.
 - b) Observation Time
 - i) Observation time must be documented on the medical record.
 - ii) A beneficiary's time in observation begins when he/she is seen by the clinic staff.
 - c) Clinical Evaluation
 - i) The beneficiary must be in the care of a physician, physician assistant, or nurse practitioner during the period of observation, as documented 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.
 - ii) 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.

6. For Medicare patients who are determined by the clinical staff to require transfer to a hospital, but whose transfer is prevented by weather or transportation conditions, the clinic is required to document weather conditions (or other situation that prevents timely transfer), the transfer time, and method of transport. If the patient's length of stay in the clinic equals or exceeds 4 hours, the FI and/or MAC will make a Medicare payment under the demonstration.
7. 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 (i.e. the allowable payment will be \$0.00). However, the clinic will be eligible to bill and receive the customary encounter-based payment for a clinic visit.
 - a) A Federally certified Rural Health Clinic will bill for the Rural Health Clinic encounter-based payment for a Medicare visit.
 - b) A Federally Qualified Health Center will bill the Federally Qualified Health Center encounter-based clinic visit for Medicare.
 - c) An Indian Health Service owned and operated clinic will bill the Indian Health Service encounter-based clinic visit for Medicare.
 - d) Tribally owned and operated clinics electing to bill as Indian Health Service, tribally operated Indian Health Service facilities, or tribally owned and operated facilities – all will bill the customary encounter based clinic rate for Medicare.
8. 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.

9. The clinic will send FESC claims to the CMS project officer for an audit every 3 months, to be accompanied by information on the time each patient spends in the clinic receiving services, and (where relevant) information on weather conditions. Neither the FIs nor the A/B MACs will have responsibility in this audit and verification process.
10. There is a 4-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. They have been updated for 2008 and 2009 by the market basket increase. The 4-hour payment rates for the clinics for 2009 are:

<u>Tribal Clinics</u>	Alicia Roberts Medical Center (Prince of Wales Island, Alaska)	\$541.24
	Haines Health Center (Haines, Alaska)	\$541.24
<u>Federally Qualified Health Centers</u>	Cross Road Medical Center (Glenallen, Alaska)	\$541.24
	Iliuliuk Family and Health Services (Unalaska, Alaska)	\$541.24
<u>Rural Health Clinics</u>	Inter-island Medical Center (Friday Harbor, Washington)	\$479.74
	Powder River Medical Clinic (Broadus, Montana)	\$435.64

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.

11. The following conditions apply:

- a. Except for Indian Health Service and tribally owned and operated clinics, 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.)
- b. For Indian Health Service and tribally owned and operated clinics, there will be no coinsurance.
- c. There will be no deductible for extended stay services.

12. Clinics may not bill for periods exceeding 48 hours (12 units), except when longer stays are required due to weather or transportation conditions
13. 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 quarterly reports submitted to CMS.
14. 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.)
15. CMS will conduct additional retrospective reviews of two circumstances pertaining to patient stays:

- i) CMS will verify the weather conditions for stays longer than 12 time units by retrospectively assessing documentation provided by clinics.

CMS will design a form that each participating clinic will use to document weather conditions or other circumstances that prevent a transfer. This form will be designed by CMS and will ask clinics to describe weather conditions, other factors that prevented or delayed transfer, and the need to provide services to the patient. A form will be recorded by the clinic for each patient held for 48 hours or more, stored onsite at the clinic, and made available to CMS for audit when requested. These forms must be documented contemporaneously to CMS when weather or transportation situations occur that prevent transfer of patients. CMS will conduct audits of these records at least once every 3 months and determine whether the clinic is in compliance with the 48 hour rule. Neither the FIs nor the A/B MACs will have responsibility in this audit and 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.

- ii) 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, it must complete the form documenting weather or other conditions that prevent transfer. CMS will conduct audits of these records at least once every 3 months and determine whether the clinic is in compliance with the rule. Neither the FI nor the A/B MAC has responsibility for monitoring these records.

16. The FI and/or A/B MAC will pay claims on an automated basis, and post-payment review will occur as is standard for RHCs and FQHCs.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)								
		A / B M A C	D M E M A C	F I	C A R R I E R	R H I	Shared-System Maintainers			
						F I S S	M C S	V M S	C W F	
6057.1	CMS will identify the clinics to participate in this demonstration. There will initially be no more than 6 clinics in the demonstration. These clinics will all be RHCs, FQHCs, or tribally owned clinics.									CMS-ORDI
6057.1.1	Contractors and shared system maintainers shall identify clinics participating in the demonstration by Medicare provider numbers. The specific contractors impacted are: Riverbend NGS Trailblazer (MAC) The specific shared systems impacted are: CWF	X		X			X		X	CMS-ORDI

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	FISS										
6057.2	Participating clinics shall use G9140 (Extended stay services, up to 4 hours) to bill for extended stays. The number of units billed shall reflect the duration of the extended stay in 4 hour increments.									Demonstration Clinic	
6057.3	The FI and A/B MAC will calculate Medicare payment specific to the demonstration from the G-code. Payment will be made through the same mechanism for RHC and FQHC payments, but the demonstration payment will be separable for accounting purposes	X		X							
6057.4	A claim that can be distinctly measured as greater than the 4 hour unit should be either rounded up or down to the closer 4 hour multiple, (i.e., a claim that reads 300 minutes should reflect one 4-hour unit; a claim of 420 minutes should reflect 2 4-units).	X		X						Demonstration Clinic	
6057.4.1	The revenue codes are 516, 519, 0529 and 0510.	X		X							
6057.5	The bill types are 71X, 73X, and 13X.	X		X							
6057.6	The FI and/or AB MAC will conduct a medical necessity screening of each Medicare patient who equals or exceeds 4 hours from the time he/she is originally seen by the clinic.	X		X			X				
6057.7	The FI and/or AB MAC will make a Medicare payment under the demonstration if: a) i)the patient's stay equals or exceeds 4 hours; and ii) there is no documentation of weather or transportation issues; and iii) 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. <u>OR:</u> b) i) there is documentation of a transfer or weather or transportation conditions preventing transfer, and, ii) the patient's stay equals or exceeds 4 hours;	X		X							
6057.8	The FI and/or MAC will use the following instructions to conduct the medical necessity screening to determine	X		X							

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	<p>whether the patient meets these requirements:</p> <p>i) All medical conditions will be eligible;</p> <p>ii)The patient's time from the point when he/she is seen in the clinic must be documented on the medical record;</p> <p>iii) A beneficiary's time must be documented on the medical record;</p> <p>iv) The claim for observation services must have a clinic visit reported in addition to the reported observation services. This service must have a line item date of service on the same day or the day before the date reported for observation.</p> <p>v) The beneficiary must be in the care of a physician, physician assistant, or nurse practitioner during the period of observation, as documented 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.</p> <p>vi) 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.</p>										
6057.9	CMS shall provide provider specific payment rates for each clinic participating in the demonstration.										CMS-ORDI
6057.10	For those claims designated for payment under the demonstration as determined by 6057.7, the FI and/or A/B MAC shall make a demonstration payment specific to each provider. This payment will be the rate of payment per time unit multiplied by the number of time units (4 hour units) in the stay.	X		X							
6057.11	Except for Indian Health Service and tribally owned and operated clinics, the FI and/or AB/MAC will apply a 20 percent coinsurance on Medicare beneficiaries receiving the extended stay services (i.e., services in the clinic beyond the first four hours.)	X		X							
6057.12	For Indian Health Service and tribally owned and operated clinics, there will be no coinsurance.	X		X							
6057.13	There will be no deductible for extended stay services.	X		X							
6057.14	The payment rates for each provider will be subject to update, per notification by CMS.										CMS

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
6057.15	Claims processed under the demonstration rules according to this CR will be tagged with a demonstration code =53. The demonstration code shall be part of the claim record sent to the national claims history file."									X	CMS-ORDI

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
6057.16	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							

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:

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

V. CONTACTS

Pre-Implementation Contact(s): Sid Mazumdar, x66673

Post-Implementation Contact(s): Sid Mazumdar, x66673

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs)* use only one of the following statements: Funding for implementation activities will be provided to contractors through the regular budget process.

Section B: For *Medicare Administrative Contractors (MACs)*, use the following statement: 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.