CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-19 Demonstrations	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 53	**Date: APRIL 27, 2007**
	Change Request 5454

NOTE: This instruction is being re-communicated. The instruction was inadvertently previously communicated without complete and correct Implementation Date. The instruction has been revised. The Transmittal Number, Issue Date and all other information remain the same.

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

I. SUMMARY OF CHANGES: This Change Request gives instructions on billing and Medicare fiscal intermediary and carrier systems so that clinics participating under the Frontier Extended Stay Clinic demonstration receive Medicare payment for extended stays authorized by the demonstration. Extended stays will be allowed for clinics that are eligible and selected for the demonstration. The characteristics of these extended stays are described in the Change Request.

New / Revised Material
Effective Date: October 1, 2007
Implementation Date: October 1, 2007 for CWF; December 3, 2007 for FISS

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

IV. ATTACHMENTS:

One-Time Notification

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

Attachment – One-Time Notification

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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 payment methodology applies specifically to a preselected group of sites, all of which are Rural Health Clinics, Federally Qualified Health Centers, or Tribally Owned clinics

Effective Date: October 1, 2007

Implementation Date: October 1, 2007 for CWF; December 3, 2007 for FISS

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 regulations 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 regulations, 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.

Clinics will be selected in early CY 2007. There will initially be no more than 6 clinics in the demonstration. Clinics will be identified by Rural Health Clinic and Federally Qualified Health Center provider numbers.

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 GXXXX 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) Unlike the requirement for APC 339, 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 both weather conditions, the transfer time and method of transport (or other situation that prevents timely transfer). 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 GXXXX 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, tribally owned and operated facilities – all will bill the customary encounter based clinic rate for Medicare.

8. If code GXXXX indicates a length of stay equal to or exceeding 4 hours by a fraction of a 4 hour period, then the clinic will receive Medicare payment for 2 units. If the indicated length of stay is between 8 and 12 hours, the Medicare payment will be for 3 units, between 12 and 16 hours, the Medicare payment will be 4 units, etc.

9. CMS will identify a payment rate for a four hour period of stay. The allowable payment may vary by provider:

    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.

    d. The FI/MAC will pay for the stays of Medicare patients at the clinic that exceed one unit, i.e., four hours, under the following conditions:

        i) When the FI and/or AB/MAC determines that the patient meets medical necessity requirements according its screening, or when there is documentation of a transfer or a weather or transportation condition preventing transfer; and

        ii) When a clinic reports the G code greater than one time units, i.e., 4 hours,

10. 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 semi-annual reports submitted to CMS.

11. 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.)

12. 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 six 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 six 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.

13. 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	DME	FI	CAR	DME	RHH	Shared-System Maintainers	OTHER

								FISS	MCS	VMS	CWF	
5454.1	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
5454.1.1	Contractors and or shared system maintainers shall identify clinics participating in the demonstration by Medicare provider numbers.	X		X				X			X	CMS-ORDI
5454.2	Participating clinics shall use GXXXX (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
5454.3	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								
5454.4.	A claim that can be distinctly measured as greater than the 4 hour unit should be counted for the next 4 hour unit, (i.e., a claim that reads 241 minutes should reflect 2 4-hour units.)	X		X								
5454.4.1	The revenue codes are 516, 519, 0529 and 0510	X		X								
5454.5	The bill types are 71X, 73X, and 13X	X		X								
5454.6	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				
5454.7	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)	X		X								

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	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;											
5454.8	The FI and/or MAC will use the following instructions to conduct the medical necessity screening to determine whether the patient meets these requirements: i) All medical conditions will be eligible; ii)The patient's time from the point when he/she is seen in the clinic must be documented on the medical record; iii) A beneficiary's time must be documented on the medical record; 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. 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. 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.	X		X								
5454.9	CMS shall provide provider specific payment rates for each clinic participating in the demonstration.											CMS-ORDI

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5454.10	For those claims designated for payment under the demonstration as determined by 5454.7, 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								
5454.11	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								
5454.12	For Indian Health Service and tribally owned and operated clinics, there will be no coinsurance	X		X								
5454.13	There will be no deductible for the extended stay services.	X		X								
5454.14	The payment rates for each provider will be subject to update, per notification by CMS.											CMS
5454.15	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 MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5454.16	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

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:

B. For all other recommendations and supporting information, use the space below: N/A

V. CONTACTS

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

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

VI. FUNDING

A. ***For TITLE XVIII Contractors:***
Funding for implementation activities will be provided to contractors through the regular process.

B. ***For Medicare Administrative Contractors (MAC)*****:**

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). 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.