CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-19 Demonstrations	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 66	**Date: November 9, 2010**
	Change Request 6452

Note to Contractor: Transmittal 61, dated June 19, 2009, is rescinded and replaced by Transmittal 66, dated November 9, 2010. This Change Request (CR) is being reissued to clarify the payment methodology for the Indian Health Service and tribally owned clinics participating in the FESC demonstration. Business requirement 6452.11 was amended to remove the exception for Indian Health Service and tribally owned clinics from the requirement that the A/B Medicare Administrative Contractors (A/B MACs) deduct a 20 percent coinsurance amount from the payment amount to the Indian Health Service and tribally owned clinics. Business Requirement 6452.12 is being removed and intentionally left blank (for numbering purposes). As with the other participating FESC clinics, the A/B MAC will pay the Indian Health Service and tribally owned clinics 80 percent of the payment amounts stated in CR 6452.

Contractors shall implement the above changes by November 30, 2010. All other information remains 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. This Change Request is adds additional information to CR 6057.

I. SUMMARY OF CHANGES: Method of Payment for Extended Stay Services Under the Frontier Extended Stay Clinic Demonstration, Authorized by Section 434 of the Medicare Modernization Act. This version contains minor changes from the previous version, CR 6057.

EFFECTIVE DATE: October 1, 2009
IMPLEMENTATION DATE: October 1, 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:
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):

Attachment – One-Time Notification

Pub. 100-19	Transmittal: 66	Date: November 9, 2010	Change Request: 6452

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Contractors shall implement the above changes by November 30, 2010. All other information remains 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. This Change Request provides additional information for CR 6057.

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

Effective Date: October 1, 2009

Implementation Date: October 1, 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 five clinics are eligible for the demonstration:

Clinic	Town	Provider Number	Clinic Type	FI or MAC
Inter-island Medical Center	Friday Harbor, WA	503893	RHC	Cahaba

Cross Road Medical Center	Glenallen, AK	021820	FQHC	NGS (legacy)
Iliuliuk Family & Health Services	Unalaska, AK	021823	FQHC	NGS (legacy)

Tribal Facilities –

Alicia Roberts Medical Center	Prince of Wales Island, AK	020027*	Trailblazer (MAC)
Haines Health Center	Haines, AK	020027*	Trailblazer (MAC)

*This provider number references the parent hospital, Mt. Edgecumbe Hospital in Sitka, Alaska.

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. 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 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.

5. The following conditions apply:
    a) All medical conditions will be eligible.
    b) Observation time must be documented on the medical record
    c) A beneficiary's time in observation begins when he/she is seen by the clinic staff.

6 . 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.

7. 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.

8. If code G9140 indicates less than 1 time unit, i.e., less than 4 hours, the clinic will not receive ny additional payment for an extended stay. That is, if G1940 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.

9. 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.

10. 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.

11. 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:

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	$541.24

	Services (Unalaska, Alaska)	
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.

12. The following conditions apply:

    a. 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. There will be no deductible for extended stay services.

13. Clinics may not bill for periods exceeding 48 hours (12 units), except when longer stays are required due to weather or transportation conditions

14. 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.

15. 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.)

16. 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. 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.

    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, 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.

17. The FI and/or A/B MAC will pay claims on an automated basis. Post payment review will be conducted as described in sections 4 through 6 of this general section.

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	
6452.1	CMS will identify the clinics to participate in this demonstration. There will initially be no more than 5 clinics in the demonstration. These clinics will all be RHCs, FQHCs, or tribally owned clinics. CMS is making the following changes to the list of clinics for the demonstration. 1) Powder River Medical Clinic in Montana will not be participating in demonstration. 2) The provider number for the two tribal facilities, Alicia Roberts Medical Center and Haines Health Center, changes to 020027. These are provider-based clinics that will bill through the parent provider, Mt. Edgecumbe Hospital in Sitka, Alaska.										CMS ORDI
6452.1.1	Contractors shall identify clinics participating in the demonstration by Medicare provider numbers. The specific contractors impacted are: Cahaba NGS Trailblazer (MAC)	X		X							CMS - ORDI
6452.2	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 Clini

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	
											c
6452.3	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							
6452.4	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
6452.4.1	The revenue codes are 516, 519, 0529 and 0510.	X		X							
6452.5	The bill types are 71X, 73X, and 13X.	X		X							
6452.6	The participating clinic will submit a form to CMS and the FI or AB/MAC for every Medicare extended stay patient. The form will be designed by CMS, This form will include the patient's name, observation time, 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	X		X							Demonstration Clinic
6452.7	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.	X		X							
6452.8	The FI and/or MAC will use the following instructions to conduct the medical necessity review: 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	X		X							

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	
	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. vi) The submitted form 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.										
6452.9	CMS shall provide provider specific payment rates for each clinic participating in the demonstration.										CMS - ORDI
6452.10	For those claims designated for payment under the demonstration as determined by 6452.8, 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							
6452.11	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							
6452.12	This requirement left intentionally blank.										
6452.13	There will be no deductible for extended stay services.	X		X							
6452.14	The payment rates for each provider will be subject to update, per notification by CMS.										CMS
6452.15	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."										CMS - ORDI

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	
6452.16	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:
6452.1	See CR 6057 Background
6452.2	See CR 6057.4.1

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 Intermediaries (RHHIs)*:

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.

IV. ATTACHMENTS:
One-Time Notification
**Unless otherwise specified, the effective date is the date of service.*