Medicare Guide to Rural Health Services Information

for Providers, Suppliers, and Physicians

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DISCLAIMER

This guide was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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MEDICARE LEARNING NETWORK

The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at *http://www.cms.hhs.gov/MLNGenInfo* on the CMS website.

MEDICARE CONTRACTING REFORM (MCR) UPDATE

In Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) Congress mandated that the Secretary of the Department of Health and Human Services replace the current contracting authority under Title XVIII of the Social Security Act with the new Medicare Administrative Contractor (MAC) authority. This mandate is referred to as Medicare Contracting Reform. Medicare Contracting Reform is intended to improve Medicare's administrative services to beneficiaries and health care providers. All Medicare work performed by Fiscal Intermediaries and Carriers will be replaced by the new A/B MACs by 2011. Providers may access the most current MCR information to determine the impact of these changes and to view the list of current MACs for each jurisdiction at *http://www.cms.hhs.gov/MedicareContractingReform/* on the CMS website.

NATIONAL PROVIDER IDENTIFIER (NPI) UPDATE

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandated that the Secretary of the Department of Health and Human Services adopt a standard unique identifier for health care providers called the National Provider Identifier (NPI). The NPI will replace health care provider identifiers that are now being used in standard transactions and will eliminate the need to use different identification numbers when conducting HIPAA standard transactions with multiple plans. Providers can apply for a NPI using one of the following methods:

- Visit *https://nppes.cms.hhs.gov* on the CMS website and complete the web-based application;
- Call (800) 465-3203 to request a paper application; or
- With the provider's permission, an Electronic File Interchange Organization can submit the application data.

For the most current information, including implementation dates, the CMS website has a dedicated web page on NPI for all health care providers. Visit *http://www.cms.hhs.gov/NationalProvIdentStand/* on the CMS website. This page also contains a section for Medicare Fee-For-Service (FFS) providers with helpful information on the Medicare NPI implementation.

ICD-9 NOTICE

The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is published by the United States Government. A CD-ROM, which may be purchased through the Government Printing Office, is the only official Federal government version of the ICD-9-CM. ICD-9-CM is an official Health Insurance Portability and Accountability Act standard.

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PREFACE

The *Medicare Guide to Rural Health Services Information* offers Medicare providers, suppliers, and physicians comprehensive rural health information and resources in a single source. It includes information that is applicable to specific rural providers as well as information that is applicable to all rural providers. The following rural health information is included in this publication:

- **Ambulance Services**
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  - How Payment Rates are Set
  - Ground Ambulance Services
  - Air Ambulance Services

- **Critical Access Hospital**
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  - Critical Access Hospital Designation
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  - Reasonable Cost Payment Principles That Do NOT Apply to Critical Access Hospitals
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    - Medicare Certification as a Rural Health Clinic
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AMBULANCE SERVICES

The Section 4531(b)(2) of the Balanced Budget Act of 1997 (Public Law 105-33), which added Section 1834(l) to the Social Security Act (the Act), mandated the establishment of a national Ambulance Fee Schedule (FS) for Medicare Part B ambulance services. The national Ambulance FS was phased in over a five-year transitional period beginning April 1, 2002.

Payment for ambulance services under the FS:

- Includes a base rate payment plus a separate payment for mileage;
- Covers both the transport of the beneficiary to the nearest appropriate facility and all medically necessary covered items and services associated with the transport (e.g., oxygen, drugs, extra attendants, and electrocardiogram testing); and
- Precludes a separate payment under the ambulance benefit for items and services furnished as part of the transport.

How Payment Rates Are Set

Effective January 1, 2006, the Ambulance FS was fully implemented. Each year, certain components of the Ambulance FS are updated by the Ambulance Inflation Factor (AIF), which is based on the percentage increase in the Consumer Price Index for All Urban Consumers (U.S. city average) for the 12-month period ending with June of the previous year. For calendar year 2008, the AIF is 2.7 percent.

Ground Ambulance Services

Section 414 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173), which added Section 1834(l)(10) to the Act, established that the ground ambulance base rate is subject to a floor amount using a blend of the national Ambulance FS and regional fee schedules. Under Section 1834(l)(10) of the Act and implementing regulations under the *Code of Federal Regulations (CFR)* at 42 CFR Section 414.617, the ground ambulance base rate for services furnished during the period July 1, 2004 through December 31, 2009 is subject to a floor amount, which is determined by establishing nine regional fee schedules for each of the nine census divisions using the same methodology as was used to establish the national Ambulance FS. If the regional FS methodology for a given census division results in an amount that is lower than or equal to the national ground base rate, the regional FS methodology is not used and the national FS amount will apply for all providers and suppliers in the census division. If the regional FS methodology for a given census division results in an amount that is greater than the national ground base rate, the FS base rate for that census division will be equal to a blend of the national rate and the regional rate. Effective January 1, 2008, the total payment amount for ground ambulance providers and suppliers is based on either 100 percent of the national Ambulance FS or a blend of 80 percent of the national Ambulance FS and 20 percent of the regional Ambulance FS,

whichever is greater. Payments for ground ambulance services under the Ambulance FS include the following elements:

- A nationally uniform base rate or conversion factor for all ground ambulance services;
- A relative value unit (RVU) assigned to each type of ground ambulance service. RVUs set a numeric value for ambulance services relative to the value of a base level ambulance service;
- A geographic adjustment factor (GAF) for each Ambulance FS locality area (practice expense portion of the geographic practice cost index [GPCI] as applied to a percentage of the base rate);
- A nationally uniform loaded mileage rate;
- An additional amount for certain mileage for a rural point-of-pickup (POP); and
- Certain additional payments for specified temporary periods.

Air Ambulance Services

As of January 1, 2006, the total payment amount for air ambulance providers and suppliers is based on 100 percent of the national Ambulance FS. Payments for air ambulance services under the Ambulance FS include the following elements:

- A nationally uniform base rate for fixed wing and a nationally uniform base rate for rotary wing;
- A GAF for each Ambulance FS locality area (practice expense portion of the GPCI as applied to a percentage of the base rate);
- A nationally uniform loaded mileage rate for each type of air service; and
- An adjustment to the base rate and mileage for services furnished for a rural POP.

To view the Ambulance FS, visit *http://www.cms.hhs.gov/AmbulanceFeeSchedule* on the CMS website. To find additional information about ambulance policies, see Chapter 15 of the Medicare Claims Processing Manual (Pub. 100-4) and Chapter 10 of the Medicare Benefit Policy Manual (Pub. 100-2) at *http://www.cms.hhs.gov/Manuals* and visit *http://www.cms.hhs.gov/center/ambulance.asp* on the CMS website. To access the *CFR*, visit *http://www.gpoaccess.gov/cfr/index.html* on the Web.

CRITICAL ACCESS HOSPITAL

Legislation enacted as part of the Balanced Budget Act (BBA) of 1997 authorized states to establish State Medicare Rural Hospital Flexibility Programs (Flex Program), under which certain facilities participating in Medicare can become Critical Access Hospitals (CAH). The following providers may be eligible to become CAHs:

- Currently participating Medicare hospitals;
- Hospitals that ceased operation during the 10 year period from November 29, 1989 through November 29, 1999; or
- Health clinics or centers (as defined by the State) that previously operated as a hospital before being downsized to a health clinic or center.

Unlike facilities such as Medicare Dependent Hospitals or Sole Community Hospitals, CAHs represent a separate provider type with their own Medicare Conditions of Participation as well as a separate payment method.

Critical Access Hospital Designation
A hospital must meet the following criteria to be designated a CAH:

- Be located in a state that has established a State Flex Program (as of December 2007, only Connecticut, Delaware, Maryland, New Jersey, and Rhode Island did not have such a program);
- Be located in a rural area or be treated as rural under a special provision that allows qualified hospital providers in urban areas to be treated as rural for purposes of becoming a CAH;
- Furnish 24-hour emergency care services, using either on-site or on-call staff;
- Provide no more than 25 inpatient acute care beds; however, a CAH may also operate a distinct part rehabilitation or psychiatric unit, each with up to 10 beds;
- Have an average annual length of stay of 96 hours or less; and
- Be located either more than 35 miles from the nearest hospital or CAH or more than 15 miles in areas with mountainous terrain or only secondary roads OR be State certified as of December 31, 2005 as a “necessary provider” of health care services to residents in the area.

Critical Access Hospital Payments
Medicare pays CAHs for most inpatient and outpatient services to Medicare beneficiaries on the basis of 101 percent of their allowable and reasonable costs. Under the Medicare ambulance benefit, if CAHs own and operate the only ambulance service within 35 miles, they are also paid based on a reasonable cost basis for ambulance services. CAHs are not subject to the Inpatient Prospective Payment System (IPPS) and Hospital Outpatient Prospective Payment System (OPPS).

The Medicare Part A and Part B deductible and coinsurance rules applicable to hospital services also apply to CAHs. All outpatient CAH services are subject to Part B deductible and coinsurance except as follows:

- The beneficiary pays no Part B deductible or coinsurance for the following services:
    - Current Procedural Terminology (CPT®) codes 90669 and 90732 – Pneumococcal vaccines;
    - Healthcare Common Procedure Coding System (HCPCS) code G0009 – Related administration of the pneumococcal vaccines;
    - CPT codes 90655, 90656, 90657, 90658, and 90660 – Influenza vaccines;
    - HCPCS code G0008 – Related administration of the influenza vaccine;
    - CPT codes 77052 and 77057 and HCPCS code G0202 – Screening mammography;
    - All codes for clinical diagnostic laboratory tests;
    - CPT code 82270 – Fecal occult blood test; and
    - HCPCS code G0328 – Fecal occult blood test (alternative to CPT code 82270).
- The beneficiary pays no Part B deductible and is responsible for paying the coinsurance for the following colorectal cancer screening services:
    - HCPCS code G0104 – Flexible sigmoidoscopy;
    - HCPCS code G0105 – Colonoscopy (high risk);
    - HCPCS code G0106 – Barium enema (alternative to HCPCS code G0104);
    - HCPCS code G0120 – Barium enema (alternative to HCPCS code G0105); and
    - HCPCS code G0121 – Colonoscopy (not high risk).

Reasonable Cost Payment Principles That Do NOT Apply to Critical Access Hospitals

Payment for inpatient or outpatient CAH services is NOT subject to the following reasonable cost principles:

- Lesser of cost or charges; and
- Reasonable compensation equivalent limits.

In addition, payment to a CAH for inpatient CAH services is not subject to ceilings on hospital inpatient operating costs or the 1-day or 3-day preadmission payment window provisions applicable to hospitals paid under the IPPS and OPPS.

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Election of Standard Payment Method or Optional (Elective) Payment Method

Standard Payment Method – Cost-Based Facility Services, With Billing of Carrier or A/B Medicare Administrative Contractor for Professional Services
Under Section 1834(g) of the Social Security Act (the Act), CAHs are paid under the Standard Payment Method unless they timely elect in writing to be paid under the Optional (Elective) Payment Method. For cost reporting periods beginning on or after January 1, 2004, outpatient CAH services payments have been increased to the lesser of:

- 80 percent of the 101 percent of reasonable costs for outpatient CAH services; or
- 101 percent of the reasonable cost of the CAH in furnishing outpatient CAH services less the applicable Part B deductible and coinsurance amounts.

Payment for professional medical services furnished in a CAH to registered CAH outpatients is made by the Medicare Carrier or A/B Medicare Administrative Contractor (MAC) under the Medicare Physician Fee Schedule (MPFS), as is the case when such professional services are furnished in a hospital outpatient department. For purposes of CAH payment, professional medical services are defined as services furnished by a physician or other qualified practitioner.

Optional (Elective) Payment Method – Cost-Based Facility Services Plus 115 Percent Fee Schedule Payment for Professional Services (Method 2)
Under Section 1834(g) of the Act, a CAH may elect the Optional (Elective) Payment Method, under which it bills the Medicare Fiscal Intermediary (FI) or A/B MAC for both facility services and professional services to its outpatients. However, even if a CAH makes this election, each practitioner furnishing professional services to CAH outpatients can choose whether to:

- Reassign his or her billing rights to the CAH, agree to be included under the Optional (Elective) Payment Method, attest in writing that he or she will not bill the Carrier or A/B MAC for professional services furnished in the CAH outpatient department, and look to the CAH for payment for the professional services; or
- File claims for his or her professional services with the Carrier or A/B MAC for standard payment under the MPFS (i.e., either by billing directly to the Carrier or A/B MAC or by authorizing the CAH to bill on his or her behalf via a valid reassignment of benefits).

If a physician or other practitioner reassigns his or her Part B billing rights and agrees to be included under a CAH's Optional (Elective) Payment Method, he or she must not bill the Carrier or A/B MAC for any outpatient professional services furnished at the CAH once the reassignment becomes effective. For each physician or practitioner who agrees to be included under the Optional (Elective) Payment method and reassigns benefits accordingly, the CAH must forward a copy of the completed assignment form (Form CMS 855R) to the FI and Carrier or A/B MAC and keep the original on file. Each practitioner must sign an attestation which clearly states that he or she will not bill the Carrier or A/B MAC for any services furnished in the CAH outpatient department once the reassignment has been given to the CAH. This attestation will remain at the CAH.

The Optional (Elective) Payment Method remains in effect for the entire cost reporting period and applies to all CAH professional services furnished in the CAH outpatient department by physicians and practitioners who have agreed to be included under the Optional (Elective) Payment Method, completed a Form CMS 855R, and attested in writing that they will not bill the Carrier or A/ B MAC for their outpatient professional services. An Optional (Elective) Payment Method election and each practitioner's agreement to be included under the election must be renewed yearly based on the cost reporting year. Form CMS 855R can be found at *http://ww.cms.hhs.gov/CMSForms/CMSForms/list.asp* on the CMS website.

As of January 1, 2004, payment for outpatient CAH services under the Optional (Elective) Method is based on the sum of:

- For facility services, the lesser of 80 percent of 101 percent of the reasonable cost of the CAH in furnishing CAH services OR 101 percent of the outpatient CAH services less applicable Part B deductible and coinsurance amounts; and
- For physician professional services, 115 percent of the allowable amount, after applicable deductions, under the MPFS. Payment for nonphysician practitioner professional services is 115 percent of the amount that otherwise would be paid for the practitioner's professional services under the MPFS.

To elect the Optional (Elective) Payment Method or to change a previous election, a CAH should notify the FI or A/B MAC at least 30 days before the start of the affected cost reporting period.

Effective January 1, 2007, the payment amount is 80 percent of the MPFS for telehealth services when the distant site physician or other practitioner is located in a CAH that has elected the Optional (Elective) Payment Method and the physician or practitioner has reassigned his or her benefits to the CAH.

Medicare Rural Pass-Through Funding for Certain Anesthesia Services

CAHs may participate in the Medicare Rural Pass-Through Program to secure reasonable cost-based funding for certain anesthesia services as an incentive to continue to serve the Medicare population in rural areas. The *Code of Federal Regulations (CFR)* under 42 CFR Section 412.113 lists the specific requirements hospitals or CAHs must fulfill to receive rural pass-through funding from Medicare for anesthesia services furnished by Certified Registered Nurse Anesthetists (CRNA) that they employ or contract with to furnish such services to CAH patients. CAHs that qualify for a CRNA pass-through exemption receive reasonable cost for CRNA professional services, regardless of whether they choose the Standard Payment Method or the Optional (Elective) Payment Method for outpatient services, unless they opt to receive payment for outpatient anesthesia as a professional service. In that case, the anesthesia is paid on the anesthesia fee schedule and the CAH gives up the CRNA pass-through exemption for both outpatient and inpatient services.

Health Professional Shortage Area Incentive Payments

Physicians (including psychiatrists) who furnish care in a CAH that is located within a geographic-based, primary medical care Health Professional Shortage Area (HPSA) and psychiatrists who furnish care in a CAH that is located in a geographic-based mental health HPSA are eligible for a 10 percent HPSA incentive payment for outpatient professional services furnished to a Medicare beneficiary. If the physician has reassigned his or her billing rights and the CAH has elected the Optional (Elective) Payment Method, the CAH will receive 115 percent of the otherwise applicable MPFS amount multiplied by 110 percent, based on all claims processed during the quarter. If the service is furnished in an area that is on the Centers for Medicare & Medicaid Services (CMS) list of Zip codes that are eligible for the HPSA incentive payment, payments are automatically paid on a quarterly basis. An area may be eligible for the HPSA incentive payment but the Zip code may not be on the list because:

1) It does not fall within a designated full county HPSA;
2) It is not considered to fall within the county based on a determination of dominance made by the U.S. Postal Service; or
3) It is partially in a sub-county HPSA.

In these situations, the CAH must utilize an AQ modifier to receive payment.

Physician Scarcity Area Bonus Payments

Primary care physicians who furnish outpatient professional services to a Medicare beneficiary in an area that has been identified as a primary care Physician Scarcity Area (PSA) and specialty physicians who furnish outpatient professional services to a Medicare beneficiary in an area that has been identified as a specialty care PSA are eligible for a PSA bonus payment of five percent. If the physician has reassigned his or her billing rights and the CAH has elected the Optional (Elective) Payment Method, the CAH will receive 115 percent of the otherwise applicable MPFS amount multiplied by 105 percent, based on all claims processed during the quarter. If the service is furnished in an area that is on the CMS list of Zip codes that are eligible for the PSA bonus payment, payments are automatically paid on a quarterly basis. If the Zip code is not on the list but the area is in a county identified as a PSA, the AR modifier must be used. If the CAH is located in an area that is both an eligible HPSA and an eligible PSA and the Optional (Elective) Payment Method is elected, payment to the CAH for a physician’s outpatient professional service will be 115 percent of the otherwise applicable MPFS amount multiplied by 115 percent.

Additional Medicare Prescription Drug, Improvement, and Modernization Act of 2003 Provisions That Impact Critical Access Hospitals

For services furnished on or after January 1, 2005, Section 405(b) extends reasonable cost reimbursement for CAH costs of compensating physician assistants, nurse practitioners, and clinical nurse specialists who are on call to furnish emergency services.

Section 405(c) states that periodic interim payments will be paid every two weeks for CAH inpatient services furnished on or after July 1, 2004 for CAHs that apply and qualify for the periodic interim payment method.

Section 405(d) mandates that for cost reporting periods beginning on and after July 1, 2004, each physician or other practitioner furnishing professional services in the CAH is not required to reassign his or her Part B benefits to the CAH in order for the CAH to elect the Optional (Elective) Payment Method. For CAHs that elected the Optional (Elective) Payment Method before November 1, 2003 for a cost reporting period that began on or after July 1, 2001, the effective date of the rule is retroactive to July 1, 2001. For CAHs that elected the Optional (Elective) Payment Method on or after November 1, 2003, the effective date of the rule is July 1, 2004.

Under Section 405(e), beginning on January 1, 2004, CAHs may operate up to 25 beds for acute (hospital-level) inpatient care, subject to the 96-hour average length of stay for acute care patients. For CAHs with swing bed agreements, any of its beds may be used to furnish either inpatient acute care or Skilled Nursing Facility level swing bed services. Prior to January 1, 2004, CAHs could not operate more than 15 acute care beds or if they had a swing bed agreement, 25 beds.

Section 405(g) states that for cost reporting periods beginning on or after October 1, 2004, CAHs may establish psychiatric units and/or rehabilitation units that are CAH distinct part units (DPU). The total number of beds in each CAH DPU may not exceed 10. These beds will not count against the CAH inpatient bed limit of 25. Psychiatric and rehabilitation DPUs must meet the applicable requirements for such beds in short-term general acute care hospitals, and Medicare payments will equal payments that would be made to general short-term acute care hospitals for these services (i.e., payments that are made under the Inpatient Psychiatric Facility Prospective Payment System or the Inpatient Rehabilitation Facility Prospective Payment System). Therefore, payment for services in DPUs of CAHs is not made on a reasonable costs basis.

Section 405(h) mandates that effective January 1, 2006, the provision permitting a state to waive the distance requirements for CAH status via State “necessary provider” designation has sunset (ended). Providers that gained CAH status via “necessary provider” designations prior to January 1, 2006 may generally continue as CAHs on and after January 1, 2006.

Grants to States Under the Medicare Rural Hospital Flexibility Program

The Flex Program, which was authorized by Section 4201 of the BBA (Public Law 105-33), consists of two separate but complementary components:

- A Medicare reimbursement program that provides reasonable cost reimbursement for Medicare-certified CAHs, which is administered by CMS; and
- A State grant program that supports the development of community-based rural organized systems of care in participating states, which is administered by the Health Resources and Services Administration through the Federal Office of Rural Health Policy.

To receive funds under the grant program, states must apply for the funds and engage in rural health planning through the development and maintenance of a State Rural Health Plan that:

- Designates and supports the conversions to CAHs;
- Promotes emergency medical services (EMS) integration initiatives by linking local EMS with CAHs and their network partners;
- Develops rural health networks to assist and support CAHs;
- Develops and supports quality improvement initiatives; and
- Evaluates State programs within the framework of national program goals.

To find additional information about State grants under the Flex Program, visit *http://www.ruralhealth.hrsa.gov* or call (301) 443-0835. To find additional information about CAHs and the Flex Program, visit *http://www.cms.hhs.gov/center/cah.asp* and see Chapter 3 of the Medicare Claims Processing Manual (Pub. 100-4) at *http://www.cms.hhs.gov/Manuals* on the CMS website. To find information about HPSA and PSA payments, including eligible Zip codes, visit *http://www.cms.hhs.gov/hpsapsaphysicianbonuses/01_overview.asp* on the CMS website. To access the *CFR*, visit *http://www.gpoaccess.gov/cfr/index.html* on the Web. See the Swing Bed Section of this guide for additional information about swing beds. To find additional information about telehealth services, see the Telehealth Section of this guide.

FEDERALLY QUALIFIED HEALTH CENTER

The Federally Qualified Health Center (FQHC) benefit under Medicare was added effective October 1, 1991 when Section 1861(aa) of the Social Security Act (the Act) was amended by Section 4161 of the Omnibus Budget Reconciliation Act of 1990. FQHCs are “safety net” providers such as community health centers, public housing centers, outpatient health programs funded by the Indian Health Service, and programs serving migrants and the homeless. The main purpose of the FQHC Program is to enhance the provision of primary care services in underserved urban and rural communities.

Federally Qualified Health Center Designation

An entity may qualify as an FQHC if it:

- Is receiving a grant under Section 330 of the Public Health Service (PHS) Act;
- Is receiving funding from such grant under a contract with the recipient of a grant and meets the requirements to receive a grant under Section 330 of the PHS Act;
- Is not receiving a grant under Section 330 of the PHS Act but determined by the Secretary of the Department of Health and Human Services (HHS) to meet the requirements for receiving such a grant (i.e., qualifies as a FQHC look-alike) based on the recommendation of the Health Resources and Services Administration;
- Was treated by the Secretary of the Department of HHS for purposes of Medicare Part B as a comprehensive Federally funded health center as of January 1, 1990; or
- Is operating as an outpatient health program or facility of a tribe or tribal organization under the Indian Self-Determination Act or as an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1, 1991.

Covered Federally Qualified Health Center Services

Payments are made directly to the FQHC for covered services furnished to Medicare beneficiaries. Services are covered when furnished to a beneficiary at the FQHC, the beneficiary’s place of residence, or elsewhere (e.g., at the scene of an accident). A FQHC generally furnishes the following services:

- Physician services;
- Services and supplies incident to the services of physicians;
- Nurse practitioner (NP), physician assistant (PA), certified nurse midwife (CNM), clinical psychologist (CP), and clinical social worker (CSW) services;
- Services and supplies incident to the services of NPs, PAs, CNMs, CPs, and CSWs;
- Visiting nurse services to the homebound in an area where the Centers for Medicare & Medicaid Services (CMS) has determined that there is a shortage of Home Health Agencies;

- Otherwise covered drugs that are furnished by, and incident to, services of physicians and nonphysician practitioners of the FQHC; and
- Outpatient diabetes self-management training and medical nutrition therapy for beneficiaries with diabetes or renal disease (effective for services furnished on or after January 1, 2006).

FQHCs also furnish preventive primary health services when furnished by or under the direct supervision of a physician, NP, PA, CNM, CP, or CSW. The following preventive primary health services are covered when furnished by FQHCs to Medicare beneficiaries:

- Medical social services;
- Nutritional assessment and referral;
- Preventive health education;
- Children's eye and ear examinations;
- Well child care including periodic screening;
- Immunizations including tetanus-diphtheria booster and influenza vaccine;
- Voluntary family planning services;
- Taking patient history;
- Blood pressure measurement;
- Weight measurement;
- Physical examination targeted to risk;
- Visual acuity screening;
- Hearing screening;
- Cholesterol screening;
- Stool testing for occult blood;
- Tuberculosis testing for high risk beneficiaries;
- Dipstick urinalysis; and
- Risk assessment and initial counseling regarding risks.

For women only:

- Prenatal and post-partum care;
- Prenatal services;
- Clinical breast examination;
- Referral for mammography; and
- Thyroid function test.

Federally Qualified Health Center Preventive Primary Services That Are NOT Covered

FQHC preventive primary services that are NOT covered include:

- Group or mass information programs, health education classes, or group education activities including media productions and publications; and
- Eyeglasses, hearing aids, and preventive dental services.

Items or services that are covered under Part B, but are NOT FQHC services include:

- Certain laboratory services;
- Durable medical equipment, whether rented or sold, including crutches, hospital beds, and wheelchairs used in the beneficiary's place of residence;
- Ambulance services;
- The technical component of diagnostic tests such as x-rays and electrocardiograms;
- The technical component of the following preventive services:
    - Screening pap smears;
    - Prostate cancer screening;
    - Colorectal cancer screening tests;
    - Screening mammography; and
    - Bone mass measurements;
- Prosthetic devices that replace all or part of an internal body organ including colostomy bags, supplies directly related to colostomy care, and the replacement of such devices; and
- Leg, arm, back, and neck braces and artificial legs, arms, and eyes including replacements (if required because of a change in the beneficiary's physical condition).

Federally Qualified Health Center Payments

Generally, Medicare pays FQHCs (which are considered suppliers of Medicare services) an all-inclusive per visit payment amount based on reasonable costs as reported on its annual cost report. The beneficiary pays no Part B deductible and is responsible for paying the coinsurance for FQHC services, with the exception of FQHC-supplied influenza and pneumococcal vaccines, which are at paid at 100 percent. Psychological or psychiatric therapeutic services (generally furnished by CPs and CSWs) are subject to the 62.5 percent outpatient mental health treatment limitation. This limit does not apply to diagnostic services. The application of the outpatient mental health treatment limitation increases the beneficiary's copayment to 50 percent of the all-inclusive encounter rate.

The FQHC all-inclusive visit rate is calculated, in general, by dividing the FQHC's total allowable cost by the total number of visits for all FQHC patients. The FQHC payment methodology includes two national per-visit upper payment limits – one for urban FQHCs and one for rural FQHCs. The two national FQHC per-visit upper payment limits are increased annually by the Medicare Economic Index applicable to primary care physician services. A FQHC is designated as an urban or rural entity based on definitions in Section 1886(d)(2)(D) of the Act. If a FQHC is not located within a Metropolitan Statistical Area (now generally known as a Core Based Statistical Area) or New England County Metropolitan Area, it is considered rural and the rural limit applies. Rural FQHCs cannot be reclassified into an urban area for FQHC payment limit purposes.

Freestanding FQHCs must complete Form CMS-222-92, Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report, in order to identify all incurred costs applicable to furnishing covered FQHC services. Form CMS-222-92 can be found in the Provider Reimbursement Manual – Part 2 (Pub. 15-2), Chapter 29, located at http://www.cms.hhs.gov/Manuals/PBM/list.asp on the CMS website.

Provider-based FQHCs must complete the appropriate worksheet designated for FQHC services within the parent provider's cost report. For example, FQHCs based in a hospital complete Worksheet M of Form CMS-2552-96, Hospital and Hospital Complex Cost Report. At the beginning of the FQHC's fiscal year, the Fiscal Intermediary or A/B Medicare Administrative Contractor calculates an interim all-inclusive visit rate based on either estimated allowable costs and visits from the FQHC (if it is new to the FQHC Program) or on actual costs and visits from the previous cost reporting period (for existing FQHCs). The FQHC's interim all-inclusive visit rate is reconciled to actual reasonable costs at the end of the cost reporting period. Form CMS-2552-96 can be found in the Provider Reimbursement Manual – Part 2 (Pub. 15-2), Chapter 36, located at http://www.cms.hhs.gov/Manuals/PBM/list.asp on the CMS website.

Influenza and Pneumococcal Vaccines Administration and Payment
The cost of the influenza and pneumococcal vaccines and related administration are separately reimbursed at annual cost settlement. There is a separate worksheet on the cost report to report the cost of these vaccines and related administration. These costs should not be reported on a FQHC claim when billing for FQHC services. The beneficiary pays no Part B deductible or coinsurance for these services. When a FQHC practitioner (e.g., a physician, NP, PA, or CNM) sees a beneficiary for the sole purpose of administering these vaccinations, the FQHC may not bill for a visit; however, the associated costs are included on the annual cost report and reimbursed at cost settlement.

Hepatitis B Vaccine Administration and Payment
The cost of the Hepatitis B vaccine and related administration are covered under the FQHC's all-inclusive rate. If other services that constitute a qualifying FQHC visit are furnished at the same time as the Hepatitis B vaccination, the charges for the vaccine and related administration can be included in the charges for the visit when billing and in calculating the coinsurance. When a FQHC practitioner (e.g., a physician, NP, PA, or CNM) sees a beneficiary for the sole purpose of administering a Hepatitis B vaccination, the FQHC may not bill for a visit; however, the associated costs are included on the annual cost report and reimbursed at cost settlement. Charges for the Hepatitis B vaccine may be included on a claim for the beneficiary's subsequent FQHC visit and used in calculating the coinsurance.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 Provisions That Impact Federally Qualified Health Centers
Section 410 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 states that professional services furnished on or after January 1, 2005 by

physicians, NPs, PAs, and CPs who are affiliated with FQHCs are excluded from the Skilled Nursing Facility Prospective Payment System, in the same manner as such services would be excluded if furnished by individuals not affiliated with FQHCs.

To find additional information about FQHCs, see Chapter 9 of the Medicare Claims Processing Manual (Pub. 100-4) and Chapter 13 of the Medicare Benefit Policy Manual (Pub. 100-2) at *http://www.cms.hhs.gov/Manuals* and visit *http://www.cms.hhs.gov/center/fqhc.asp* on the CMS website.

HEALTH PROFESSIONAL SHORTAGE AREA INCENTIVE PAYMENT

The Omnibus Budget Reconciliation Act of 1987 established Medicare's Incentive Payment Program, which encouraged primary care physicians to work in underserved rural areas and to improve access to care for Medicare beneficiaries and paid primary care physicians an incentive payment of five percent for services furnished to Medicare beneficiaries in Federally-designated Health Professional Shortage Areas (HPSA). In 1991, Congress increased the incentive payment to 10 percent and expanded eligibility to include physician's services in both rural and urban HPSAs.

Under Section 1833(m) of the Social Security Act, physicians (including psychiatrists) who furnish care in an area that is designated as a geographic-based, primary medical care HPSA and psychiatrists who furnish care in an area that is designated as a geographic-based mental health HPSA are eligible for a 10 percent HPSA incentive payment for outpatient professional services furnished to a Medicare beneficiary. The HPSA incentive payment is available only for the physician's professional services. If a service is billed with both a professional and a technical component, only the professional component will receive the incentive payment.

If the service is furnished in an area that is on the Centers for Medicare & Medicaid Services (CMS) list of Zip codes that are eligible for the HPSA incentive payment, payments are automatically paid on a quarterly basis. The list of eligible Zip codes is updated annually and is effective for services on or after January 1 of each calendar year. An area may be eligible for the HPSA incentive payment but the Zip code may not be on the list because:

1) It does not fall within a designated full county HPSA;
2) It is not considered to fall within the county based on a determination of dominance made by the U.S. Postal Service; or
3) It is partially in a sub-county HPSA.

In these situations, the physician must utilize an AQ modifier to receive payment for claims with dates of service on or after January 1, 2006. If the Zip code of the place of service is not on the HPSA list for automated payment, eligibility must be verified with the Fiscal Intermediary or A/B Medicare Administrative Contractor before submitting a claim with the AQ modifier.

If a physician provides services in an area that is both an eligible HPSA and an eligible Physician Scarcity Area (PSA), he or she will receive a 15 percent bonus payment on a quarterly basis. The bonus payment is based on the paid amount of the claim.

Additional information about HPSA and PSA payments can be found in Chapter 12 of the Medicare Claims Processing Manual (Pub. 100-4) at
http://www.cms.hhs.gov/Manuals, and the list of eligible Zip codes can be found at
http://www.cms.hhs.gov/hpsapsaphysicianbonuses/01_overview.asp on the CMS

website. To determine if an area is in a qualified HPSA, visit *http://www.hpsafind.hrsa.gov* and select the advanced search option. To determine the census tract of the place of service, visit *http://www.ffiec.gov/Geocode/default.aspx* and enter the address. To find additional information about PSA bonus payments, see the Physician Scarcity Area Bonus Payment Section of this guide.

HOME HEALTH

Under the Home Health Prospective Payment System (HH PPS) consolidated billing requirement, Home Health Agencies (HHA) must bill for all of the following:

- Skilled nursing services;
- Physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services;
- Routine and non-routine medical supplies;
- HH aide services; and
- Medical social services.

Durable medical equipment (DME) is excluded from the consolidated billing requirement and is paid on the fee schedule outside the HH PPS rate. Effective July 1, 2008, HHAs that furnish DME and are located in an area where DME items are subject to a competitive bidding program must either:

- Be awarded a contract to furnish the competitively bid items in this area; or
- Use a contract supplier in the community to furnish these items.

HHA claims for competitively bid DME should be submitted to DME Medicare Administrative Contractors. Claims that are not subject to competitive bidding should be submitted to Regional Home Health Intermediaries (RHHI).

Coverage of Home Health Services

Medicare covers HH services when the following criteria are met:

- The beneficiary to whom the services are furnished is an eligible Medicare beneficiary who is not enrolled in a Medicare Advantage Plan;
- The HHA that furnishes the services has in effect a valid agreement to participate in the Medicare Program;
- The beneficiary qualifies for coverage of HH services;
- The services are a covered Medicare benefit;
- Medicare is the appropriate payer; and
- The services are not otherwise excluded from payment.

To qualify for the Medicare HH benefit, a beneficiary must:

- Be confined to the home;
- Be under the care of a physician;
- Be receiving services under a plan of care established and periodically reviewed by a physician; and
- Be in need of skilled nursing care on an intermittent basis (furnished or needed on fewer than 7 days each week or less than 8 hours of each day for periods of 21 days or less, with extensions in exceptional circumstances when the need for additional care is finite and predictable), be in need of PT or SLP services, or have a continuing need for OT services.

A beneficiary’s residence is wherever he or she makes his or her home (e.g., own dwelling, apartment, relative’s home, home for the aged, or other type of institution). Hospitals, Skilled Nursing Facilities, and most nursing facilities under the Medicaid

Program are not considered a beneficiary's residence under the HH benefit if they meet the requirements under Sections 1861(e)(1) or 1819 (a)(1) of the Social Security Act.

For a beneficiary to be considered confined to the home, leaving home requires a considerable and taxing effort. The beneficiary may be considered homebound if absences from the home are infrequent, for periods of relatively short duration, or for the need to receive health care treatment. In general, a beneficiary is considered homebound if leaving home is medically contraindicated or he or she has a condition due to an illness or injury that restricts the ability to leave the place of residence except with the aid or assistance of:

- A supportive device (e.g., crutches, cane, wheelchair, or walker);
- Special transportation; or
- Another person.

Elements of the Home Health Prospective Payment System

The elements of the HH PPS include the following:

- Payment for the 60-day episode – The unit of payment under the HH PPS is a 60-day episode of care. The HHA receives approximately half of the estimated base payment for the full 60 days when the RHHI receives the request for anticipated payment and the residual half at the close of the 60-day episode unless there is an applicable adjustment to that amount. The adjusted base payment is based on the beneficiary's condition and care needs or case-mix assignment. Another 60-day episode can be initiated for longer-stay beneficiaries.
- Case-mix adjustment – After a physician prescribes a HH plan of care, the HHA uses the Outcome and Assessment Information Set (OASIS) to assess the beneficiary's condition and the likely skilled nursing care, therapy, medical social services, and HH aide services that will be needed at the beginning of the episode of care. OASIS items that describe the beneficiary's condition and his or her PT, OT, and SLP services needs are used to determine the case-mix adjustment to the standard payment rate. Currently, one hundred and fifty-three case-mix groups called Home Health Resource Groups (HHRG) as measured by the OASIS are available for classification. The assessment must be completed for each subsequent episode of care a beneficiary receives.
- Outlier payment – An additional payment is made to the 60-day case-mix adjusted episode payment for beneficiaries who incur unusually large costs. The outlier cost is imputed for each episode by applying standard per-visit amounts to the number of visits by discipline (skilled nursing visits; PT, OT, and SLP services; or HH aide services) reported on claims. The outlier payment is determined by subtracting the sum of the case-mix and wage adjusted amount and the outlier threshold amount from the imputed cost, of which eighty percent (the loss-sharing ratio) is paid to the HHA as the outlier payment. Annual total national outlier payments for HH services may not be more than five percent of the estimated total HH PPS payments.
- Adjustment for four or fewer visits – A low-utilization payment adjustment (LUPA) is made for beneficiaries who require four or fewer visits during the

60-day episode. These episodes are paid the labor adjusted, standardized, service-specific per-visit amount multiplied by the number of visits actually furnished during the episode. Beginning in calendar year (CY) 2008, for LUPA episodes that occur as the only episode or the first episode in a sequence of adjacent episodes for a given beneficiary, there is an increase in payment of $87.93 to account for the front-loading of assessment costs and administrative costs.

- Adjustment for change in condition – Currently, when a beneficiary experiences significant change in condition (SCIC) during the 60-day episode that was not envisioned in the original physician's plan of care and case-mix adjustment, a SCIC adjustment can occur, which requires the determination of a new payment amount. Beginning on January 1, 2008, the SCIC adjustment policy will be eliminated based on comments from the public and continued analysis of the policy.
- Adjustment for transfer to another HHA – A partial episode payment (PEP) adjustment is made when a beneficiary elects to transfer to another HHA or is discharged and readmitted to the same HHA during the 60-day episode. The PEP adjustment is determined by proportionally adjusting the original 60-day episode payment to reflect the length of time the beneficiary remained under the HHA's care before the intervening event. The new episode is paid an initial episode payment of one half of the new HHRG. A new plan of care and assessment is required when a new 60-day episode begins.

During the period January 1, 2008 through December 31, 2008, the Centers for Medicare & Medicaid Services (CMS) will pay for the delivery of HH services based on whether or not HHAs have submitted the OASIS quality data required by the statute during the time period after July 1, 2006 and before July 1, 2007 (the reporting requirement for CY 2008 payment). HHAs that submit quality data will be paid CY 2008 HH PPS rates based on the full HH market basket update of 3.0 percent. HHAs that do not submit quality data will be paid based on a 1.0 percent market basket update.

To find additional HH information, see Chapter 7 of the Medicare Benefit Policy Manual (Pub. 100-2) at *http://www.cms.hhs.gov/Manuals* and visit *http://www.cms.hhs.gov/HomeHealthPPS* and *http://www.cms.hhs.gov/center/hha.asp* on the CMS website.

HOSPICE

Hospice care is an elected benefit covered under Medicare Part A for a beneficiary who meets all the following conditions:

- The individual is eligible for Part A;
- The individual is certified as having a terminal illness with a prognosis of six months or less if the illness runs its normal course;
- The individual receives care from a Medicare-approved hospice program; and
- The individual signs a statement indicating that he or she elects the hospice benefit and waives all other rights to Medicare payments for services for the terminal illness and related conditions. In addition to covered hospice services, Medicare will continue to pay for covered benefits that are not related to the terminal illness.

Hospice is not a basic benefit under the Medicare Advantage (MA) Program and MA Plans are not required to provide a hospice benefit. Enrollees in MA Plans receive the hospice benefit under Original Medicare. Upon enrollment, and annually thereafter, MA Plans must inform enrollees of the availability of the Medicare hospice option and any approved hospices in the MA plan's service area including those that the MA organization owns, controls, or in which it has a financial interest.

Hospice Services

Medicare may provide the following hospice services for the terminal illness and related conditions:

- Doctor services;
- Nursing care;
- Medical equipment;
- Medical supplies;
- Drugs for symptom control and pain relief;
- Home health aide and homemaker services;
- Physical therapy;
- Occupational therapy;
- Speech-language pathology services;
- Social worker services;
- Dietary counseling;
- Spiritual counseling;
- Grief and loss counseling for the individual and his or her family;
- Short-term inpatient care for pain control and symptom management and for respite care; and
- Any other services as identified by the hospice interdisciplinary group.

Hospice care is available for 2 periods of 90 days and an unlimited number of subsequent 60-day periods.

Medicare will NOT pay for the following services when hospice care is chosen:

- Hospice care furnished by a hospice other than the hospice designated by the individual (unless furnished under arrangement by the designated hospice); and
- Any Medicare services that are related to treatment of the terminal illness or a related condition for which hospice care was elected or that are equivalent to hospice care, with the exception of the following:
    - Care furnished by the designated hospice;
    - Care furnished by another hospice under arrangements made by the designated hospice; or
    - Care furnished by the individual's attending physician who is not an employee of the designated hospice or receiving compensation from the hospice for those services.

Certification Requirements

For the first 90-day period of hospice coverage, the hospice must obtain a certification of the terminal illness by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician (if he or she has an attending physician) no later than two calendar days after hospice care is initiated. Only a medical doctor or a doctor of osteopathy can certify or recertify a terminal illness. An attending physician is a doctor of medicine or osteopathy or a nurse practitioner (NP) who is identified by the beneficiary, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of his or her medical care. However, a NP may not certify the terminal illness pursuant to Section 1814(a)(7)(A)(i)(I) of the Social Security Act.

Written certification must be on file in the beneficiary's clinical record prior to submission of a claim to the Fiscal Intermediary or A/B Medicare Administrative Contractor and must include:

- A statement that the individual is certified as having a terminal illness with a prognosis of six months or less if the terminal illness runs its normal course;
- Specific clinical findings and other documentation that support a life expectancy of six months or less; and
- Signature(s) of the physician(s).

How Payment Rates Are Set

Medicare pays hospice agencies a daily rate for each day a beneficiary is enrolled in the hospice benefit. The daily payments are made regardless of the amount of services furnished on a given day and are intended to cover costs that the hospice incurs in furnishing services identified in the beneficiary's plan of care. Payments are made based on the level of care required:

- Routine home care;
- Continuous home care;
- Inpatient respite care; and
- General inpatient care.

The daily hospice payment rates are adjusted to account for differences in wage rates among markets. Each category of care's base rate has a labor share and a nonlabor share. The labor share of the base payment amount is adjusted by the hospice wage index. Base rates are updated annually based on the hospital market basket index.

There are two caps that apply to the hospice benefit:

1) The number of days of inpatient care the hospice may furnish is limited to not more than 20 percent of total patient care days; and
2) An aggregate payment amount that a Medicare hospice provider may receive.

The hospice aggregate cap is adjusted annually by the medical expenditure category of the Consumer Price Index for all Urban Consumers. For the cap year ending October 31, 2007, the cap is $21,410.04.

For claims with dates of service on or after January 1, 2008, hospices must report on claims the Core Based Statistical Area for the location where services are furnished for all levels of hospice care.

To find additional information about the hospice benefit, visit *http://www.cms.hhs.gov/center/hospice.asp* on the Centers for Medicare & Medicaid Services website. This web page also contains a link to hospice program transmittals and hospice manual information (Chapter 9 of the Medicare Benefit Policy Manual, Pub. 100-2, and Chapter 11 of the Medicare Claims Processing Manual, Pub. 100-4).

MEDICARE ADVANTAGE (PART C)

Medicare Advantage (MA) (Medicare Part C) is a program through which organizations that contract with the Centers for Medicare & Medicaid Services (CMS) furnish or arrange for the provision of health care services to Medicare beneficiaries who:

- Are entitled to Medicare Part A and enrolled in Part B;
- Permanently reside in the service area of the MA Plan; and
- Elect to enroll in a MA Plan.

Individuals with End-Stage Renal Disease are generally excluded from enrolling in MA Plans.

New Options for Beneficiaries

Since 2006, beneficiaries have been able to enroll in regional Preferred Provider Organization (PPO) Plans throughout the U.S., providing another option in some rural areas. In addition, in many rural areas, beneficiaries are able to choose options such as Private Fee-for-Service Plans (PFFS), Health Maintenance Organizations (HMO), local PPOs (currently the most popular type of employer-sponsored plan), and Medicare Medical Savings Account (MSA) Plans (combines a high-deductible health plan with a MSA). Under these options, the MA Program has created new opportunities for rural providers who may choose to:

- Enter into contracts with MA organizations to furnish health care services to MA enrollees. In general, the provisions of these contracts, including payment rates, are matters that MA organizations and providers will negotiate.
- Elect to furnish services to MA PPO enrollees on a non-contract basis. In general, when providers furnish medically necessary covered services to MA enrollees on a non-contract basis, the plan pays providers what they would have been paid had they furnished services to Original Medicare Plan enrollees. With the exception of emergency services, certain urgently needed services, and out of area End-Stage Renal Disease services, for services to be covered for a beneficiary enrolled in a MA HMO Plan, non-contract services must be pre-authorized by the MA HMO Plan if it does not offer a Point of Service Option. Regional and local PPO Plan enrollees, in contrast, may directly access non-contracting providers without a referral, although higher cost sharing will generally apply.
- Providers who elect to furnish services to beneficiaries enrolled in MA PFFS Plans must follow the PFFS Plan terms and conditions of payment. Medicare MSA Plans may or may not have contracted providers, but MSA Plans cannot restrict access to a network of providers.

Strengthening Federally Qualified Health Centers

Federally Qualified Health Centers (FQHC) play an important role in rural health care. FQHCs that contract with MA organizations must be paid an amount similar to what they pay other providers for similar services. CMS is required to make up the difference, if any, between such MA organizations' payments (including beneficiary cost sharing) and 100 percent of the FQHC's reasonable costs for furnishing care to MA organization beneficiaries served at FQHCs.

Medicare Prescription Drug Plans (Medicare Part D) provide prescription drug coverage to all beneficiaries under stand-alone Prescription Drug Plans (PDP) or through MA Prescription Drug (MA-PD) Plans. PDPs offer only prescription drug coverage, and MA-PD Plans offer prescription drug coverage that is integrated with the health care coverage furnished to beneficiaries under Medicare Part C.

To find additional information about the MA Program, visit *http://www.cms.hhs.gov/HealthPlansGenInfo* on the CMS website. MA-PD and PDP information can be found at *http://www.cms.hhs.gov/PrescriptionDrugCovGenIn* on the CMS website.

MEDICARE DEPENDENT HOSPITAL

For cost reporting periods that begin on or after April 1, 1990 and end before October 1, 1994 or that begin on or after October 1, 1997 and end before October 1, 2006, a Medicare Dependent Hospital (MDH) is a rural hospital that meets the following criteria:

- It has 100 or fewer beds;
- It is not classified as a Sole Community Hospital; and
- At least 60 percent of its inpatient days or discharges were attributed to Medicare Part A beneficiaries:
    - For its cost reporting period ending on or after September 30, 1987 and before September 30, 1988;
    - For its cost reporting period beginning on or after October 1, 1986 and before October 1, 1987 (if it does not meet the preceding requirement); or
    - For at least two of the last three settled cost reporting periods.

Medicare Dependent Hospital Payments
Payment for an MDH's inpatient operating costs are the sum of the Federal payment rate plus half of the amount that exceeds the Federal payment rate based on the highest hospital specific base year costs per discharge for Medicare beneficiaries from 1982 or 1987, trended forward.

Additional payment guidelines that apply to MDHs include the following:

- A MDH is eligible for a special payment adjustment under the Hospital Inpatient Prospective Payment System;
- If its caseload falls by more than five percent due to circumstances beyond the MDH's control, it may receive payments necessary to fully compensate for fixed costs;
- A MDH does not receive preferential treatment for Disproportionate Share Hospital payments or geographic reclassification; and
- The actual payment amount for each MDH bill is determined by the Pricer based on information maintained in Fiscal Intermediary or A/B Medicare Administrative Contractor provider specific files. After the MDH's annual cost report is reviewed, lump sum adjustments may be paid.

To find additional information about MDHs, see Chapter 3 of the Medicare Claims Processing Manual (Pub. 100-4) at *http://www.cms.hhs.gov/Manuals* on the Centers for Medicare & Medicaid Services website.

MEDICARE DISPROPORTIONATE SHARE HOSPITAL

Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272) amended Section 1886(d)(5) of the Social Security Act (the Act) to add new subparagraph (F), known as the Medicare Disproportionate Share Hospital (DSH) adjustment provision, which became effective for discharges occurring on or after May 1, 1986.

Methods to Qualify for the Medicare Disproportionate Share Hospital Adjustment
A hospital can qualify for the Medicare DSH adjustment by using one of the following two methods:

Primary Method
The primary method for qualifying for the Medicare DSH adjustment pertains to hospitals that serve a significantly disproportionate number of low-income patients and is based on the disproportionate patient percentage (DPP), which is equal to the sum of the percentage of Medicare inpatient days (including Medicare Advantage inpatient days) attributable to patients entitled to both Medicare Part A and Supplemental Security Income (SSI) and the percentage of total patient days attributable to patients eligible for Medicaid but not eligible for Medicare Part A. If a hospital's DPP equals or exceeds a specified threshold amount, the hospital qualifies for the Medicare DSH adjustment. The Medicare DSH adjustment is determined by using a complex formula (the applicable formula is also based on a hospital's particular DPP).

Medicare Disproportionate Patient Percentage

Disproportionate Patient Percentage	$\dfrac{\text{Medicare/SSI Days}}{\text{Total Medicare Days}} + \dfrac{\text{Medicaid, Non-Medicare Days}}{\text{Total Patient Days}}$

Alternate Special Exemption Method
The alternate special exception method for qualifying for the Medicare DSH adjustment applies to hospitals that are located in an urban area, have 100 or more beds, and can demonstrate that more than 30 percent of their total net inpatient care revenues come from State and local government sources for indigent care (other than Medicare or Medicaid). These hospitals are also known as "Pickle" hospitals as defined under Section 1886(d)(5)(F)(i)(II) of the Act. If a hospital qualifies under this method, the statute provides for a specific Medicare DSH adjustment.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and Deficit Reduction Act of 2005 Provisions That Impact Medicare Disproportionate Share Hospitals

Section 402 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 further amended Section 1886(d)(5)(F) of the Act so that for discharges occurring on or after April 1, 2004, regarding hospitals under the primary qualifying method, the Medicare DSH payment adjustment percentage formulas for large, urban hospitals apply to additional types of hospitals (e.g., thereby increasing the DSH payment adjustment percentage for hospitals such as rural hospitals with fewer than 500 beds and urban hospitals with fewer than 100 beds). In addition, Section 402 of the MMA imposed a 12 percent cap on the DSH payment adjustment for certain hospitals (exempted from the cap are hospitals classified as Rural Referral Centers [RRC], urban hospitals with 100 or more beds, and hospitals located in rural areas with 500 or more beds). Per Section 5003 of the Deficit Reduction Act of 2005, as of October 1, 2006, Medicare Dependent Hospitals (MDH) are also exempt from the cap. Under the primary qualifying method, the formulas to establish a hospital's Medicare DSH payment adjustment percentage are based on certain hospital-specific information including its:

- Geographic designation (i.e., urban or rural);
- Number of beds; and
- Status as a RRC or MDH.

Number of Beds in Hospital Determination

Under the *Code of Federal Regulations (CFR)* at 42 CFR Section 412.106(a)(1)(i), the number of beds in a hospital is determined, in accordance with 42 CFR Section 412.105(b), by dividing the number of available bed days during the cost reporting period by the number of days in the cost reporting period.

In addition, for purposes of Medicare DSH, the number of patient days in a hospital includes only those days attributable to units or wards of the hospital furnishing acute care services generally payable under the Inpatient Prospective Payment System (IPPS) and excludes patient days associated with:

- Beds in excluded distinct part hospital units;
- Beds counted as outpatient observation, skilled nursing swing bed, or ancillary labor/delivery services;
- Beds in units or wards that are not occupied to furnish a level of care under the acute care hospital IPPS at any time during the three preceding months; and
- Beds in units or wards that are otherwise occupied that could not be made available for inpatient occupancy within 24 hours for 30 consecutive days.

Medicare Disproportionate Share Hospital Payment Adjustment Formulas

Under Section 1886(d)(5)(F) of the Act, additional Medicare DSH payments are made under the IPPS to acute hospitals that serve a large number of low-income patients or hospitals that qualify as "Pickle" hospitals. The disproportionate share adjustment percentage for a "Pickle" hospital is equal to 35 percent. The adjustment formulas under the primary qualifying method are not applicable to "Pickle" hospitals. Under the primary

qualifying method, a PPS hospital is eligible to receive Medicare DSH payments when its DPP meets or exceeds 15 percent. The chart below depicts Medicare DSH payment adjustment formulas for hospitals qualifying under the primary method.

Medicare Disproportionate Share Hospital Payment Adjustment Formulas – Primary Qualifying Method

STATUS/LOCATION NUMBER OF BEDS	THRESHOLD	ADJUSTMENT FORMULA
URBAN HOSPITALS		
0 - 99 Beds	≥15%, ≤20.2%	2.5% + [.65 x (DPP – 15%)] **Not to Exceed 12%**
	≥20.2%	5.88% + [.825 x (DPP – 20.2%)] **Not to Exceed 12%**
100 or more Beds	≥15%, ≤20.2%	2.5% + [.65 x (DPP – 15%)] **No Cap**
	≥20.2%	5.88% + [.825 x (DPP – 20.2%)] **No Cap**
RURAL REFERRAL CENTERS	≥15%, ≤20.2%	2.5% + [.65 x (DPP – 15%)] **No Cap**
	≥20.2%	5.88% + [.825 x (DPP – 20.2%)] **No Cap**
MEDICARE DEPENDENT HOSPITALS	≥15%, ≤20.2%	2.5% + [.65 x (DPP – 15%)] **No Cap**
	≥20.2%	5.88% + [.825 x (DPP – 20.2%)] **No Cap**
OTHER RURAL HOSPITALS		
0 - 499 Beds	≥15%, ≤20.2%	2.5% + [.65 x (DPP – 15%)] **Not to Exceed 12%**
	≥20.2%	5.88% + [.825 x (DPP – 20.2%)] **Not to Exceed 12%**
500 or more Beds	≥15%, ≤20.2 %	2.5% + [.65 x (DPP – 15%)] **No Cap**
	≥20.2%	5.88% + [.825 x (DPP – 20.2%)] **No Cap**

Below is an example of a Medicare DPP calculation and the corresponding payment adjustment calculation under the primary qualifying method:

Hospital A has 62 beds and is located in an urban area. In fiscal year 2003, it had 5,000 total patient days, 1,000 Medicaid/non-Medicare days, 2,000 Medicare Part A days, and 300 Medicare Part A/SSI days. Hospital A's Medicare DPP is 35 percent.

Medicare Disproportionate Patient Percentage

Disproportionate Patient Percentage	300 Medicare/SSI Days / 2,000 Total Medicare Days	+	1,000 Medicaid, Non-Medicare Days / 5,000 Total Patient Days	= 35

Because Hospital A is located in an urban area, has less than 100 beds, and has a DPP of more than 20.2 percent, the formula for determining the Medicare DSH adjustment is:

5.88% + [.825 x (DPP – 20.2%]

5.88% + [.825 x (35% – 20.2%)]

5.88% + 12.21% = 18.09%

Urban hospitals with less than 100 beds are subject to a maximum DSH adjustment of 12 percent. Hospital A's Medicare DSH adjustment is 12 percent.

To find additional information about Medicare DSHs, see Chapter 3 of the Medicare Claims Processing Manual (Pub. 100-4) at http://www.cms.hhs.gov/Manuals on the Centers for Medicare & Medicaid Services website. Additional information about the number of beds in a hospital can be found in the *CFR* at http://www.gpoaccess.gov/cfr/index.html on the Web.

MEDICARE HOSPITAL RECLASSIFICATION

Under Section 1886(d)(10) of the Social Security Act, the Medicare Geographic Classification Review Board (MGCRB) considers applications by hospitals for geographic reclassification for purposes of payment under the Inpatient Prospective Payment System. Hospitals must apply to the MGCRB to reclassify by September 1 of the year preceding the year during which reclassification is sought. For example, an application must be submitted by September 1, 2008 for a reclassification for fiscal year (FY) 2010, which begins on October 1, 2009. In general, hospitals must be proximate to the labor market area to which they are seeking reclassification and must demonstrate characteristics similar to hospitals located in that area. The MGCRB issues its decisions by the end of February for reclassifications that become effective for the following FY. Reclassifications granted by the MGCRB for hospital wage index purposes will be effective for a three-year period. Requirements applicable to hospital reclassifications by the MGCRB are located in the *Code of Federal Regulations (CFR)* under 42 CFR Sections 412.230 through 412.280.

To find geographic reclassification applications and instructions, visit *http://www.cms.hhs.gov/MGCRB* on the Centers for Medicare & Medicaid Services website. To access the *CFR*, visit *http://www.gpoaccess.gov/cfr/index.html* on the Web.

PHYSICIAN SCARCITY AREA BONUS PAYMENT

The Physician Scarcity Area (PSA) Bonus Payment Program was created under Section 413(a) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 to facilitate the recruitment and retention of physicians who furnish care to Medicare beneficiaries in PSAs. Physicians who furnish outpatient professional services in a PSA receive a five percent bonus payment. The two PSA categories are:

- Primary care, which is determined by the ratio of primary care physicians to Medicare beneficiaries; and
- Specialty care, which is determined by the ratio of specialty physicians to Medicare beneficiaries.

Determination of eligibility for the bonus payment is made based on the ZIP code where the service was furnished. If the service is furnished in an area that is on the Centers for Medicare & Medicaid Services (CMS) list of Zip codes that are eligible for the PSA bonus payment, payments are automatically paid on a quarterly basis. If the Zip code is not on the list but the area is in a county designated as a PSA, the AR modifier must be used.

For purposes of the PSA Bonus Payment Program, a primary care physician is defined as a:

- General practitioner;
- Family practice practitioner;
- General internist;
- Obstetrician; or
- Gynecologist.

A specialty care physician is defined as a physician other than a primary care physician.

The following providers are NOT eligible for the PSA bonus payment:

- Dentists;
- Chiropractors;
- Optometrists; and
- Podiatrists.

If a physician furnishes services in an area that is both an eligible PSA and an eligible Health Professional Shortage Area (HPSA), he or she will receive a 15 percent bonus payment on a quarterly basis. The bonus payment is based on the paid amount of the claim.

To find additional information about PSAs and the list of Zip codes eligible for the automatic PSA bonus payment, visit http://www.cms.hhs.gov/hpsapsaphysicianbonuses/01_overview.asp on the CMS website. Additional information can also be found in Chapter 12 of the Medicare Claims Processing Manual (Pub. 100-4) at http://www.cms.hhs.gov/Manuals on the CMS website. See the Health Professional Shortage Area Incentive Payment Section of this guide for additional information about HPSAs.

PRESCRIPTION DRUG PLANS (PART D)

Under Section 101 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 Medicare Part D provides prescription drug coverage to all beneficiaries who elect to enroll in a Prescription Drug Plan or Medicare Advantage (MA) Prescription Drug Plan.

Defined standard coverage in 2008 includes:

- An average $25.00 monthly premium (this is an estimated amount; the premium depends on plan bids and which prescription drug plan or MA Plan the beneficiary selects);
- $275.00 yearly deductible;
- 25 percent coinsurance up to an initial coverage limit of $2,510;
- 100 percent cost sharing once a beneficiary has reached the initial coverage limit of $2,510 in total drug spending but before he or she has reached the out-of-pocket threshold of $4,050 in true out-of-pocket (TrOOP) spending; and
- Catastrophic coverage once a beneficiary has incurred $4,050 in TrOOP costs for the year. Catastrophic coverage cost sharing consists of the greater of:
    - A $2.25 copayment for generics and preferred multiple source drugs or a $5.60 copayment for all other drugs; or
    - 5 percent coinsurance.

Plans have the flexibility to offer alternatives to the defined standard coverage while providing the same overall value to enrollees. For example, plans may create actuarially equivalent tiered cost sharing structures or design benefit packages which have a value that exceeds the defined standard benefit (enrollees must pay a supplemental premium for these additional benefits).

Medicare provides low-income cost sharing and premium subsidies for certain low-income individuals. The Medicare subsidy for cost sharing counts toward a beneficiary's TrOOP costs.

Coverage for those beneficiaries with incomes below 135 percent of the Federal poverty level and limited assets includes:

- A reduction in the premium for basic coverage up to the amount of the low-income premium subsidy for the region, but never to exceed the plan's premium;
- No yearly deductible;

- One of the following three copayment structures until an out-of-pocket threshold is reached:
    - A $2.25 copayment maximum for generics and preferred multiple source drugs or a $5.60 copayment for all other drugs;
    - A $1.05 copayment maximum for generics and preferred multiple source drugs and a $3.10 copayment for all other drugs for beneficiaries who are eligible for full benefits under Medicare and Medicaid (full-benefit dual eligible beneficiaries) with incomes under 100 percent of the Federal poverty level and limited resources; or
    - No copayment for institutionalized full-benefit dual eligibles; and
- Once the out-of-pocket threshold of $4,050 in TrOOP costs is reached, there is no cost sharing for covered drugs.

Coverage for 1) those beneficiaries with a certain level of assets and incomes between 135 and 150 percent of the Federal poverty level and 2) those beneficiaries with incomes below 135 percent of the Federal poverty level if their assets are such that they cannot meet the asset test for incomes below 135 percent of the Federal poverty level but can meet the higher asset test used for those with incomes below 150 percent of the Federal poverty level includes:

- A reduction in the premium ranging from 0 to 100 percent of the premium amount;
- $56.00 yearly deductible;
- 15 percent coinsurance up to the out-of-pocket threshold; and
- Copayments not to exceed $2.25 for generic or preferred multiple source drugs or $5.60 for all other drugs once the out-of-pocket threshold is reached.

The MMA added a new exception to the anti-kickback statute under which pharmacies are permitted to waive or reduce cost sharing amounts provided they do so in an unadvertised, nonroutine manner after determining that the beneficiary in question is financially needy or after failing to collect the cost sharing amount despite reasonable efforts. In addition, pharmacies may waive or reduce a beneficiary's Part D cost sharing without regard to these standards for Part D enrollees eligible for the low-income subsidy provided they do not advertise that the waivers or cost sharing reductions are available. By law, any Part D cost sharing paid by a group health plan, insurance, government-funded health program, or other third party payment arrangement will not count toward a beneficiary's TrOOP expenditures. However, payments made by the following will count toward TrOOP:

- Assistance provided by family members;
- Help from qualified State pharmaceutical assistance programs;
- Assistance from charities unaffiliated with employers or unions; and
- Medicare low-income cost sharing subsidies.

Generally, waivers or reductions of cost sharing by pharmacies will count toward TrOOP. However, to the extent that the party paying for cost sharing on behalf of a Part D enrollee is a group health plan, insurance, government-funded health program, or party to a third party payment arrangement with an obligation to pay for covered

Part D drugs, that party's payment for covered Part D drugs will not count toward TrOOP expenditures. Thus, payments made for beneficiary cost sharing by any entity, including a 340B pharmacy, that has an obligation to pay for covered Part D drugs on behalf of Part D enrollees or that voluntarily elects to use public funds for that purpose will not count toward that beneficiary's TrOOP expenditures.

Rural Pharmacy Network Access

Rural pharmacies, including those located or co-located in hospital outpatient departments, Federally Qualified Health Centers, and Rural Health Clinics, may contract with Part D Plans to become Part D network pharmacies. By law, "any willing pharmacy" (i.e., any pharmacy willing to meet the standard contracting terms and conditions offered by a Part D Plan) must be allowed to participate in a Part D Plan's network. Any beneficiary cost sharing that is subsidized by providers that are either group health plans, insurance, government-funded health programs, or other third party payment arrangements with an obligation to pay covered Part D drugs will not count toward the beneficiary's TrOOP costs.

To find additional information about prescription drug coverage, visit *http://www.cms.hhs.gov/PrescriptionDrugCovGenIn* on the Centers for Medicare & Medicaid Services website.

QUALITY IMPROVEMENT IN RURAL AREAS

The Quality Improvement Organization (QIO) Program consists of a national network of 53 QIOs that are responsible for each U.S. state, territory, and the District of Columbia. Under the direction of the Centers for Medicare & Medicaid Services (CMS), QIOs work with consumers, physicians, hospitals, and other caregivers to refine care delivery systems to ensure that beneficiaries receive the right care at the right time, particularly beneficiaries from underserved populations. The QIO Program also investigates beneficiary complaints about quality of care and safeguards the integrity of the Medicare Trust Fund by ensuring that payment is made only for medically necessary services.

8th Scope of Work

For the first time, the 8th Scope of Work includes a dedicated task for QIOs to work with Critical Access Hospitals (CAH) and rural Prospective Payment System (PPS) hospitals. The three performance improvement areas are:

- Increase the number of CAHs submitting Hospital Quality Alliance (HQA) data to the CMS clinical warehouse for public reporting via technical assistance from the QIO;
- Improve the performance of CAH locally selected HQA measure(s) via quality improvement assistance; and
- Improve the safety climate in an Identified Participant Group of CAH/PPS rural hospitals.

It is also anticipated that during the course of the contract, new rural-sensitive measures will be added to HQA measures and submitted to the clinical warehouse for local benchmarking purposes rather than public reporting.

Organizations interested in finding additional information about QIOs may visit *http://www.cms.hhs.gov/QualityImprovementOrgs* on the CMS website. Medicare beneficiaries who have complaints about quality of care issues or want to file an appeal regarding a discharge decision or termination of services should be directed to contact the QIO in their state. QIO telephone numbers can be found at *http://www.medicare.gov/Contacts/Include/DataSection/Questions/SearchCriteria.asp#astep2* on the Medicare website.

RURAL HEALTH CLINIC

The Rural Health Clinic Services Act of 1977 (Public Law 95-210) was established to address an inadequate supply of physicians serving Medicare beneficiaries and Medicaid recipients in rural areas and to increase the utilization of nonphysician practitioners (NPP) such as nurse practitioners (NP) and physician assistants (PA) in rural areas. To qualify as a Rural Health Clinic (RHC), a facility must be in an area determined to be non-urban and designated by the Health Resources and Services Administration as having a shortage of personal health care services or primary care medical services.

Rural Health Clinic Services

RHCs furnish:

- Physician services;
- Services and supplies incident to the services of a physician;
- NP, PA, certified nurse midwife (CNM), clinical psychologist (CP), and clinical social worker (CSW) services;
- Services and supplies incident to the services of a NP, PA, CNM, CP, and CSW;
- Medicare Part B covered drugs that are furnished by and incident to services of physicians and NPPs of the RHC; and
- Visiting nurse services to the homebound in an area where the Centers for Medicare & Medicaid Services (CMS) has certified that there is a shortage of Home Health Agencies.

Medicare Certification as a Rural Health Clinic

To qualify as a RHC, a facility must be located in:

- An area determined to be non-urban, as defined by the U.S. Census Bureau; and
- An area with one of the following current designations:
    - Primary Care Geographic Health Professional Shortage Area (HPSA) under Section 332(a)(1)(A) of the Public Health Service (PHS) Act;
    - Primary Care Population-Based HPSA under Section 332(a)(1)(B) of the PHS Act;
    - Medically Underserved Area under Section 330(b)(3) of the PHS Act; or
    - Governor-designated and Secretary-certified shortage area under Section 6213(c) of the Omnibus Budget Reconciliation Act of 1989.

RHCs must also:

- Employ a NP or PA;
- Have available a NP, PA, or CNM to furnish services at least 50 percent of the time the RHC operates;
- Directly furnish routine diagnostic and laboratory services;
- Have arrangements with one or more hospitals to furnish medically necessary services that are not available at the RHC;
- Have available drugs and biologicals necessary for the treatment of emergency cases;

- Furnish onsite the following laboratory tests:
  - Chemical examination of urine by stick or tablet method or both;
  - Hemoglobin or hematocrit;
  - Blood sugar;
  - Examination of stool specimens for occult blood;
  - Pregnancy tests; and
  - Primary culturing for transmittal to a certified laboratory;
- Have a quality assessment and performance improvement program;
- Must not be a rehabilitation agency or a facility that is primarily for the treatment of mental disease; and
- Must meet other applicable State and Federal requirements.

A facility cannot be Medicare approved concurrently as a RHC and a Federally Qualified Health Center.

Rural Health Clinic Visits

A RHC visit is defined as a medically necessary face-to-face encounter between the beneficiary and a physician, NP, PA, CNM, CP, or CSW during which a RHC service is furnished. In certain limited situations, a RHC visit may also include a visit by a registered professional nurse or a licensed practical nurse to a homebound beneficiary.

Encounters at a single location on the same day with more than one health professional and multiple encounters with the same health professional constitute a single visit, except when one of the following conditions exist:

- The beneficiary suffers an illness or injury requiring additional diagnosis or treatment subsequent to the first encounter; or
- The beneficiary has a medical visit AND a CP or CSW visit.

Rural Health Clinic Payments

RHCs receive cost-based reimbursement for a defined set of core physician and certain nonphysician outpatient services. Payment for RHC services furnished to Medicare beneficiaries is made on the basis of an all-inclusive payment methodology, subject to a maximum payment per visit and annual reconciliation. The per-visit payment limit to RHCs is established by Congress and is increased each year by the percentage increase in the Medicare Economic Index. Payment is made directly to the RHC for covered services. Laboratory tests are paid separately. A RHC that is an integral and subordinate part of a hospital with fewer than 50 beds can receive an exception to the payment limit. Psychological or psychiatric therapeutic services (generally furnished by CPs and CSWs) are subject to the 62.5 percent outpatient mental health treatment limitation. This limit does not apply to diagnostic services. The application of the outpatient mental health treatment limitation increases the beneficiary's copayment to 50 percent of the all-inclusive encounter rate.

The Part B deductible applies to RHC services and is based on billed charges. Noncovered expenses do not count toward the deductible. After the deductible has

been satisfied, RHCs will be paid 80 percent of the all-inclusive interim encounter payment rate for each RHC visit, with the exception of all psychological or psychiatric therapeutic services furnished by CPs and CSWs.

Influenza and Pneumococcal Vaccine Administration and Payment
The cost of the influenza and pneumococcal vaccines and related administration are separately reimbursed at annual cost settlement. There is a separate worksheet on the cost report to report the cost of these vaccines and related administration. These costs should not be reported on a RHC claim when billing for RHC services. The beneficiary pays no Part B deductible or coinsurance for these services. When a RHC practitioner (e.g., a physician, NP, PA, or CNM) sees a beneficiary for the sole purpose of administering these vaccinations, the RHC may not bill for a visit; however, the associated costs are included on the annual cost report and reimbursed at cost settlement.

Hepatitis B Vaccine Administration and Payment
The cost of the Hepatitis B vaccine and related administration are covered under the RHC's all-inclusive rate. If other services that constitute a qualifying RHC visit are furnished at the same time as the Hepatitis B vaccination, the charges for the vaccine and related administration can be included in the charges for the visit when billing and in calculating the deductible and/or coinsurance. When a RHC practitioner (e.g., a physician, NP, PA, or CNM) sees a beneficiary for the sole purpose of administering a Hepatitis B vaccination, the RHC may not bill for a visit; however, the associated costs are included on the annual cost report and reimbursed at cost settlement. Charges for the Hepatitis B vaccine may be included on a claim for the beneficiary's subsequent RHC visit and used in calculating the deductible and/or coinsurance.

Cost Reports
Independent RHCs must complete Form CMS-222-92, Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report, in order to identify all incurred costs applicable to furnishing covered RHC services. Form CMS-222-92 can be found in the Provider Reimbursement Manual – Part 2 (Pub. 15-2), Chapter 29, located at *http://www.cms.hhs.gov/Manuals/PBM/list.asp* on the CMS website.

Provider-based RHCs must complete Worksheet M of Form CMS-2552-96, Hospital and Hospital Complex Cost Report, in order to identify all incurred costs applicable to furnishing covered RHC services. A RHC that is based in a hospital with less than 50 beds is not subject to the per-visit payment limit and has an encounter rate that is based on its full reasonable cost. If a RHC is in its initial reporting period, the all-inclusive visit rate is determined on the basis of a budget the RHC submits. The budget estimates the allowable cost that will be incurred by the RHC during the reporting period and the number of expected visits during the reporting period. Form CMS-2552-96 can be found in the Provider Reimbursement Manual – Part 2 (Pub. 15-2), Chapter 36, which can be found at *http://www.cms.hhs.gov/Manuals/PBM/list.asp* on the CMS website.

Annual Reconciliation
At the end of the annual cost reporting period, RHCs submit a report to the Fiscal Intermediary (FI) or A/B Medicare Administrative Contractor (MAC) that includes actual allowable costs and actual visits for RHC services for the reporting period and any other information that may be required. After reviewing the report, the FI or A/B MAC divides allowable costs by the number of actual visits to determine a final rate for the period. The FI or A/B MAC determines the total payment due and the amount necessary to reconcile payments made during the period with the total payment due. Both the final rate and the interim rate are subject to screening guidelines for evaluating the reasonableness of the RHC's productivity, payment limit, and mental health treatment limit.

To find additional information about RHCs, see Chapter 9 of the Medicare Claims Processing Manual (Pub. 100-4) and Chapter 13 of the Medicare Benefit Policy Manual (Pub. 100-2) at *http://www.cms.hhs.gov/Manuals* on the CMS website.

RURAL REFERRAL CENTER

The Rural Referral Center (RRC) Program was established to support high-volume rural hospitals that treat a large number of complicated cases.

Rural Referral Center Program Requirements

The *Code of Federal Regulations (CFR)* under 42 CFR Section 412.96 contains a full description of the criteria for RRCs. In general, a Medicare participating acute care hospital is classified as a RRC if it is located in a rural area and it meets ONE of the following criteria:

1) It has 275 or more beds available for use during its most recently completed cost reporting period. If the hospital's bed count has changed, written documentation may be submitted with the application regarding one or more of the following reasons for the change:
    - The merger of two or more hospitals;
    - Acute care beds that previously were closed for renovation are reopened;
    - Acute care beds that previously were classified as part of an excluded unit are transferred to the Prospective Payment Systems; or
    - The hospital expands the number of acute care beds for use and these beds are permanently maintained for inpatients (such expansion does not include beds in corridors or other temporary beds); OR
2) It shows the following three elements:
    - At least 50 percent of the hospital's Medicare patients are referred from other hospitals or from physicians who are not on the staff of the hospital;
    - At least 60 percent of the hospital's Medicare patients live more than 25 miles from the hospital; and
    - At least 60 percent of all services the hospital furnishes to Medicare beneficiaries are furnished to beneficiaries who live more than 25 miles from the hospital; OR

3) If the criteria in 1) or 2) above cannot be met, it must be a rural facility as defined at 42 CFR Section 412.62(f)(1)(iii) that meets the criteria in a) and b) AND at least ONE of the criteria in c), d), or e) listed below:
   a) Case-Mix Index – For discharges during the most recent Federal fiscal year (FY) ending at least one year prior to the beginning of the cost reporting period for which the hospital is seeking RRC status, its case-mix index is at least equal to the national case-mix index value as established by the Centers for Medicare & Medicaid Services (CMS) or the median case-mix index value for urban hospitals located in each region; AND
   b) Number of Discharges – Its number of discharges is at least 5,000 or the median number of discharges for urban hospitals set by CMS yearly in Inpatient Prospective Payment System rulemaking, in accordance with 42 CFR Section 412.96(c)(2). For an osteopathic hospital, its number of discharges is at least 3,000; AND
   c) Medical Staff – More than 50 percent of the hospital's active medical staff are specialists who meet the conditions specified under 42 CFR Section 412.96(c)(3); OR
   d) Source of Inpatients – At least 60 percent of all discharges are for inpatients who reside more than 25 miles from the hospital; OR
   e) Volume of Referrals – At least 40 percent of all inpatients treated at the hospital are referred from other hospitals or from physicians who are not on the hospital's staff.

Section 4202(b) of the Balanced Budget Act of 1997 states that any hospitals designated as RRCs in FY 1991 are grandfathered as such.

To find additional RRC information, see Chapter 3 of the Medicare Claims Processing Manual (Pub. 100-4) at *http://www.cms.hhs.gov/Manuals* on the CMS website. To access the *CFR*, visit *http://www.gpoaccess.gov/cfr/index.html* on the Web.

SOLE COMMUNITY HOSPITAL

A hospital is eligible to be classified as a Sole Community Hospital (SCH) if it is located more than 35 miles from other like hospitals. A hospital may also be classified as a SCH if it is located in a rural area AND it meets at least ONE of the following three conditions:

1) The hospital is located between 25 and 35 miles from other like hospitals AND meets ONE of the following criteria:
    - No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital or, if larger, within its service area;
    - The hospital has fewer than 50 beds and would meet the 25 percent criterion above were it not for the fact that some beneficiaries or residents were forced to seek specialized care outside of the service area due to the unavailability of necessary specialty services at the hospital; or
    - Other like hospitals are inaccessible for at least 30 days in each of two out of three years because of local topography or prolonged severe weather conditions;
2) The hospital is located between 15 and 25 miles from other like hospitals but because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each of two out of three years; or
3) Because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest like hospital is at least 45 minutes.

Sole Community Hospital Payments

Payments to SCHs are made under the Prospective Payment System (PPS), but PPS payments are determined based on which of the following yields the greatest aggregate payment for the cost reporting period:

- The Federal rate applicable to the hospital;
- The updated hospital-specific rate based on fiscal year (FY) 1982 costs per discharge;
- The updated hospital-specific rate based on FY 1987 costs per discharge;
- For purposes of payment to SCHs for which the FY 1996 hospital-specific rate yields the greatest aggregate payment, payments for discharges during FYs 2001, 2002, and 2003 are based on a blend of the FY 1996 hospital-specific rate and the greater of the Federal rate or the updated FY 1982 or FY 1987 hospital-specific rate; or
- For discharges beginning in FY 2004, the hospital specific rate is 100 percent of the FY 1996 hospital-specific rate.

To find additional information about SCHs, see Chapter 3 of the Medicare Claims Processing Manual (Pub. 100-4) at *http://www.cms.hhs.gov/Manuals* on the Centers for Medicare & Medicaid Services website.

SWING BED

A hospital or Critical Access Hospital (CAH) with a Medicare agreement to furnish swing bed services may use its beds as needed to furnish either acute or Skilled Nursing Facility (SNF) level care. In order to be granted approval to furnish post-acute level SNF care via a swing bed agreement, the following requirements must be met:

- For a hospital:
  - The hospital is located in a rural area;
  - The hospital has fewer than 100 beds (excluding beds for newborns and intensive care-type units);
  - The hospital has a Medicare provider agreement, as a hospital;
  - The hospital is substantially in compliance with the following SNF participation requirements:
    - Residents rights;
    - Admission, transfer, and discharge rights;
    - Resident behavior and facility practices;
    - Patient activities;
    - Social services;
    - Discharge planning;
    - Specialized rehabilitative services; and
    - Dental services;
  - The hospital has not had a nursing waiver granted as stated in the *Code of Federal Regulations (CFR)* under 42 CFR Section 488.54(c); and
  - The hospital has not had a swing bed approval terminated within the two years previous to application for participation.
- For a CAH:
  - The CAH is substantially in compliance with the following SNF participation requirements:
    - Residents rights;
    - Admission, transfer, and discharge rights;
    - Resident behavior and facility practices;
    - Patient activities (except for direction);
    - Social services;
    - Comprehensive assessment, comprehensive care plan, and discharge planning (with some exceptions);
    - Specialized rehabilitative services;
    - Dental services; and
    - Nutrition.

A CAH may provide no more than 25 inpatient beds. When a CAH has Medicare approval to furnish swing bed services, it may use any of its 25 inpatient beds for either acute care or SNF level care. Any bed that is within a CAH distinct part unit that is Medicare certified to furnish SNF, rehabilitation, or psychiatric care does not count as part of its maximum 25 inpatient beds.

Rural hospitals and CAHs that have swing bed approval increase Medicare beneficiary access to post-acute SNF care and maximize the efficiency of operations by meeting unpredictable demands for acute and long-term care.

Medicare beneficiaries must receive acute care as a hospital or CAH inpatient for a medically necessary stay of at least three consecutive calendar days in order to qualify for coverage of SNF level services.

Effective with cost reporting periods beginning on or after July 1, 2002, short term hospitals, long term hospitals, and rehabilitation hospitals certified as swing bed hospitals must be paid as SNFs under the SNF Prospective Payment Systems (PPS). The SNF PPS covers all costs (ancillary, routine, and capital) related to covered services furnished to Medicare beneficiaries under a Medicare Part A covered SNF stay, with the exception of certain specified services that are separately billable to Part B. A Part A covered SNF stay in a CAH swing bed is reimbursed on the basis of reasonable costs.

To find additional information about swing beds services, see Chapter 6 of the Medicare Claims Processing Manual (Pub. 100-4) and Chapter 8 of the Medicare Benefit Policy Manual (Pub. 100-2) at http://www.cms.hhs.gov/Manuals and visit http://www.cms.hhs.gov/SNFPPS/03_SwingBed.asp on the Centers for Medicare & Medicaid Services website. To access the *CFR*, visit http://www.gpoaccess.gov/cfr/index.html on the Web. See the Critical Access Hospital Section of this guide for additional information about CAHs.

TELEHEALTH

Effective January 1, 1999, Section 4206 of the Balanced Budget Act (BBA) authorized payment for professional consultations provided via telecommunications to Medicare beneficiaries located in rural Health Professional Shortage Areas (HPSA). Section 223 of the Benefits Improvement and Protection Act expanded the BBA telehealth provision and became effective on October 1, 2001.

Originating Sites

Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site. Originating sites (location of the beneficiary) include the following:

- Physician or practitioner offices;
- Hospitals;
- Critical Access Hospitals (CAH);
- Rural Health Clinics (RHC); and
- Federally Qualified Health Centers (FQHC).

The originating site must be located in a rural HPSA or non-Metropolitan Statistical Area county. Entities that participate in a Federal telemedicine demonstration project approved by (or receiving funding from) the Secretary of the Department of Health and Human Services as of December 31, 2000 qualify regardless of geographic location.

Distant Site Practitioners

Practitioners at the distant site who may furnish and receive payment for telehealth services are:

- Physicians;
- Nurse practitioners (NP);
- Physician assistants (PA);
- Nurse midwives;
- Clinical nurse specialists (CNS);
- Clinical psychologists;
- Clinical social workers;
- Registered dietitians (effective January 1, 2006); and
- Nutrition professionals (effective January 1, 2006).

Telehealth Services
The current list of Medicare telehealth services include:

- Consultations (Current Procedural Terminology [CPT®] codes 99241 – 99255) (as of January 1, 2006);
- Office or other outpatient visits (CPT codes 99201 – 99215);
- Individual psychotherapy (CPT codes 90804 – 90809);
- Pharmacologic management (CPT code 90862);
- Psychiatric diagnostic interview examination (CPT code 90801) (effective March 1, 2003);
- End-Stage Renal Disease (ESRD)-related services included in the monthly capitation payment (Healthcare Common Procedure Coding System [HCPCS] codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318) (effective January 1, 2005);
- Medical nutrition therapy (MNT) (HCPCS code G0270 and CPT codes 97802 – 97803); and
- Neurobehavioral status examination (HCPCS code 96116) (effective January 1, 2008.

For ESRD-related services, at least one face-to-face, “hands on” visit (not telehealth) must be furnished each month to examine the vascular access site by a physician, NP, PA, or CNS.

As a condition of payment, an interactive audio and video telecommunications system must be used that permits real-time communication between the physician or practitioner at the distant site and the beneficiary at the originating site. Asynchronous “store and forward” technology is permitted only in Federal telehealth demonstration programs conducted in Alaska or Hawaii.

Billing and Payment
Payment is made for the telehealth service furnished by the physician or practitioner at the distant site and a telehealth facility fee is made to the originating site. Claims for telehealth services should be submitted using the appropriate CPT or HCPCS code for the professional service and the telehealth modifier GT, “via interactive audio and video telecommunications system” (e.g., 99243 GT). In the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii, the appropriate CPT code and telehealth modifier GQ, “via asynchronous telecommunications system” (e.g., 99243 GQ), may be submitted.

Physicians and practitioners at the distant site are paid 80 percent of the appropriate Medicare Physician Fee Schedule (MPFS) amount for telehealth services and bill the Medicare Carrier or A/B Medicare Administrative Contractor (MAC) for covered telehealth services. Effective January 1, 2007, the payment amount is 80 percent of the MPFS for telehealth services when distant site physicians and other practitioners are

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located in a CAH and have reassigned their billing rights to a CAH that has elected the Optional (Elective) Method of reimbursement. In that case, services are billed to the Fiscal Intermediary (FI) or A/B MAC by the CAH. Hospitals and CAHs must also submit claims to the FI or A/B MAC for any MNT services furnished to inpatients or outpatients. In all other cases, telehealth services furnished by physicians and other practitioners at the distant site must be billed to the Carrier or A/B MAC.

For telehealth services, originating sites are paid an originating site facility fee (as described by HCPCS code Q3014). Physician and practitioner offices that serve as telehealth originating sites bill the Medicare Carrier or A/B MAC for the originating site facility fee. Hospitals, CAHs, RHCs, and FQHCs that serve as Medicare telehealth originating sites bill the FI or A/B MAC.

To find additional information about Medicare telehealth services, see Chapter 15 of the Medicare Benefit Policy Manual (Pub. 100-2) and Chapter 12 of the Medicare Claims Processing Manual (Pub. 100-4) at *http://www.cms.hhs.gov/Manuals* and visit *http://www.cms.hhs.gov/Telehealth* on the Centers for Medicare & Medicaid Services website.

REFERENCE SECTION

REFERENCE A
HELPFUL WEBSITES

Centers for Medicare & Medicaid Services' Websites

Ambulance Fee Schedule
http://www.cms.hhs.gov/AmbulanceFeeSchedule

Ambulance Services Center
http://www.cms.hhs.gov/center/ambulance.asp

CMS Forms
http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp

CMS Manuals
http://www.cms.hhs.gov/Manuals

CMS Paper-Based Manuals
http://www.cms.hhs.gov/Manuals/PBM/list.asp

Critical Access Hospital Center
http://www.cms.hhs.gov/center/cah.asp

Federally Qualified Health Centers Center
http://www.cms.hhs.gov/center/fqhc.asp

Health Plans General Information (Medicare Advantage)
http://www.cms.hhs.gov/HealthPlansGenInfo

Home Health Agency Center
http://www.cms.hhs.gov/center/hha.asp

Home Health PPS
http://www.cms.hhs.gov/HomeHealthPPS

Hospice Center
http://www.cms.hhs.gov/center/hospice.asp

Hospital Center
http://www.cms.hhs.gov/center/hospital.asp

HPSA/PSA (Physician Bonuses)
http://www.cms.hhs.gov/hpsapsaphysicianbonuses/01_overview.asp

Medicare Geographic Classification Review Board
http://www.cms.hhs.gov/MGCRB

Medicare Helpful Contacts
http://www.medicare.gov/Contacts/Include/DataSection/Questions/SearchCriteria.asp#astep2

Medicare Learning Network
http://www.cms.hhs.gov/MLNGenInfo

MLN Matters Articles
http://www.cms.hhs.gov/MLNMattersArticles

OASIS
http://www.cms.hhs.gov/OASIS

Physician's Resource Partner Center
http://www.cms.hhs.gov/center/physician.asp

Prescription Drug Coverage
http://www.cms.hhs.gov/PrescriptionDrugCovGenIn

Private Fee-for-Service Plans
http://www.cms.hhs.gov/PrivateFeeforServicePlans

Quality Improvement Organizations
http://www.cms.hhs.gov/QualityImprovementOrgs

Regulations & Guidance
http://www.cms.hhs.gov/home/regsguidance.asp

Rural Health Center
http://www.cms.hhs.gov/center/rural.asp

Skilled Nursing Facility PPS
http://www.cms.hhs.gov/SNFPPS/03_SwingBed.asp

Telehealth
http://www.cms.hhs.gov/Telehealth

Other Organizations' Websites

American Hospital Association Section for Small or Rural Hospitals
http://www.aha.org/aha/key_issues/rural/index.html

Federal Financial Institutions Examination Council
http://www.ffiec.gov

FFIEC Geocoding System (census tract information)
http://www.ffiec.gov/Geocode/default.aspx

Government Printing Office
Code of Federal Regulations
http://www.gpoaccess.gov/cfr/index.html

Health Professional Shortage Areas (find HPSAs)
http://www.hpsafind.hrsa.gov

Health Resources and Services Administration
http://www.hrsa.gov

National Association of Community Health Centers
http://www.nachc.org

National Association of Rural Health Clinics
http://www.narhc.org

National Rural Health Association
http://www.nrharural.org

Rural Assistance Center
http://www.raconline.org

State Medicare Rural Hospital Flexibility Programs
http://www.ruralhealth.hrsa.gov

U.S. Census Bureau
http://www.Census.gov

REFERENCE B
REGIONAL OFFICE RURAL HEALTH COORDINATORS

Below is a list of contact information for the Centers for Medicare & Medicaid Services Regional Office Rural Health Coordinators who provide technical, policy, and operational assistance on rural health issues.

Region I – Boston
George Kazanjian
E-mail: george.kazanjian@cms.hhs.gov
Telephone: (617) 565-1282
States: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

Region II – New York
Frank Lifrieri
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Telephone: (212) 616-2519
States: New Jersey, New York, Puerto Rico, and Virgin Islands

Region III – Philadelphia
Patrick Hamilton
E-mail: patrick.hamilton@cms.hhs.gov
Telephone: (215) 861-4097
States: Delaware, Maryland, Pennsylvania, Virginia, West Virginia, and the District of Columbia

Region IV – Atlanta
Lana Dennis
E-mail: lana.dennis@cms.hhs.gov
Telephone: (404) 562-7379
States: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee

Region V – Chicago
Christine Davidson
E-mail: christine.davidson@cms.hhs.gov
Telephone: (312) 886-3642
States: Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin

Region VI – Dallas
Becky Peal-Sconce
E-mail: becky.pealsconce@cms.hhs.gov
Telephone: (214) 767-6444
States: Arkansas, Louisiana, New Mexico, Oklahoma, and Texas

Region VII – Kansas City
Robert Epps
E-mail: robert.epps@cms.hhs.gov
Telephone: (816) 426-6538
States: Iowa, Kansas, Missouri, and Nebraska

Region VIII – Denver
Lyla Nichols
E-mail: lyla.nichols@cms.hhs.gov
Telephone: (303) 844-6218
States: Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming

Region IX – San Francisco
Neal Logue
E-mail: neal.logue@cms.hhs.gov
Telephone: (415) 744-3501
States: Arizona, California, Hawaii, Nevada, Guam, Commonwealth of the Northern Mariana Islands, and American Samoa

Region X – Seattle
Alma Hardy
E-mail: alma.hardy@cms.hhs.gov
Telephone: (206) 615-2387
States: Alaska, Idaho, Oregon, and Washington

REFERENCE C
GLOSSARY

A

Appeal
Complaint a beneficiary, provider of services, or supplier can make if he or she disagrees with a Medicare coverage or payment decision.

B

Balanced Budget Act of 1997
Law that amended Sections of the Social Security Act to include anti-fraud and abuse provisions, program integrity, and preventive care benefits. Also established the State Children's Health Insurance Program and Medicare Advantage.

Beneficiary
Individual eligible to receive Medicare or Medicaid payment and/or services.

Benefits Improvement and Protection Act of 2000
Law that amended Titles XVIII, XIX and XXI of the Social Security Act to provide benefits improvements and beneficiary protections in the Medicare and Medicaid programs and the State Child Health Insurance Program.

C

Carrier
Centers for Medicare & Medicaid Services Contractor that determines reasonable charges, accuracy, and coverage for Medicare Part B services and processes Part B claims and payments (see Medicare Administrative Contractor).

Centers for Medicare & Medicaid Services
Federal agency that administers and oversees the Medicare Program and a portion of the State Medicaid Program.

Claim
Request for payment of Medicare benefits or services furnished by a provider or received by a beneficiary.

Code of Federal Regulations
Official compilation of Federal rules and requirements.

Coinsurance
Under Original Medicare or a Private Fee-for-Service Plan, a percentage of covered charges that the Medicare beneficiary may have to pay after he or she has met the applicable deductible.

Copayment
In some Medicare health plans, the amount that is paid by the beneficiary for each medical service.

Cost-Based Reimbursement
When payment is made to a provider on the basis of its current Medicare-allowable costs.

Cost Report
Report required from providers on an annual basis in order to make a proper determination of amounts payable under the Medicare Program.

Covered Service
Reasonable and necessary service furnished to Medicare or Medicaid beneficiaries and reimbursable to the provider or beneficiary.

Critical Access Hospital
A hospital that is located in a state that has established a State Medicare Rural Hospital Flexibility Program; is located in a rural area or is treated as rural under a special provision that allows qualified hospital providers in urban areas to be treated as rural for purposes of becoming a CAH; furnishes 24-hour emergency care services, using either on-site or on-call staff; provides no more than 25 inpatient acute care beds (may also operate a distinct part rehabilitation or psychiatric unit, each with up to 10 beds); has an average annual length of stay of 96 hours or less; and is located either more than 35 miles from the nearest hospital or CAH or more than 15 miles in areas with mountainous terrain or only secondary roads OR is State certified as of December 31, 2005 as a “necessary provider” of health care services to residents in the area.

D

Deductible
Amount a beneficiary must pay before Medicare begins to pay for covered services and supplies.

Deficit Reduction Act of 2005
Legislation enacted on February 8, 2006 that saves funds by slowing the growth in spending for Medicare and Medicaid and other measures.

Department of Health and Human Services
Federal department that administers many health and welfare programs for citizens of the U.S and is the parent department of the Centers for Medicare & Medicaid Services.

Distinct Part Unit of an Institution
Refers to a portion of an institution or institutional complex (e.g., a Skilled Nursing Facility [SNF], Critical Access Hospital, or hospital) that is certified to furnish SNF, Nursing Facility, psychiatric, and/or rehabilitation services.

Durable Medical Equipment
Medical equipment ordered by a physician or, if Medicare allows, a nurse practitioner, physician assistant or clinical nurse specialist for use in the home. The item must be able to withstand repeated use (e.g., walkers, wheelchairs, or hospital beds).

F

Federal Fiscal Year
Yearlong period that runs from October 1 through September 30.

Federally Qualified Health Center
Entity that is receiving a grant under Section 330 of the Public Health Service Act (PHS); is receiving funding from such grant under a contract with the recipient of a grant and meets the requirements to receive a grant under Section 330 of the PHS Act; is not receiving a grant under Section 330 of the PHS Act but determined by the Secretary of the Department of Health and Human Services (HHS) to meet the requirements for receiving such a grant (i.e., qualifies as a FQHC look-alike) based on the recommendation of the Health Resources and Services Administration; was treated by the Secretary of the Department of HHS for purposes of Medicare Part B as a comprehensive Federally funded health center as of January 1, 1990; or is operating as an outpatient health program or facility of a tribe or tribal organization under the Indian Self-Determination Act or as an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1, 1991.

Fee Schedule
Complete list of fees used by health plans to pay physicians and other providers.

Fiscal Intermediary
Centers for Medicare & Medicaid Services Contractor that processes claims for services covered under Medicare Part A and most types of claims for services covered under Medicare Part B (see Medicare Administrative Contractor).

H

Healthcare Common Procedure Coding System
The uniform method for providers and suppliers to report professional services, procedures, and supplies. It includes Current Procedure Technology codes and national alphanumeric codes.

Health Professional Shortage Area Incentive Payment
A 10 percent incentive payment that is paid on a quarterly basis to physicians (including psychiatrists) who furnish care in an area designated as a geographic-based, primary medical care Health Professional Shortage Area (HPSA) and psychiatrists who furnish care in an area that is designated as a geographic-based mental health HPSA.

Homebound
For a beneficiary to be considered confined to the home, leaving home requires a considerable and taxing effort and absences from the home are infrequent, for periods of relatively short duration, or for the need to receive health care treatment. In general, a beneficiary is considered homebound if leaving home is medically contraindicated or he or she has a condition due to an illness or injury that restricts the ability to leave the place of residence except with the aid or assistance of: a supportive device (e.g., crutches, cane, wheelchair, or walker), special transportation; or another person.

Home Health
Medicare covers home health (HH) services when the following criteria are met: the beneficiary to whom the services are furnished is an eligible Medicare beneficiary who is not enrolled in a Medicare Advantage Plan; the Home Health Agency that furnishes the services has in effect a valid agreement to participate in the Medicare Program; the beneficiary qualifies for coverage of HH services; the services are a covered Medicare benefit; Medicare is the appropriate payer; and the services are not otherwise excluded from payment.

Hospice
An elected benefit covered under Part A for a beneficiary who meets all the following conditions: the individual is eligible for Part A; the individual is certified as having a terminal illness with a prognosis of six months or less if the illness runs its normal course; the individual receives care from a Medicare-approved hospice program; and the individual signs a statement indicating that he or she elects the hospice benefit and waives all other rights to Medicare payments for services for the terminal illness and related conditions. Medicare will continue to pay for covered benefits that are not related to the terminal illness.

M

Medically Necessary
Services or supplies that are proper and needed for the diagnosis or treatment of the beneficiary's medical condition; furnished for the diagnosis, direct care, and treatment of the beneficiary's medical condition; meet the standards of good medical practice; and are not mainly for the convenience of the beneficiary, provider, or supplier.

Medicare Administrative Contractor
All Medicare work performed by Fiscal Intermediaries and Carriers will be replaced by these Centers for Medicare & Medicaid Services Contractors by 2011, as mandated in Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Medicare Advantage
A program through which organizations that contract with the Centers for Medicare & Medicaid Services furnish or arrange for the provision of health care services to Medicare beneficiaries (with the exception of individuals with End-Stage Renal Disease who are generally excluded from enrolling) who: are entitled to Medicare Part A and enrolled in Part B; permanently reside in the service area of the MA Plan; and elect to enroll in a Medicare Advantage Plan.

Medicare Dependent Hospital
For cost reporting periods that begin on or after April 1, 1990 and end before October 1, 1994 or that begin on or after October 1, 1997 and end before October 1, 2006, a rural hospital that has 100 or fewer beds; is not classified as a Sole Community Hospital; and at least 60 percent of its inpatient days or discharges were attributed to Part A beneficiaries for its cost reporting period ending on or after September 30, 1987 and before September 30, 1988, for its cost reporting period beginning on or after October 1, 1986 and before October 1, 1987 (if it does not meet the preceding requirement), or for at least two of the last three settled cost reporting periods.

Medicare Disproportionate Share Hospital Adjustment
Adjustment that hospitals may qualify for under one of two methods: 1) primary, which pertains to hospitals that serve a significantly disproportionate number of low-income patients and is based on the disproportionate patient percentage; or 2) the alternate special exemption method, which applies to hospitals that are located in an urban area, have 100 or more beds, and can demonstrate that more than 30 percent of their total net inpatient care revenues come from State and local government sources for indigent care (other than Medicare or Medicaid).

Medicare Economic Index
Index often used in the calculation of the increases in the prevailing charge levels that help to determine allowed charges for physician services. Since 1992, the Medicare Economic Index is considered in connection with the update factor for the Medicare Physician Fee Schedule.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003
Comprehensive bill that was signed by President George W. Bush on December 8, 2003 that expands many parts of the Medicare Program.

O

Outcome and Assessment Information Set
Group of data elements that Home Health Agencies use to assess a beneficiary’s condition and the likely skilled nursing care, therapy, medical social services, and home health aide services that will be needed at the beginning of the episode of care.

P

Part A of the Medicare Program
Hospital insurance that helps pay for inpatient hospital care, inpatient care in a Skilled Nursing Facility following a covered hospital stay, some home health care, and hospice care.

Part B of the Medicare Program
Medical insurance that helps pay for medically necessary services furnished by physicians in a variety of medical settings including but not limited to the physician's office, an inpatient or outpatient hospital setting, and Ambulatory Surgical Centers; home health care; ambulance services; clinical laboratory and diagnostic services; surgical supplies; durable medical equipment and supplies; and services furnished by practitioners with limited licensing such as advanced registered nurse practitioners, independently practicing physical therapists, independently practicing occupational therapists, certified registered nurse anesthetists, licensed clinical social workers, audiologists, nurse midwives, clinical psychologists, and physician assistants.

Part C of the Medicare Program
See Medicare Advantage.

Part D of the Medicare Program
See Prescription Drug Plans.

Physician Scarcity Area Bonus Payment
A five percent bonus payment paid to physicians who furnish outpatient professional services to a Medicare beneficiary in an area that has been identified as a primary care Physician Scarcity Area (PSA) and specialty physicians who furnish outpatient professional services to a Medicare beneficiary in an area that has been identified as a specialty care PSA.

Physician Services
Services furnished by an individual licensed under State law to practice medicine or osteopathy.

Prescription Drug Plans
Prescription drug coverage available to all beneficiaries who elect to enroll in a Prescription Drug Plan or Medicare Advantage Prescription Drug Plan.

Pricer
Software modules in Medicare claims processing systems that are specific to certain benefits and used in pricing claims, most often under Prospective Payment Systems.

Prospective Payment System
Method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount.

Q

Quality Improvement Organization Program
Program that consists of a national network of 53 Quality Improvement Organizations (QIO) that are responsible for each U.S. state, territory, and the District of Columbia. QIOs work with consumers, physicians, hospitals, and other caregivers to refine care delivery systems to ensure that beneficiaries receive the right care at the right time, particularly beneficiaries from underserved populations; and investigates beneficiary complaints about quality of care and safeguards the integrity of the Medicare Trust Fund by ensuring that payment is made only for medically necessary services.

R

Reasonable Cost
Medicare reimbursement that is based on the actual cost of furnishing services including direct and indirect cost of providers and excluding any costs that are unnecessary in the efficient delivery of services covered by the program. Fiscal Intermediaries, Carriers, and A/B Medicare Administrative Contractors use the Centers for Medicare & Medicaid guidelines to determine reasonable costs incurred by individual providers in furnishing covered services to Medicare beneficiaries.

Rural Health Clinic
A facility that is in an area determined to be non-urban and designated by the Health Resources and Services Administration as having a shortage of personal health care services or primary care medical services.

Rural Referral Center Program
Program established to support high-volume rural hospitals that treat a large number of complicated cases. Requirements under 42 CFR Section 412.96 of the *Code of Federal Regulations* must be met in order for a hospital to be classified as a Rural Referral Center.

S

Skilled Nursing Care
Level of care that includes services that can only be performed safely and correctly by a licensed nurse.

Skilled Nursing Facility
Facility that meets specific regulatory certification requirements and primarily furnishes inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services and does not furnish the level of care or treatment available in a hospital.

Social Security Act (the Act)
Public Law 74-271 that was enacted on August 14, 1935, with subsequent amendments.

Sole Community Hospital
A hospital that is located more than 35 miles from other like hospitals or is located in a rural area and meets certain additional requirements**.**

Swing Bed
Beds that a small rural hospital can use for either Skilled Nursing Facility or hospital acute-level care on an as-needed basis if the hospital has obtained approval from the Department of Health and Human Services.

T

Telehealth
Professional consultations, office or other outpatient visits, individual psychotherapy, pharmacologic management, psychiatric diagnostic interview examinations, End-Stage Renal Disease-related services included in the monthly capitation payment (except for one visit per month to examine the access site), individual medical nutrition therapy, and neurobehavioral status examinations furnished by an interactive telecommunications system to Medicare beneficiaries in rural areas.

REFERENCE D
ACRONYMS

AIF	Ambulance Inflation Factor
AMA	American Medical Association
BBA	Balanced Budget Act
CAH	Critical Access Hospital
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CNM	Certified Nurse Midwife
CNS	Clinical Nurse Specialist
CP	Clinical Psychologist
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetist
CSW	Clinical Social Worker
CY	Calendar Year
DME	Durable Medical Equipment
DPP	Disproportionate Patient Percentage
DPU	Distinct Part Unit
DRA	Deficit Reduction Act of 2005
DSH	Disproportionate Share Hospital
EMS	Emergency Medical Services
ESRD	End-Stage Renal Disease
FI	Fiscal Intermediary
FQHC	Federally Qualified Health Center

FS	Fee Schedule
FY	Fiscal Year
GAF	Geographic Adjustment Factor
GPCI	Geographic Practice Cost Index
HCPCS	Healthcare Common Procedure Coding System
HH	Home Health
HHA	Home Health Agency
HHRG	Home Health Resource Group
HHS	Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
HPSA	Health Professional Shortage Area
HQA	Hospital Quality Alliance
ICD	International Classification of Diseases
IPPS	Inpatient Prospective Payment System
LUPA	Low-Utilization Payment Adjustment
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MA-PD	Medicare Advantage Prescription Drug
MCR	Medicare Contracting Reform
MDH	Medicare Dependent Hospital
MGCRB	Medicare Geographic Classification Review Board
MLN	Medicare Learning Network

MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MNT	Medical Nutrition Therapy
MPFS	Medicare Physician Fee Schedule
MSA	Medical Savings Account
NP	Nurse Practitioner
NPI	National Provider Identifier
NPP	Nonphysician Practitioner
OASIS	Outcome and Assessment Information Set
OPPS	Outpatient Prospective Payment System
OT	Occupational Therapy
PA	Physician Assistant
PDP	Prescription Drug Plan
PEP	Partial Episode Payment
PFFS	Private Fee-for-Service
PHS	Public Health Service
POP	Point-of-Pickup
PPO	Preferred Provider Organization
PPS	Prospective Payment System
PSA	Physician Scarcity Area
PT	Physical Therapy
QIO	Quality Improvement Organization
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary

RRC	Rural Referral Center
RVU	Relative Value Unit
SCH	Sole Community Hospital
SCIC	Significant Change in Condition
SLP	Speech-Language Pathology
SNF	Skilled Nursing Facility
SSI	Supplemental Security Income
TrOOP	True Out-of-Pocket