	MEDICAL ASSISTANCE BULLETIN **COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF PUBLIC WELFARE**		
	NUMBER: 35-98-10, 36-98-10	**ISSUE DATE**: July 31, 1998	**EFFECTIVE DATE**: January 1, 1996
SUBJECT: Medicare Cost-Sharing Payments for Nursing Facility Residents	**BY:**  **Robert S. Zimmerman, Jr., M.P.H** Deputy Secretary for Medical Assistance Programs		

PURPOSE:

This bulletin informs nursing facility providers of changes to the Department's payment processes that will: 1) permit facilities to obtain payment of full Medicare coinsurance and deductible (cost-sharing) amounts for Medicare Part A or Medicare Part B services provided to Qualified Medicare Beneficiaries (QMBs) during the period January 1, 1996 through December 31, 1997; and, 2) permit payment of Medicare cost-sharing amounts up to the applicable MA per diem rate or fee for Medicare Part A and Part B services provided to dual eligible nursing facility residents, including QMBs, effective January 1, 1998.

SCOPE:

This bulletin applies to all nursing facility providers enrolled in the Medical Assistance (MA) Program and the Medicare Program.

BACKGROUND:

Following the decision of the Third Circuit Court of Appeals in Pennsylvania Medical Society v. Snider, 29 F. 3d 886 (July 20, 1994), the Department amended its payment procedures to pay MA outpatient providers full Medicare cost-sharing amounts relating to Medicare Part B services provided to QMBs. The Department continued to limit reimbursement to nursing facility providers for Medicare Part A cost-sharing amounts to the Department's MA per diem rate, and did not establish a payment process to reimburse nursing facility providers for Medicare Part B cost-sharing amounts.

As the result of a written Stipulation of Settlement in Pennsylvania Health Care Association v. Houstoun, No. 1-CV-97-0934 (M.D. Pa.), the Department has agreed to pay nursing facility providers full Medicare coinsurance and deductible amounts for Medicare Part A and Part B services rendered to QMBs during the period January 1, 1996 through December 31, 1997 and that were paid for by Medicare through a fiscal intermediary or carrier or that were not paid for because of the application of a deductible. The procedure that the Department will follow in making these full cost-sharing payments is described below. The Department's payment of Medicare cost-sharing amounts for Medicare Part A services is subject to the patient pay amount (the amount that the resident is required to contribute toward the cost of his/her nursing facility care as specified below).

DISCUSSION:

A. Payment of Medicare Cost-Sharing for Medicare Part A and Part B services provided to QMB nursing facility residents from January 1, 1996 through December 31, 1997.

For purposes of making these retroactive full cost-sharing payments, only those nursing facility residents who were Medicare beneficiaries and who were MA-eligible in the following categories and program status codes at the time services were provided are considered QMBs.

Table: QMB Category/Status Code

CATEGORY	STATUS CODE

A	Any
J	Any
M	Any
PG	Any
PL	Any
PS	70 or 90
PA	80
PJ	80
PM	80
B	80

QMB CATEGORY/STATUS CODE TABLE

To determine whether a resident was MA-eligible in one of the above-mentioned category and status code combinations, providers should examine the resident's Notice of Eligibility (PA-162) effective for the dates of service in question. If the resident's PA-162 does not contain the resident's category or status code, providers may access the Eligibility Verification System (EVS) to obtain the resident's eligibility category and status code. The toll-free telephone number for the EVS is 1-800-766-5387. For further instructions on how to use the EVS, see Section II, Recipient Eligibility, of the Nursing Facility Services Handbook. If you are unable to determine a recipient's category/status code combination from examining the PA-162 or through the EVS, or need documentation showing a recipient's category/status code for Medicare audit purposes, you may contact the County Assistance Office.

B. Payment of Medicare cost-sharing for Medicare Part A and Part B services provided to non-QMB dual eligible nursing facility residents from January 1, 1996 through December 31, 1997.

During the period January 1, 1996 through December 31, 1997, any dual eligible MA resident with a category and status code combination other than those identified in the QMB Category/Status Code Table in Section A above was not a QMB. For non-QMB dual eligible residents, the Department's payment of Medicare coinsurance and deductible amounts remains governed by 55 PA. Code § 1187.102, and other applicable billing and payment regulations. Under these regulations, DPW pays Medicare cost-sharing amounts only if the Medicare payment received by the facility is less than the facility's MA per diem rate in the case of Part A services or the applicable MA fee in the case of Part B services. If the Medicare payment received by the facility is less than the MA per diem rate or fee, the Department pays cost-sharing amounts to the extent that the Medicare payment and Department's payment do not exceed the MA per diem rate or fee up to the maximum cost-sharing amount. The Department will not pay more than the maximum cost-sharing amount. The Department's payment of Medicare cost-sharing amounts for Medicare Part A services is subject to the patient pay amount (the amount that the resident actually contributed toward the cost of his/her nursing facility services).

If the Medicare payment received by the facility is equal to or greater than the facility's MA per diem rate or fee, the Department will not make any payment for Medicare cost-sharing amounts for non-QMB MA residents, and any claims for such cost-sharing amounts for non-QMB MA residents shall be deemed denied regardless of whether the claims were actually submitted. In addition, if the Medicare payment received by the facility is less than the MA per diem rate, the Department will pay cost-sharing amounts up to the MA per diem rate or fee. To the extent that claims for cost-sharing amounts would result in a payment which together with the Medicare payment would exceed the MA per diem rate or fee, claims shall be considered to have been made and deemed denied.

C. Payments of Medicare cost-sharing amounts for Medicare Part A and Part B services provided to nursing facility residents after January 1, 1998.

DPW's payment of cost-sharing amounts for Medicare Part A and Part B services provided to MA residents on or after January 1, 1998 is governed by 55 Pa. Code § 1187.102 and other applicable billing and payment regulations. **Effective January 1, 1998, the MA per diem rate or fee is the maximum payment that may be received by the facility for services provided to both QMB MA residents and non-QMB MA residents. If the Medicare payment received by the facility is equal to or greater than the MA per diem rate in the case of Part A services or the applicable MA fee in the case of Part B services, the Department is not required to make any payment for Medicare cost-sharing amounts.** Nursing facilities are reminded that they may not seek or accept payment for an MA-covered service or item from a source other than Medicare for any portion of the Medicare co-insurance amount

that is not paid by the Department on behalf of an eligible resident because of the limit of the nursing facility's MA per diem rate or MA fee, and that they may not claim unreimbursed cost-sharing amounts as deductions or expenses against patient pay amounts on the Medical Assistance Long Term Care Invoice (MA 309C). In addition, nursing facilities should be aware that recent amendments to federal law make it illegal for facilities and other providers of Medicare services to bill QMBs for any cost-sharing amounts that are not reimbursed by DPW because of the application of an MA payment or fee limit. See: Balanced Budget Act of 1997, § 4714, P.L. 105-33, § 4711(a) and (b).

Effective on or after January 1, 1998, nursing facility residents who are Medicare beneficiaries and who are MA-eligible in the following categories and program status codes at the time that the services are provided are considered QMBs:

Table: QMB Category/Status Code

CATEGORY	STATUS CODE
A	Any
J	Any
M	Any
PG	Any
PL	Any
PS	70 or 90
PA	80
PJ	80
PM	80
B	80
*TA	80
*TB	80
*TJ	80

*** Effective April 1, 1998**

PROCEDURE:

A. Required Provider Certification and Agreement Form.

A nursing facility must submit the attached Provider Certification and Agreement Form to DPW as a condition of receiving payment of cost-sharing amounts for Medicare Part A and Part B services provided to QMBs during the period January 1, 1996 through December 31, 1997. By submitting the attached form the nursing facility, among other things, will certify to DPW that it may not and will not claim as deduction or expense against a patient pay amount on a Medical Assistance Long Term Care Invoice (MA 309C) any cost-sharing amount for which the facility is seeking direct payment from DPW or reimbursement from Medicare as "bad debt". If a nursing facility has claimed any such cost-sharing amount as a deduction or expense against a patient pay amount on an MA 309C that has been approved for payment by the Department in the past, or that is approved for payment by the Department under the payment process described in this bulletin, the facility has been or will be overpaid by DPW in an amount equal to the cost-sharing amount claimed as expenses or deductions and the facility must repay DPW the overpayment in full no later than February 15, 1999. The nursing facility may be subject to sanctions and penalties, as deemed appropriate by the Department, if the facility does not repay the Department overpayments made as the result of such improper deductions and expenses against patient pay amounts, or if the facility continues to make such improper deductions and expenses against patient pay amounts.

The nursing facility must submit the attached Provider Certification and Agreement Form bearing an original signature to:

Department of Public Welfare
Bureau of Long Term Care Programs
Division of Provider Services
P.O. Box 8025 Harrisburg, PA 17105-8025
ATTENTION: MEDICARE EXCEPTIONS

The Certification and Agreement Form must be signed by a person with legal authority to bind the facility. **DPW will not process and pay a facility's cost-sharing claims unless it receives a properly executed Certification and Agreement Form on or before September 1, 1998. In the event DPW pays a facility cost-sharing amounts without having obtained a properly executed Certification and Agreement Form, DPW will recover such payments from the facility's monthly MA payments until the amount is recovered in full.**

(The Certification and Agreement Form is attached to this bulletin.)

B. Payment processing of Medicare cost-sharing claims for services provided to QMB nursing facility residents from January 1, 1996 through December 31, 1997.

Claims for Medicare cost-sharing for Medicare Part A and Part B services provided to QMB nursing facility residents from January 1, 1996 through December 31, 1997 will be processed and paid by DPW subject to the following:

1. **Cost-Sharing claims previously submitted and paid.**

   a. **Medicare Part A:** DPW has permitted nursing facilities to claim Medicare cost-sharing amounts for Medicare Part A services, but has limited payment of such claims to the facilities' MA per diem rate. Consequently, some facilities may have submitted invoices and received payment, in whole or in part, of Medicare cost-sharing claims for Part A services provided from January 1, 1996 through December 31, 1997. DPW will adjust invoices that have already been processed and approved for the dates of services January 1, 1996 through December 31, 1997, for residents with the QMB category/status code combinations identified in the QMB Category/Status Code Table to pay at the full Medicare coinsurance rate in effect for the date of service. These invoices will be processed and paid in a special cycle during September 1998. Nursing facilities will not be required to submit claim adjustments for these claims.

   b. **Medicare Part B:** Some nursing facilities may have submitted claims to and received payment from Medicare carriers for Part B services provided to nursing facility residents. Since the inception of the Medicare Crossover Project with Medicare Carriers, such claims "crossed over" to Medical Assistance from the carriers, but, in most instances, were dropped, and therefore, not paid by DPW, or were not paid in full. DPW will process these dropped "cross-over" claims from Provider Types 35 and 36 to pay the full Medicare cost-sharing amount for the services identified on the "cross-over" claim. These claims will be processed and paid in a special cycle during September 1998. Nursing facilities will not have to submit invoices for these cost-sharing amounts.

2. **Cost-Sharing claims not previously submitted and paid.**

   a. **Medicare Part A:** After the invoices processed in the special cycle described in **Procedure**: Section (B)(1)(a) above have been paid, nursing facilities should examine their books and records to determine whether they have any Medicare Part A cost-sharing claims that were not previously submitted and paid for the dates of services from January 1, 1996 through December 31, 1997, for residents with QMB category/status code combinations identified in the QMB Category/Status Code Table. Nay previously submitted claims that were not paid under **Procedure**: Section (B)(1)(a) may also be submitted for payment in this process. Nursing facilities may submit Long Term Care invoices (MA 309C) for any such unpaid Medicare Part A cost-sharing claims and receive payment from DPW subject to the following requirements: The invoices (MA 309C) must be submitted no later than December 15, 1998 to:

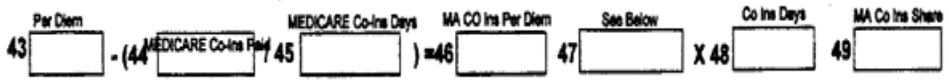
   The invoices (MA 309C) must be submitted **no later than December 15, 1998 to:**

   Department of Public Welfare
   Bureau of Long Term Care Programs
   Division of Provider Services
   P.O. Box 8025
   Harrisburg, PA 17105-8025
   ATTENTION: MEDICARE EXCEPTIONS

   Invoices submitted on or after December 16, 1998 will be rejected as untimely.

   The invoices (MA 309C) must be completed in accordance with the billing instructions in the Nursing Facility Services Handbook with the following exceptions:

The Medicare fields must be completed as follows:



43 PER DIEM (Optional) - This field is optional because the per diem is entered in field 38. If entering a per diem rate, enter the Medical Assistance per diem rate in effect on the dates of service.

44 MEDICARE CO INS PAID (Must if applicable) - Leave this field blank only when billing for the Medicare co-insurance for the dates of service from January 1, 1996 through December 31, 1997.

45 MEDICARE CO INS DAYS (Must if applicable) - Enter the number of co-insurance days for which you are billing.

46 MA CO INS PER DIEM (Must if applicable) - You may leave this field blank or enter the Medicare co-insurance rate in effect on the dates of service. The coinsurance rate was $92/day during calendar year 1996 and $95/day during calendar year 1997.

47 LESSER OF MA CO INS PER DIEM OR MEDICARE CO INS RATE (Must if applicable) - Enter the Medicare co-insurance rate in effect on the dates of service; this amount was $92/day during calendar year 1996 and $95/day during calendar year 1997.

48 CO INS DAYS (Optional) - This field is optional because the number of co-insurance days is entered in field 45.

49 MA CO INS SHARE (Must if applicable) - Enter the amount calculated by multiplying the number of co-insurance days from field 45 times the Medicare co-insurance rate in field 47. This amount should be carried on t field 50 to be added to the amount in field 51 (or field 39) to determine the amount in field 52 the Total Facility/Leave Day Allowance.

Patient Pay fields (fields 53 through 57) should be completed using the amounts that were actually applied to the service period for which you are billing.

b. **Medicare Part B:** After the "cross-over" claims processed in the special cycle described under **Procedure**: Section (B)(1)(b) above have been paid, nursing facilities should examine their books and records to determine whether they have any Medicare Part B cost-sharing claims that were not previously submitted and paid for the dates of service January 1, 1996 through December 31, 1997, for residents with QMB category/status code combinations identified in the QMB Category/Status Code Table. Any previously submitted claims that were not paid under **Procedure**: Section (B)(1)(b) may also be submitted for payment in this process. Nursing facilities may submit Medical Services Invoices (MA 319) for such unpaid Medicare Part B cost-sharing claims and receive payment for DPW subject tot the following requirements:

The invoices (MA 319) must be submitted **no later than December 15, 1998** to:

Department of Public Welfare
Bureau of Long Term Care Programs
Division of Provider Services
P.O. Box 8025
Harrisburg, PA 17105-8025
ATTENTION: MEDICARE EXCEPTIONS

Invoices submitted on or after December 16, 1998 will be rejected as untimely.

The invoices (MA 319) must be completed in accordance with the instructions for completion of the Medical Services Invoice (MA 319) which are included with this bulletin:

c. **Resubmission of denied claims:** In the event an invoice submitted pursuant to Procedure: Section (B)(2)(a) or (b) is rejected by DPW for any reason other than timeliness, a nursing facility may submit one claim adjustment (resubmission) within sixty (60) days of the date of the remittance advice notifying the nursing facility of the rejection. That resubmission must be completed in accordance with the instructions contained in Procedure: Section (B)(2)(a) and (b) of this bulletin and submitted to:

Bureau of Long Term Care Programs
Division of Provider Services
P.O. Box 8025 Harrisburg, PA
17105-8025 ATTENTION: MEDICARE EXCEPTIONS

Any resubmission received by DPW later than sixty (60) days from the date of the remittance advice will be rejected by DPW as untimely.

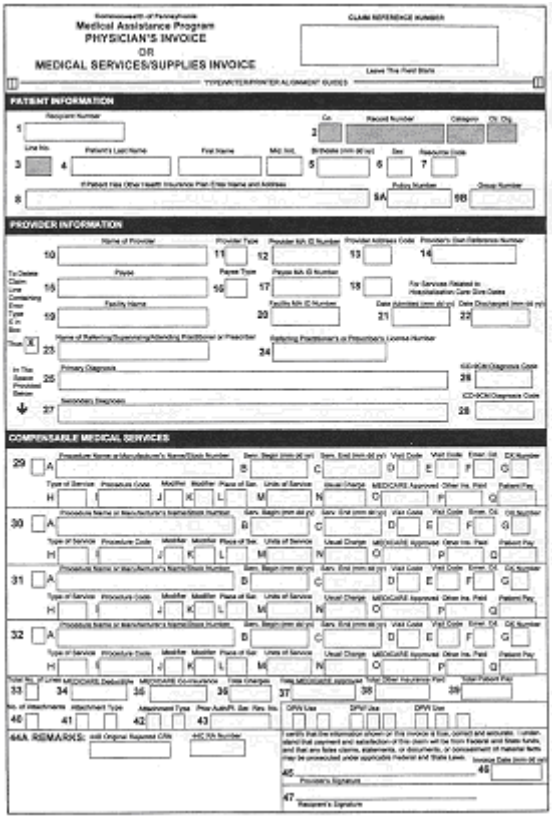
C. Payment processing of Medicare cost-sharing claims for services provided to nursing facility residents on or after January 1, 1998.

Nursing facilities will continue to bill on the Medical Services/Supplies Invoice (MA 319) for Medicare Part B deductibles and coinsurance for dual eligible residents whether they are QMBs or non-QMBs. Nursing facilities will bill for Medicare Part A coinsurance on the MA 309C, Long Term Care Invoice, for the MA coinsurance share as they have done prior to January 1, 1996. The invoices will be paid insofar as the amounts paid by Medicare do not exceed the MA per diem rate or fee, up to the maximum cost-sharing amount.

Except as permitted below, invoices for cost-sharing claims for dates of service on or after January 1, 1998 must be submitted in accordance with the time frames contained in 55 Pa. Code § 1101.68(b). Invoice exception requests for cost-sharing amounts are subject to 55 Pa. Code § 1101.68(c) and (d). Exception requests must be submitted to:

Department of Public Welfare
Bureau of Long Term Care Programs
Division of Provider Services
P.O. Box 8025
Harrisburg, PA 17105-8025
ATTENTION: MEDICARE EXCEPTIONS

Invoices for Part B cost-sharing claims for January 1, 1998 through March 31, 1998 will be granted a one-time extension for submission. We will accept invoices for Part B cost-sharing amounts for dates of service January 1, 1998 through March 31, 1998 at the exception request address noted above until November 15, 1998. Unless an invoice would otherwise meet the requirements set forth in 55 Pa. Code § 1101.68(c) and (d), we will reject any invoice as untimely for Part B cost-sharing claims for dates of service January 1, 1998 through March 31, 1998 submitted on or after November 16, 1998.


Medical Assistance Program
PHYSICIAN'S INVOICE
OR
MEDICAL SERVICES/SUPPLIES INVOICE

PATIENT INFORMATION

PROVIDER INFORMATION

COMPENSABLE MEDICAL SERVICES

ATTACHMENTS:

- Instructions for Completion of Medical Services/Supplies (MA 319) Invoice
- Provider Certification and Agreement Regarding Medicare Cost-Sharing Payments
- Medical Assistance Literature Subscription Form

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:
Bureau of Long Term Care Programs
Division of Provider Services
P.O. Box 8025
Harrisburg, PA 17105-8025
1-800-932-0939

Visit the Office of Medical Assistance Programs website at www.dpw.state.pa.us/omap.