CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 654 **Date: AUGUST 19, 2005**

CHANGE REQUEST 3781

SUBJECT: Services Not Provided Within United States

I. SUMMARY OF CHANGES: Although the typical exceptions to Medicare's "foreign exclusion" involve services that are furnished in Canada and Mexico, it is possible for Medicare to make payment to foreign hospitals besides those located in Canada and Mexico. For example, if an emergency necessitated that inpatient hospital services be furnished to a Medicare beneficiary who is living in Guam and the nearest adequately equipped hospital to treat that beneficiary was located in the Philippines, Medicare payment would not be prohibited under Medicare's "foreign exclusion" because Medicare payment may be permitted for the services under section 1814(f) of the Social Security Act (42 U.S.C. 1395f(f)).

NEW/REVISED MATERIAL– EFFECTIVE/IMPLEMENTATION DATES:
November 17, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1//10.1.4/Services Received by Medicare Beneficiaries Outside the United States
R	1//10.1.4.3/Source of Part B Claims
R	1/10.1.4.5/Appeals of Denied Charges for Physicians and Ambulance Services in Connection With Foreign Hospitalization
R	3/Table of Contents
R	3/110.1/Services Rendered in Nonparticipating Providers
R	3/110.5/Coverage Requirements for Emergency Hospital Services in Foreign Countries
R	3/110.6/Services Furnished in a Foreign Hospital Nearest to Beneficiary's U.S. Residence
R	3/110.7/Coverage of Physician and Ambulance Services Furnished Outside U.S.
R	3/110.8/Payment by the RRB for Services Furnished in Canada to Qualified Railroad Retirement Beneficiaries
R	3/110.10/Foreign Religious Nonmedical Health Care Facility Claims

R	3/110.11/Elections to Bill for Services Rendered Nonparticipating Hospitals
R	3/110.12/Processing Claims
R	3/110.13/Appeals on Claims for Emergency and Foreign Services
R	3/120.1/Payment for Services from Foreign Hospitals
R	3/120.3.8/Full Denial - Foreign Claim - Beneficiary Filed

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 654	Date: August 19, 2005	Change Request 3781

SUBJECT: Services Not Provided Within United States

I. GENERAL INFORMATION

A. Background: Although the typical exceptions to Medicare's "foreign exclusion" involve services that are furnished in Canada and Mexico, it is possible for Medicare to make payment to foreign hospitals besides those located in Canada and Mexico. For example, if an emergency necessitated that inpatient hospital services be furnished to a Medicare beneficiary who is living in Guam and the nearest adequately equipped hospital to treat that beneficiary was located in the Philippines, Medicare payment would not be prohibited under Medicare's "foreign exclusion" because Medicare payment may be permitted for the services under section 1814(f) of the Social Security Act (the Act) (42 U.S.C. 1395f(f)).

B. Policy: Section 1814(f)(2) of the Act permits payment to be made to a foreign hospital for emergency inpatient services provided to a beneficiary where the beneficiary was present in the United States at the time the emergency that necessitated the inpatient hospital services occurred and the hospital outside the U.S. was closer to, or substantially more accessible from, the place where the emergency arose than the nearest adequately equipped hospital within the U.S. For purposes of section 1814(f) of the Act, the United States includes the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, The Northern Mariana Islands, and for purposes of services rendered on board ship, the territorial waters adjoining the land areas of the U.S.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3781.1	Medicare intermediaries and carriers shall permit payment to be made to a foreign hospital for emergency inpatient services provided to a beneficiary where the beneficiary was present in the United States at the time the emergency that necessitated the inpatient hospital services occurred and the hospital outside the U.S. was closer to, or substantially more accessible from,	X		X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	the place where the emergency arose than the nearest adequately equipped hospital within the U.S.									

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3781.2	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X						

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: November 17, 2005 **Implementation Date:** November 17, 2005 **Pre-Implementation Contact(s):** Fred Grabau (410-786-0206 **Post-Implementation Contact(s):** Fred Grabau (410-786-0206	**No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.**

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

10.1.4 - Services Received by Medicare Beneficiaries Outside the United States

(Rev. 654; Issued: 08-19-05; Effective and Implementation Dates: 11-17-05)

Items and services *furnished outside the United States are excluded from coverage* except for *the following services, and certain services rendered on board a ship:*

- *Emergency inpatient hospital services where the emergency occurred:*
  - *While the beneficiary was physically present in the United States; or*
  - *In Canada while the beneficiary was traveling without reasonable delay and by the most direct route between Alaska and another State.*

  See Chapter 3, Inpatient Hospital Billing, Section 110 for a description of claims processing procedures.
- *Emergency or nonemergency inpatient hospital services furnished by a hospital located outside the United States, if the hospital was closer to, or substantially more accessible from, the beneficiary's United States residence than the nearest participating United States hospital that was adequately equipped to deal with, and available to provide treatment for the illness or injury (see Chapter 3, Inpatient Hospital Billing, Section 110 for a description of claims processing procedures);*
- *Physician and ambulance services furnished in connection with, and during a period of, covered foreign hospitalization. Program payment may not be made for any other Part B medical and other health services, including outpatient services furnished outside the United States (see Chapter 1, General Billing Requirements, Section 10.1.4.1 for a description of claims processing procedures);*
- Services *rendered* on board a ship in a United States port, or within 6 hours of when the ship arrived at, or departed from, a United States port, are considered to have been furnished in United States territorial waters. Services not furnished in a United States port, or *within* 6 hours *of when the ship arrived at, or departed from,* a United States port, are considered to have been furnished outside United States territorial waters, even if the ship is of United States registry (see Chapter 1, General *Billing Requirements*, Section 10.1.4.7 for a description of claims processing procedures).

The term "United States" means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, American Samoa and, for purposes of services rendered on a ship, includes the territorial waters adjoining the land areas of the United States.

A hospital that is not physically situated in one of the above jurisdictions is considered to be outside the United States, even if it is owned or operated by the United States Government.

Payment *may* not be made for any item provided or delivered to the beneficiary outside the United States, even though the beneficiary may have contracted to purchase the item while he or she was within the United States or purchased the item from an American firm.

Under the Railroad Retirement Act, payment is made to Qualified Railroad Retirement Beneficiaries (QRRBs) by the RRB for covered hospital services furnished in Canadian hospitals as well as in the U.S. Physician and ambulance services are not covered by the Railroad Retirement Act; however, under an agreement between CMS and RRB, if the QRRB claims payment for Part B services in connection with Canadian hospitalization, RRB processes the Part B claim. In such cases the RRB determines:

- *Whether the requirements in are met for the inpatient services; and*
- *Whether the physician and/or ambulance services were furnished in connection with the services.*

Services for an individual who has elected Religious Nonmedical Health Care status may be covered if the above requirements are met but this revokes the Religious Nonmedical Health Care Institution election.

10.1.4.3 - Source of Part B Claims

(Rev. 654; Issued: 08-19-05; Effective and Implementation Dates: 11-17-05)

Because coverage of Part B services furnished *by a hospital located outside the United States* is contingent upon coverage of related inpatient hospital services, carriers designated in §10.1.4.2 will receive such claims from the FI servicing the foreign hospital only after the FI has determined that the Part A services are covered. (However, if the claimant is a qualified railroad retirement beneficiary, see §10.1.4.6 for special procedures.)

NOTE: If a designated carrier in §10.1.4.2 receives a claim for Part B services (*that were furnished outside the United States)* from any source other than an FI and there is an indication the services were furnished in connection with covered inpatient services, carriers send the claim to the appropriate FI. If the claim does not show that the beneficiary was hospitalized, carriers send the beneficiary a front-end rejection notice. In filling out the Notification of Medicare Determination, carriers check "other" and include the following explanation: "Foreign physician or ambulance services are not covered unless they were furnished in connection with a covered inpatient stay."

The FI controls the claim and holds it pending a determination on the related Part A claim.

The following FIs are responsible for processing foreign claims:

Canadian Claims

Provinces:	**FIs:**
New Brunswick Newfoundland Nova Scotia Quebec Prince Edward Island	Associated Hospital Services of Maine 2 Gannett Drive Portland, Maine 04106-6911
Ontario	*United Government Services, LLC* *P.O. Box 9150* *Oxnard, CA 93031*
Saskatchewan Alberta Manitoba	Blue Cross of Montana 3360 10th Avenue, South P.O. Box 5017 Great Falls, Montana 59403
British Columbia Vancouver Yukon Territories	*Noridian Administrative Services* *Medicare Operations Center 901 40th St S Suite 1* *Fargo, ND 58103*

Mexican Claims

Areas	**Carriers:**
Western Mexico (Sonora and the Bajas)	Blue Cross of California 21555 Oxnard St. Woodland Hills, CA 91367
Eastern Mexico (Chihuahua, Coahuila, Nuevo Leon, Tamaulipas, etc.)	*Trail Blazer Health Enterprises, LLC,* *8330 LBJ Freeway, Executive Center III,* *Dallas, Texas 75243*

Prior to submitting the claim to the carrier, the FI determines whether the requirements in §10.1.4.1.A and B are met. If these requirements are not met, the FI denies the Part A claim and related Part B claim and notifies the enrollee. Where the FI determines that the requirements in §10.1.4.1.A or B are met, the Part A FI determines whether other applicable Part A coverage requirements are met. If the FI disallows the Part A claim, it denies the related Part B claim and notifies the enrollee. If the FI approves the Part A claim, it sends the Part B claim to the appropriate carrier for consideration of whether the other requirements for Part B coverage are met, and for further processing. However, carriers will not be involved in the processing of *foreign claims* if, for any reason, the related Part A claim is denied. Claims for services provided in countries other than Canada or Mexico should be sent to the *carrier who is responsible for the state or territory where the emergency arose. In other words, the foreign claim would be processed similarly to how claims are processed in the state or territory where the emergency arose.*

10.1.4.5 - Appeals of Denied Charges for Physicians and Ambulance Services in Connection With Foreign Hospitalization

(Rev. 654; Issued: 08-19-05; Effective and Implementation Dates: 11-17-05)

Where a request for review of an initial determination is received, the office that made the initial determination will conduct the review. If the request deals with an initial determination made by the Regional Office (RO), the RO will conduct the review and will notify the enrollee of the decision; if the request relates to a carrier determination, the carrier will conduct the review determination and notify the enrollee.

All requests for a hearing on claims for physician/ambulance services furnished in *foreign countries* fall within the jurisdiction of a hearing officer of the appropriate carrier in §10.1.4.2 regardless of who made the review determination. However, a hearing request on an RO review determination (e.g., whether the emergency or accessibility requirements are met) will normally be in connection with the Part A claim and will be considered and processed as such. If, however, the enrollee already had a Part A hearing on the RO part of the decision and then requests a hearing on the same issue for the Part B claim, the RO should forward all pertinent information regarding the initial and review determinations and the hearing to the carrier as soon as it is aware of the Part B hearing request.

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

Table of Contents

(Rev. 654, 08-19-05)

110.1 - Services Rendered in Nonparticipating Providers

(Rev. 654; Issued: 08-19-05; Effective and Implementation Dates: 11-17-05)

A. Services in Nonparticipating Domestic Hospital

Payment may be made for certain Part A inpatient and Part B outpatient hospital services provided in a nonparticipating U.S. hospital where they are necessary to prevent the death or serious impairment of the health of the individual. Because of the threat to the life or health of the individual, the use of the most accessible hospital equipped to furnish such services is necessary. Items and services furnished in a domestic nonparticipating hospital may be reimbursed if the following apply:

- The hospital meets the definition of an emergency hospital. (See §110.2.)
- The services meet the definition of emergency services. (See §110.1.)
- The hospital is substantially more accessible from the site of the emergency than is the nearest participating hospital. (See §110.5.)

B. Beneficiary Services Outside United States

Items and services furnished outside the United States are excluded from coverage except for the following services, and certain services rendered on board a ship:

- Emergency inpatient hospital services where the emergency occurred:
    - While the beneficiary was physically present in the United States; or
    - In Canada while the beneficiary was traveling without reasonable delay and by the most direct route between Alaska and another State.

  See section 110 for a description of claims processing procedures.
- Emergency or nonemergency inpatient hospital services furnished *by a hospital located outside the United States, if the* hospital *was* closer to, or substantially more accessible from, the beneficiary's United States residence than the nearest participating United States hospital which was adequately equipped to deal with and available to provide treatment of the illness or injury (see section 110 for a description of claims processing procedures);
- Physician and ambulance services furnished in connection with, and during a period of, covered foreign hospitalization. Program payment may not be made for any other Part B medical and other health services, including outpatient services furnished outside the United States (see Medicare Claims Processing Manual Chapter 1, General *Billing Requirements*, Section 10.1.4.1 for a description of claims processing procedures);
- *Services rendered on board a ship in a United States port, or within 6 hours of when the ship arrived at, or departed from, a United States port, are considered to have been furnished in United States territorial waters. Services not furnished in a United States port, or within 6 hours of when the ship arrived at, or departed from, a United States port, are considered to have been furnished outside United States territorial waters, even if the ship is of United States registry (see Chapter*

1, General Billing Requirements, Section 10.1.4.7 for a description of claims processing procedures).

The term “United States” means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, American Samoa and, for purposes of services rendered on a ship, *includes* the territorial waters adjoining the land areas of the United States.

A hospital that is not physically situated in one of *the above* jurisdictions is considered to be outside the United States, even if it is owned or operated by the United States Government.

Payment may not be made for any item provided or delivered to the beneficiary outside the United States, even though the beneficiary may have contracted to purchase the item while they were within the United States or purchased the item from an American firm.

Under the Railroad Retirement Act, payment is made to Qualified Railroad Retirement Beneficiaries (QRRBs) by the RRB for covered hospital services furnished in Canadian hospitals as well as in the U.S. Physician and ambulance services are not covered by the Railroad Retirement Act; however, under an agreement between CMS and RRB, if the QRRB claims payment for Part B services in connection with Canadian hospitalization, RRB processes the Part B claim. In such cases the RRB determines:

- *Whether the requirements in are met for the inpatient services; and*
- *Whether the physician and/or ambulance services were furnished in connection with the services.*

Services for an individual who has elected Religious Nonmedical Health Care status may be covered if the above requirements are met but this revokes the Religious Nonmedical Health Care Institution election.

110.5 - Coverage Requirements for Emergency Hospital Services in Foreign Countries

(Rev. 654; Issued: 08-19-05; Effective and Implementation Dates: 11-17-05)

The following requirements must be met for payment to be made for emergency services received by Medicare beneficiaries in foreign hospitals:

- The hospital must meet the definition of an emergency hospital and be licensed *or approved by the appropriate agency of the country in which it is located.*
- The services meet the criteria of emergency services.

The foreign hospital must be closer to or substantially more accessible from the site of the emergency than the nearest U.S. hospital that was adequately equipped and available to treat the illness or injury.

1. Emergency Occurred in the U.S. *(See §110.1.B for definition of the U.S.)*

   If the individual was physically present in the U.S. at the time the emergency occurred, the individual's reason for departure from the U.S. must have been specifically to obtain treatment at the foreign hospital. Services are not covered where the person's departure from the U.S. is part of a trip abroad and the *foreign* hospital is more accessible simply because the individual was in the process of travel. For example, the airplane on which the individual was traveling could not readily return to permit the person's removal.

2. Emergency Occurred in Canada

   If the emergency occurred in Canada, the beneficiary must have been traveling, without unreasonable delay, by the most direct route between Alaska and another State. Benefits are not payable if the emergency occurred while a beneficiary was vacationing. The requirement of travel without unreasonable delay by the most direct route will be considered met if the emergency occurred while the beneficiary was enroute between Alaska and another State by the shortest practicable route, or while making a necessary stopover in connection with such travel.

   NOTE: An emergency occurring within the Canadian inland waterway between the States of Washington and Alaska is considered to have occurred in Canada.

   Ordinarily, the "shortest practicable route" is the one that results in the least amount of travel in Canada, consistent with the mode of travel used between the point of entry into Canada and the intended point of departure. The amount of travel in the U.S., prior to entering Canada is not pertinent. A route involving greater travel within Canada may be considered the "shortest practicable route" if the additional travel resulted in a saving of time or was necessary because of such factors as:

   - Road or weather conditions;
   - The age of the traveler;
   - Health, or physical condition of the traveler;
   - The need to make suitable travel arrangements; or

- The need to obtain acceptable accommodations.

However, the individual would be considered to have deviated from the "shortest practicable route" if the detour was unrelated to the purpose of reaching their destination (e.g., for the principal purpose of sightseeing or vacationing).

The term "necessary stopover" means a routine stopover for rest, food, or servicing of the vehicle, and a non-routine stopover (even though of significant duration) caused by such factors as unsuitable road or weather conditions, the age, health, or physical condition of the traveler, the need to make suitable travel arrangements, or to obtain acceptable accommodations.

110.6 - Services Furnished in a Foreign Hospital Nearest to Beneficiary's U.S. Residence

(Rev. 654; Issued: 08-19-05; Effective and Implementation Dates: 11-17-05)

Coverage is provided for inpatient hospital services furnished in a *foreign* hospital that is closer to, or substantially more accessible from, the beneficiary's U.S. residence than the nearest available participating U.S. hospital that is adequately equipped to deal with the illness or injury, whether or not an emergency existed and without regard to where the illness or injury occurred.

"Residence" means the beneficiary's fixed and permanent home to which they intend to return whenever they are away or a dwelling where the beneficiary periodically spends some time (e.g., a summer home).

The *foreign* hospital must meet accreditation requirements equivalent to JCAHO standards. *For example,* the Canadian Council on Hospital Accreditation (CCHA) has equivalent requirements. Thus, Canadian hospitals accredited by the CCHA meet the qualifying requirements. In the case of Mexican hospitals, the Dallas or San Francisco RO makes the determination, depending upon the hospital's location. *Claims for services provided in countries other than Canada or Mexico should be sent to the carrier that is responsible for the state or territory where the emergency arose. In other words, the foreign claim would be processed similarly to how claims are processed in the state or territory where the emergency arose.*

See §110.12.1 below for discussion of accessibility criteria.

Some claims for services furnished in a foreign hospital nearest to the beneficiary's U.S. residence will not be "emergency." In these nonemergency situations, it may be necessary to deny payment in whole or part, (even though it has been approved with regard to accessibility) because the services are not medically reasonable and necessary or involve custodial care (i.e., exclusions under §§1862(a)(1) and (9)).

Where a denial is made in a nonemergency foreign claim for reasons other than accessibility (e.g., cosmetic surgery benefits exhausted), the usual beneficiary denial notice procedures apply. However, in the case of denials under the medical necessity and custodial care exclusions, the FI applies the limitation on liability considerations under §1879 of the Act before issuing the denial notice.

The FI examines claims involving medical necessity or custodial care denials to determine if there is any evidence that the beneficiary (or the person acting on behalf of the beneficiary) was aware that the beneficiary did not require, or no longer required, a covered level of care. The foreign hospital, since it is not participating, is not under any obligation to furnish a written notice of noncoverage to a beneficiary in order to protect itself from being held liable under the §1879 waiver of liability provision. However, there may be instances where the medical records of the denied foreign claim show that the beneficiary was advised that the beneficiary did not require, or no longer required, Medicare covered services, (e.g., written notice of noncoverage from the hospital's staff or a prior CMS denial notice). It will probably be rare where a finding is made that the beneficiary had knowledge of noncoverage, so that, generally, payments are made under the waiver of liability provision. The FI uses appropriate Medicare Summary Notice (MSN) and Remittance Advice denial messages for determinations involving the limitation on liability provision. See Chapter 21.

110.7 - Coverage of Physician and Ambulance Services Furnished Outside U.S.

(Rev. 654; Issued: 08-19-05; Effective and Implementation Dates: 11-17-05)

Physician and ambulance services which meet the coverage requirements of the Act and which are furnished in connection with inpatient services meeting the requirements of §§110.4 or 110.6 are covered under Part B. When these requirements are met, Part B payment is possible even though there may be no Part A payment because Part A benefits are exhausted or there is no Part A entitlement.

Where inpatient services in a *foreign* hospital are covered, payment will be made for:

- Physicians' services rendered to the beneficiary while an inpatient.
- Physicians' services rendered to the beneficiary outside the hospital on the day of admission as an inpatient, provided the services were for the same condition for which the beneficiary was hospitalized.
- Services of a *foreign* ship's physician who furnished emergency services in *foreign* waters on the day the beneficiary is admitted to a *foreign* hospital for a covered emergency stay.
- Ambulance services, where necessary, for the trip to the hospital in conjunction with the beneficiary's admission. Return ambulance trips from a foreign hospital are not covered.

In cases involving foreign ambulance services, the general requirements in Medicare Benefit Policy Manual, chapter 10, and this manual, chapter 15 are applicable, unless the foreign hospitalization was covered as emergency services, then necessity and destination requirements are met.

The definition of "physician," for purposes of coverage of services furnished outside the U.S., includes a foreign practitioner, provided the practitioner is legally licensed to practice in the country in which the services were furnished.

Only the beneficiary may file for Part B benefits. The assignment method may not be used. However, where the beneficiary is deceased, the rule for settling Part B underpayments is applicable, i.e., payment may be made to the foreign physician or ambulance company on the basis of an unpaid bill, provided the physician or ambulance company accepts the carrier's reasonable charge determination as the full charge.

The regular deductible and coinsurance requirements apply to physicians' and ambulance services.

110.8 – Payment by the RRB for Services Furnished in Canada to Qualified Railroad Retirement Beneficiaries

(Rev. 654; Issued: 08-19-05; Effective and Implementation Dates: 11-17-05)

A. Canadian Claims

Under the Railroad Retirement Act, payment is made by the RRB to Qualified Railroad Retirement Beneficiaries (QRRB) for covered hospital services furnished in Canadian hospitals as well as in the U.S. The Railroad Retirement Act does not cover physician and ambulance services; however, under an agreement between CMS and RRB, if the QRRB claims payment for Part B services in connection with Canadian hospitalization, RRB processes the Part B claim. In such cases the RRB determines:

- Whether the requirements in §§110.1.B and 110.7 are met in regard to the inpatient services; and
- Whether the physician and/or ambulance services were furnished in connection with the services.

If either is not met, RRB denies the claim and notifies the beneficiary. If met, RRB refers the claim to the RRB carrier, PGBA, to determine if the coverage criteria for physician and/or ambulance services are met.

The hospital must forward all claims for services furnished QRRBs in Canada to:

Railroad Retirement Board

844 Rush Street

Chicago, IL 60611

If a QRRB is a resident of Canada, Medicare payments are reduced by the amount of payment made for the same services by the Canadian Provincial Health Insurance Plan.

B. Claims for services furnished in other foreign countries

The RRB does not pay for health care services furnished in *foreign countries other than Canada.* For services furnished to QRRB's in foreign countries other than Canada, see §110.1, §110.5, §110.6, §110.7, and §110.10.

110.10 - *Foreign* Religious Nonmedical Health Care Facility Claims

(Rev. 654; Issued: 08-19-05; Effective and Implementation Dates: 11-17-05)

A. Coverage

Payment may be made for otherwise covered religious nonmedical health care institution services furnished in a *foreign* facility under the same requirements of §§110.1.B and 110.10 provided that the foreign sanatorium is closer to or more accessible from the beneficiary's residence in the U.S., (or, if applicable, the site of the emergency) than the nearest U.S. religious nonmedical health care institution. This is true even where there is a closer or more accessible general hospital. For accreditation, it is sufficient that the First Church of Christ, Scientist, in Boston, MA, certify the Religious nonmedical health care facility.

B. Claims Processing

Claims for services in a religious nonmedical health care facility are sent to RNHC FI

Riverbend Government Benefits Administrator

730 Chestnut Street

Chatanooga TN, 37401

for accessibility and/or emergency determination and processing. If the requirements are not met, the FI denies the claim.

110.11 - Elections to Bill for Services Rendered Nonparticipating Hospitals

(Rev. 654; Issued: 08-19-05; Effective and Implementation Dates: 11-17-05)

A. Nonparticipating U.S. Hospitals

As a nonparticipating U.S. hospital meeting emergency requirements, the hospital has the option to bill the program during a calendar year by filing an election with its FI. If it files an election, it should submit claims for the following services furnished all Medicare beneficiaries throughout the year:

- Emergency inpatient services; and
- Emergency outpatient services.

In addition, the hospital may not bill any beneficiary beyond deductibles, coinsurance, and noncovered services in that calendar year. It must agree to refund any monies incorrectly collected. It may not file an election for the calendar year if it has already charged any beneficiary for covered services furnished in that year.

If the hospital does not file a billing election, the beneficiary can file a claim. The beneficiary may request information from the hospital or the FI as appropriate.

During November of each year, the FI will send the non-participating hospital a letter (see §120.3.1). Also, during November of each year, the FI will send a letter to each domestic hospital, giving it an opportunity to elect to bill Medicare if it has not been doing so (§120.3.2).

If during the year the hospital requests to bill the program, its FI will send the model letter in §120.3.3.

B. Billing for Services Furnished Prior to Certification

The following rules apply if a bill is submitted for services rendered before and after a hospital's certification (participation) date:

- PPS hospitals are paid the DRG, if the date of discharge is after the certification date.
- Other hospitals are paid for services rendered after the certification date. However, the hospital must include services before certification date on its cost report.

It should annotate in the upper right hand corner of the claim "Emergency Conversion."

C. *Foreign* Hospitals

Foreign hospitals may submit a statement to the appropriate FI stating that they will bill for all claims. If they do not, the beneficiary may claim the payment. When the FI is aware that a hospital is willing to bill the program for all covered services, it solicits the hospital's agreement to:

- Bill for all covered services for the calendar year (except for deductible and coinsurance amounts);
- Not bill the beneficiary for any amounts other than for deductible and coinsurance and charges for noncovered services; and
- Refund to the beneficiary any monies incorrectly collected.

A hospital may not file an election for a calendar year if it has charged any beneficiary for covered services during that year.

D. Submitting Claims

The beneficiary or the hospital that has elected to bill the program may submit emergency claims for payment to the appropriate FI for evaluation of accessibility or emergency factors.

The hospital completes the claim (*Form* CMS-1450 or electronic equivalent) according to billing instructions in Chapter 25. It enters "hospital filed emergency admission" in Item 94 "Remarks." It sends the completed bill and the necessary emergency documentation (Form CMS-1771, Attending Physicians Statement and Documentation of Medicare Emergency) or medical records to substantiate the emergency to the appropriate FI.

NOTE: See §120.2, "Designated FIs."

If the hospital submits a claim but has not filed an election to bill the program, it will be contacted to determine if it is qualified and wish to bill the program. If it declines, the claim will be denied. A claim will be solicited from the beneficiary.

If the hospital has filed a billing election and the beneficiary files a claim, the beneficiary's claim is denied and the hospital is contacted for the claim.

110.12 - Processing Claims

(Rev. 654; Issued: 08-19-05; Effective and Implementation Dates: 11-17-05)

All claims are subject to development to determine whether the Medicare secondary payer provisions apply. (See *Pub. 100-05,* Medicare Secondary Payer Manual.)

A. Nonparticipating Hospitals

The processing FI is responsible for making accessibility and medical emergency determinations for physician and ambulance services.

1. Claims Subject to Technical Denials

The following claims are subject to technical denial:

- Foreign nonemergency services claims if:
  - The residence requirement is not met. (See §110.6.)
  - The hospital rendering the service does not meet JCAHO or equivalent accreditation requirements set by a hospital approval program of the country in which it is located.
  - The accessibility requirements are not met. (See §110.12.1.)
- Canadian travel claims when the requirements in §110.5 are not met.
- Emergency services claims for which the hospital does not meet the definition of an emergency hospital.
- Claims for which the query response shows the beneficiary is not entitled to benefits.
- Any foreign claim when Part A benefits are exhausted and Part B physician or ambulance claims are not involved.

2. Either the Accessibility or Medical Emergency Requirements are Not Met

Claim is denied but retained in case of appeal.

NOTE: Even though Part A or Part B emergency services furnished by U.S. hospitals are denied, Part B payment may be possible for Medical and Other Health Services specified in *Pub. 100-02,* Medicare Benefit Policy Manual, Chapter 6. Claim is retained in case of appeal.

3. Emergency Services Partially Denied

When the medical emergency is approved but not for the entire period, the claim is processed and payment made for the covered period.

B. *Foreign* Part B Physician and Ambulance Claims

The hospital must attach any Part B claim for foreign physician and ambulance services to the corresponding Part A claim and forward to the FI.

If the FI determines that the inpatient services were covered, it sends the physician and/or independent ambulance claim to the designated carrier for processing and payment. (See §110.7.)

If the Part A claim is denied on the basis of accessibility of medical emergency, the FI denies the Part B claim, and sends a denial letter to the claimant. It retains copies in case of appeal.

NOTE: Even though Part A benefits are totally or partially exhausted, payment may be made by the carrier for physician and independent ambulance services furnished if all coverage requirements are met.

If a Part A claim was partially denied because the emergency terminated, the FI makes a decision on the claim and any provider-based ambulance claim. It sends copies to the appropriate carrier for processing.

110.13 - Appeals on Claims for Emergency and Foreign Services

(Rev. 654; Issued: 08-19-05; Effective and Implementation Dates: 11-17-05)

A. Part A

The FI will conduct reconsiderations on claims it processes and will notify the claimant of the decision. It will follow the guidelines in chapter 29. It will review the initial determination of the claim, including all documentation. It will prepare the necessary beneficiary notification and retain the file for 6 months after the month of the final determination. A reconsideration determination is a final and binding determination of the Secretary, unless it is reopened and revised, or unless a hearing revises an initial determination.

NOTE: The RRB conducts reconsiderations for hospital services under the Railroad Retirement Act for services rendered in Canada.

B. Part B

Where the FI or carrier receives a request for review of an initial determination, it conducts the review and sends the determination.

C. Appeal of Reconsideration

All Part B hearing requests on claims for physician and independent ambulance services furnished in a *foreign* country are within the jurisdiction of a carrier hearing officer regardless of who made the review determination. However, a hearing request on an FI determination is normally in connection with the Part A claim and considered and processed as such. If the enrollee had a Part A hearing and then requests a hearing on the same issue for the Part B claim, all pertinent information regarding the initial and reconsideration determinations and the hearing request are forwarded to the carrier. The beneficiary is notified of the transfer.

120.1 - Payment for Services from Foreign Hospitals

(Rev. 654; Issued: 08-19-05; Effective and Implementation Dates: 11-17-05)

A. Hospital Filed Claim

A *foreign* hospital that elects to bill the Medicare program receives 100 percent of its customary charges, subject to applicable deductible and coinsurance amounts. The hospital establishes its customary charges for the services by submitting an itemized bill with each claim. This eliminates the need to file a cost report.

Regardless of the billing form used, the FI must:

- Recode the bill using revenue codes for the Form CMS-1450;
- Prepare an HUIP or HUOP input record for CWF; and
- Send a Medicare Summary Notice (MSN) to the beneficiary.

The *foreign* hospital must file a statement of election for each calendar year to receive direct payment from Medicare for all claims filed that year.

Payment is subject to the official exchange rate on the date the patient is discharged.

B. Beneficiary Filed Claim

To calculate the amount paid by Medicare for Part B Hospital-Based Ambulance Claims, the hospital must subtract any unmet Part B deductible from the total covered charges and apply the 80 percent payment rate.

Payment to the beneficiary is subject to the official exchange rate on the date of discharge.

120.3.8 - Full Denial - Foreign Claim - Beneficiary Filed

(Rev. 654; Issued: 08-19-05; Effective and Implementation Dates: 11-17-05)

MODEL DENIAL NOTICE

(FI'S NAME AND ADDRESS)

Date: _____

Beneficiary: _____ Claim Number:_____

DETERMINATION ON FOREIGN HOSPITAL SERVICES

We are sorry, but payment cannot be made for your stay from _____ through _____ at (hospital) in (country).

Medicare law prohibits payment for items and services furnished outside the United States except for certain limited services.

If you have a supplemental insurance policy, you should check with the company carrying that policy to see if they cover these services and what procedures you should follow in submitting your claim.

If you have further questions concerning this issue, please send your correspondence to the above address.

Sincerely,