2024 Indian Health Service Partnership Conference

Rural Emergency Hospital Guidelines

August 2024

Disclaimer

- All Current Procedural Terminology (CPT) only are copyright 2023 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable Federal Acquisition Regulation/ Defense Federal Acquisition Regulation (FARS/DFARS) Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.
- The information enclosed was current at the time it was presented. Medicare policy changes frequently; links to the source documents have been provided within the document for your reference. This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations.
- Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.
- Novitas Solutions' employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.
- This presentation is a general summary that explains certain aspects of the Medicare program but is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.
- Novitas Solutions does not permit videotaping or audio recording of training events.

Acronym List

Acronym	Definition
CAH	Critical Access Hospital
CMS	Centers for Medicare and Medicaid Services
COP	Conditions of participation
IHS	Indian Health Services
OPPS	Outpatient prospective payment system
PECOS	Provider Enrollment Chain and Ownership System
PPS	Prospective payment system
REH	Rural emergency hospital
SNF	Skilled nursing facility
TOB	Type of bill
UB-04	Uniform billing form

Agenda

1 REH Background

2 Enrolling as an REH

3 Billing as an REH

REH Background

IHS REH

- Background:
  - Beginning January 1, 2024:
    - A tribal or IHS operated hospital (as defined in 42 Code of Federal Regulations (C.F.R) § 413.65(m)) that converts to an REH (IHS-REH) that provides hospital outpatient services to a Medicare beneficiary may be paid for such services under the outpatient hospital All-Inclusive Rate (AIR) that is established and published annually by the IHS, rather than the rates for REH services described at 42 CFR § 419.92(a)(1)
- Who is eligible to convert to an REH?
  - A facility is eligible to convert to an REH if it was a Critical Access hospital (CAH) or rural hospital with 50 beds or less as of December 27, 2020
  - Including a hospital that closed after December 27, 2020
- References:
  - Provider specialty: Rural emergency hospital (REH)
  - Medicare Program Integrity Manual, Pub. 100-08, Chapter 10 - Medicare Enrollment, Section 10.2.1.8.1.1, "Indian Health Service (IHS) Rural Emergency Hospital (REH)"
  - 42 CFR Chapter IV, Subchapter G, Part 485, "CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS"
  - REH FAQs
  - Change Request (CR) 13312 - Indian Health Service (IHS) Rural Emergency Hospital (REH) Provider Enrollment

REH Eligibility

- Be in a rural area and licensed as a CAH or small rural hospital
- Be enrolled Medicare program
- Cannot provide any acute care inpatient services:
  - Exception is post hospital care services furnished in a distinct part unit licensed as a SNF
- Have an established transfer agreement with a level I or level II trauma center
- Meet staff training and certification requirements
- Meet conditions of participation; applicable to CAHs with respect to emergency services and applicable by the Secretary to hospital emergency departments:
  - Conditions of Participation for Rural Emergency Hospitals and Critical Access Hospital COP

Additional REH Eligibility Requirements

- Meet annual average length of stay requirements:
  - Annual per patient average length of stay does not exceed 24 hours
  - Calculation for determining the length of stay:
    - Patient receiving REH services begins with:
      - Registration
      - Check-in or triage (whichever occurs first)
      - Ends with discharge of patient from the REH, when the physician or appropriate clinician signs the discharge order or outpatient services are completed
- Meet state licensure requirements for an REH
- Have an action plan including provisions for staffing, a transition plan, and description of services offered

REH Services

- Must provide:
  - 24/7 emergency services
  - A physician, nurse practitioner, clinical nurse specialist or physician assistant available to furnish services 24 hours a day
  - Stay complaint with the annual average length of stay of less than 24 hours for all REH services
  - Staffing requirements similar to those for CAHs
    - 42 CFR 485.618, Condition of participation: Emergency services
- Diagnostic lab and radiological services
- Pharmacy drug storage area
- Discharge planning

REH Additional Services

- REH facilities can furnish additional services such as:
  - Observation care
  - Maternal Health
  - Outpatient surgery
  - Post-hospital care (non-inpatient)
  - Primary care services
  - Behavioral health
  - Outpatient rehabilitation
  - Telehealth services
  - Ambulance services
- Distinct unit skilled nursing facility (SNF); meeting the requirements of a SNF:
  - Does not include Swing Beds
- Note:
  - Not an all-inclusive list
- Reference:
  - Medicare Benefit Policy Manual, Pub. 100-02, Chapter 6 - Hospital Services Covered Under Part B, Section 20, "Outpatient Hospital Services"

Enrolling as an REH

NOVITAS
SOLUTIONS

Part A Institutional Providers Applications

- There are two options to enroll/convert to a REH:
  - Internet-based PECOS
    - When using PECOS there is an application Questionnaire:
      - Select Institutional Provider, this will populate the CMS-855A facility application
      - Under Part A Providers of Services, select the type of facility that you will be enrolling or updating
      - There is a drop-down box for you to select Novitas as the Fee for Service contractor
  - The paper CMS-855A Institutional Providers application:
    - Section 1(A): check the box indicating the reason you are submitting the application and following the instructions on completing the required sections
    - Section 2(A)(1): check the type of provider that you will be enrolling or updating
    - CMS-855A Tutorial
    - When submitting paper applications, the IHS cover sheet should be submitted:
      - IHS Part A coversheet
- The enrollment application fee is not required
- When enrolling via PECOS or the paper CMS-855 applications there is an application questionnaire asking if the application is an Indian Health Service (IHS) facility:
  - All Indian Health Services, Tribes and Urban Indian providers/suppliers should always select yes when enrolling with Novitas
  - This question does not affect the laws that you go by, it just assures Novitas receives your application from PECOS and that we process your application into the correct processing system

Internet-Based PECOS Institutional provider Application

- To enroll as a REH via PECOS, you must create an Initial Enrollment application for provider type REH
- Selecting the **Create Initial Enrollment Application** button on the My Associates page or My Enrollment page
- Select "Rural Emergency Hospital" under the Part A Provider Services dropdown box
- Complete all applicable sections
- Upload all required state licenses/certifications for operation as an REH (if available)
- Submit application through PECOS

Medicare Enrollment
for Providers and Suppliers

CMS Validation
Home | Help | Log Out

My Application Progress 0%

Home > My Associates > My Enrollments > Application Questionnaire

Application Questionnaire

(*) Red asterisk indicates a required field.

Primary Medicare Services Rendered

Note: A separate application is required for each primary healthcare service rendered.

* Please select the primary Medicare Services rendered by the applicant.

Part B Supplier Services

Select Supplier Type

Part A Provider Services

Select Provider Type

Select Provider Type
COMMUNITY MENTAL HEALTH CENTER
COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY
CRITICAL ACCESS HOSPITAL
END-STAGE RENAL DISEASE FACILITY (ESRD)
FEDERALLY QUALIFIED HEALTH CENTER (FQHC)
HISTOCOMPATIBILITY LABORATORY
HOME HEALTH AGENCY
HOSPICE
HOSPITAL
INDIAN HEALTH SERVICES FACILITY
INDIAN HEALTH SERVICES RURAL EMERGENCY HOSPITAL
ORGAN PROCUREMENT ORGANIZATION (OPO)
OTHER
OUTPATIENT PHYSICAL THERAPY/OCCUPATIONAL THERAPY/SPEECH PATHOLOGY SERVICES
RELIGIOUS NON-MEDICAL HEALTH CARE INSTITUTION (RNHCI)
RURAL EMERGENCY HOSPITAL (REH)
RURAL HEALTH CLINIC
SKILLED NURSING FACILITY

Paper CMS-855A Institutional Providers Application

- Follow the instructions for changing your Medicare information:
  - Sections to be completed:
    - Section 1(A): check the "You are changing your Medicare information" box
    - Section 2(A)(1): check the type of provider, "Rural emergency hospital"
    - Complete Sections 2(B): with REH information
    - Compete Section 3: Final Adverse Legal Actions
    - Compete Section 15: Certification Statement
- When submitting paper applications, the IHS cover sheet should be submitted:
  - IHS Part A coversheet
- Report any additions/deletions/changes to current enrollment information:
  - Current CAH or rural hospital enrollment will stem from its conversion to an REH (e.g., new billing agency, adding/deleting two managing employees, deleting a 10 percent owner)
- Submit all required state licenses/certifications for operation as an REH (if available)
- Once completed:
  - Upload the application using the Provider Enrollment Gateway; this portal allows for paper applications to be uploaded and submitted online or
  - The application can be mailed

Paper CMS-855A Paper Section 1A: Basic Information Reason for Submission

SECTION 1: BASIC INFORMATION *(Continued)*

A. Check one box and complete the required sections

☐ Your organization has **Consolidated** with another organization You are the: ☐ Former organization ☐ New organization	Medicare Identification Number of the Seller/Former Owner *(if issued)*: NPI: Tax Identification Number:	**Former Organizations: 1A, 2H, 13,** and either **15** or **16** **New Organization: Complete all** sections except **2F** and **2G**
☐ You are **changing** your Medicare information	Medicare Identification Number *(if issued)*: NPI:	**Go to Section 1B**
☐ You are **revalidating** your Medicare enrollment	Enter your Medicare Identification Number (if issued) and the NPI you would like to link to this number in Section 4.	**Complete all applicable sections except 2F, 2G, and 2H**

Paper CMS-855A Section 1B: Changing Information

SECTION 1: BASIC INFORMATION *(Continued)*

B. Check all that apply and complete the required sections:

	REQUIRED SECTIONS
☐ Identifying Information	1, 2 (complete only those sections that are changing), 3, 13, and either 15 (if you are the authorized official) **or** 16 (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Adverse Legal Actions/Convictions	1, 2B1, 3, 13, and either 15 (if you are the authorized official) **or** 16 (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☒ Practice Location Information, Payment Address & Medical Record Storage Information	1, 2B1, 3, 4 (complete only those sections that are changing), 13, and either 15 (if you are the authorized official) **or** 16 (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Ownership Interest and/or Managing Control Information (Organizations)	1, 2B1, 3, 5, 13, and either 15 (if you are the authorized official) **or** 16 (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Ownership Interest and/or Managing Control Information (Individuals)	1, 2B1, 3, 6, 13, and either 15 (if you are the authorized official) **or** 16 (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Chain Home Office Information	1, 2B1, 3, 7, 13, and either 15 (if you are the authorized official) **or** 16 (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Billing Agency Information	1, 2B1, 3, 8 (complete only those sections that are changing), 13, and either 15 (if you are the authorized official) **or** 16 (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Special Requirements for Home Health Agencies	1, 2B1, 3, 12, 13, and either 15 (if you are the authorized official) **or** 16 (if you are the delegated official), and Section 6 for the signer if that authorized or delegated official has not been established for this provider.
☐ Authorized Official(s)	1, 2B1, 3, 6, 13, and 15.
☐ Delegated Official(s) (Optional)	1, 2B1, 3, 6, 13, 15, and 16.

Paper CMS-855A Section 2A1: Identifying Information

SECTION 2: IDENTIFYING INFORMATION

A. TYPE OF PROVIDER

The provider must meet all Federal and State requirements for the type of provider checked. Check only one provider type. If the provider functions as two or more provider types, a separate enrollment application (CMS-855A) must be submitted for each type.

1. Type of Provider (other than Hospitals— See 2A2). Check only one:

- ☐ Community Mental Health Center
- ☐ Comprehensive Outpatient Rehabilitation Facility
- ☐ Critical Access Hospital
- ☐ End-Stage Renal Disease Facility
- ☐ Federally Qualified Health Center
- ☐ Histocompatibility Laboratory
- ☐ Home Health Agency
- ☐ Hospice
- ☐ Indian Health Services Facility
- ☐ Opioid Treatment Program
- ☐ Organ Procurement Organization
- ☐ Outpatient Physical Therapy/Occupational Therapy/ Speech Pathology Services
- ☐ Religious Non-Medical Health Care Institution
- ☐ Rural Emergency Hospital
- ☐ Rural Health Clinic
- ☐ Skilled Nursing Facility
- ☐ Other *(Specify)*: ____________

2. If this provider is a hospital, check all applicable subgroups and units listed below and complete Section 2A3.

- ☐ Hospital—General
- ☐ Hospital—Acute Care
- ☐ Hospital—Children's (excluded from PPS)
- ☐ Hospital—Long-Term (excluded from PPS)
- ☐ Hospital—Psychiatric (excluded from PPS)
- ☐ Hospital—Rehabilitation (excluded from PPS)
- ☐ Hospital—Short-Term (General and Specialty)
- ☐ Hospital—Swing-Bed approved
- ☐ Hospital—Psychiatric Unit
- ☐ Hospital—Rehabilitation Unit
- ☐ Hospital—Specialty Hospital (cardiac, orthopedic, or surgical)
- ☐ Hospital—Transplant Program (Identify organ type(s)): ____________
- ☒ Other *(Specify)*: IHS rural emergency hospital

3. If "hospital" was checked in Section 2A1 or 2A2, does this hospital have a compliance plan that states that the hospital checks all managing employees against the exclusion/debarment lists of both the HHS Office of the Inspector General (OIG) and the General Services Administration (GSA)? .... ○ Yes ○ No

4. Is the provider a physician-owned hospital (as defined in the Special Enrollment Notes on page 8)? .... ○ Yes ○ No

Paper CMS-855A Section 2B: Identifying Information

SECTION 2: IDENTIFYING INFORMATION *(Continued)*

B. IDENTIFICATION INFORMATION

1. Business Information

Legal Business Name as reported to the Internal Revenue Service (IRS)

Other Name *(if applicable)*

Tax Identification Number (TIN)	Medicare Identification Number (PTAN) *(if issued)*	National Provider Identifier (NPI)

What is the provider's year end cost report date? *(mm/dd/yyyy)*

Type of Other Name *(if applicable)*
Check box indicating Type of Other Name:
☐ Former Legal Business Name ☐ Doing Business As Name ☐ Other *(Specify)*: ____________

IRS Business Designation
Identify how your business is registered with the IRS. (**NOTE:** If your business is a Federal and/or State government supplier, indicate "Non-Profit" and specify the level below. In addition, government-owned entities do not need to provide an IRS Form 501(c)(3)).

☐ Proprietary
☐ Non-Profit (Submit IRS Form 501(c)(3))
☐ Disregarded Entity (Submit IRS Form 8832, if applicable)

NOTE: If a checkbox identifying how the business is registered with the IRS is not completed, the supplier will be defaulted to "Proprietary."

Identify the business structure: *(Check one)*

☐ Corporation
☐ Limited Liability Company
☐ Partnership
☐ Sole Proprietor
☐ Other *(Specify)*: ____________

☐ Federal and/or State Government Type:
- ☐ Federal
- ☐ State
- ☐ City
- ☐ County
- ☐ City-County
- ☐ Hospital District
- ☐ Other (Specify): ____________

Is this provider an Indian Health Service (IHS) Facility? .... ○ Yes ○ No

Paper CMS-855A Section 3: Final Adverse Legal Actions

SECTION 3: FINAL ADVERSE LEGAL ACTIONS

This section captures information regarding final adverse legal actions, such as convictions, exclusions, license revocations and license suspensions. All applicable final adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

NOTE: To satisfy the reporting requirement, Section 3 must be filled out in its entirety, **and all applicable attachments must be included.**

A. FEDERAL AND STATE CONVICTIONS ("Conviction" as defined in 42 C.F.R. Section 1001.2) WITHIN THE PRECEDING 10 YEARS

1. Any federal or state felony conviction(s) by the provider, supplier, or any owner or managing employee o the provider or supplier.
2. Any crime, under Federal or State law, where an individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld, or the criminal conduct has been expunged or otherwise removed, or there is a post-trial motion or appeal pending, or the court has made a finding of guilt or accepted a plea of guilty or nolo contendere.
3. Any misdemeanor conviction, under federal or state law, related to: (a) the delivery of an item or service under Medicare or a state health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
4. Any misdemeanor conviction, under federal or state law, related to the theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
5. Any misdemeanor conviction, under federal or state law, related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.
6. Any misdemeanor conviction, under federal or state law, related to the interference with or obstruction of any investigation into any criminal offence described in 42 C.F.R. section 1001.101 or 1001.201.

Paper CMS-855A Section 15: Certification Statement

SECTION 15: CERTIFICATION STATEMENT

An **AUTHORIZED OFFICIAL** is defined as an appointed official (for example, chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner) to whom the organization has granted the legal authority to enroll it in the Medicare program, to make changes or updates to the organization's status in the Medicare program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicare program.

A **DELEGATED OFFICIAL** is defined as an individual who is delegated by an authorized official the authority to report changes and updates to the provider's enrollment record. A delegated official must be an individual with an "ownership or control interest" in (as that term is defined in section 1124(a)(3) of the Social Security Act), or be a W-2 managing employee of the provider.

Delegated officials may not delegate their authority to any other individual. Only an authorized official may delegate the authority to make changes and/or updates to the provider's Medicare status. Even when delegated officials are reported in this application, an authorized official retains the authority to make any such changes and/or updates by providing his or her printed name, signature, and date of signature as required in section 15B.

NOTE: Authorized officials and delegated officials must be reported in section 6, either on this application or on a previous application to this same MAC. If this is the first time an authorized and/or delegated official has been reported on the CMS-855A, you must complete Section 6 for that individual and that individual must sign section 15.

By his/her signature(s), an authorized official binds the provider to all of the requirements listed in the Certification Statement and acknowledges that the provider may be denied entry to or revoked from the Medicare program if any requirements are not met.

Only an authorized official has the authority to sign (1) the initial enrollment application on behalf of the provider and (2) add or remove additional authorized officials and delegated officials. Once the delegation of authority has been established all other enrollment application submissions can be signed by either an authorized official or delegated official.

By signing this application, an authorized official agrees to immediately notify the MAC if any information furnished on this application is not true, correct, or complete. In addition, an authorized official, by his/her signature, agrees to notify the MAC of any future changes to the information contained in this form after the provider is enrolled in Medicare, in accordance with the timeframes established in 42 C.F.R. section 424.516.

The provider can have as many authorized officials as it wants. If the provider has more than two authorized officials, it should copy and complete this section as needed.

EACH AUTHORIZED AND DELEGATED OFFICIAL MUST HAVE AND DISCLOSE HIS/HER SOCIAL SECURITY NUMBER.

Application Inquiries

- Throughout the course of application processing and once finalized, CMS authorizes the release of enrollment-related information to the following individuals listed on the application:
  - Authorized official
  - Delegated official
  - Contact person:
    - No limit on the number of contacts per file
    - If you have multiple contacts and want to designate a primary contact, provide that on the application
- If you have any enrollment-related questions, please contact the provider enrollment helpdesk:
  - JH: 1-855-252-8782

Development – What this Means to You

- Definition:
  - Document requesting any missing or incorrect data elements and/or supporting documentation needed to process an enrollment application
- Purpose:
  - Retrieve all necessary information for a successful enrollment into Medicare
- Development process may result in delaying the processing of your application:
  - Development period allows for a 30-day response time
  - Failure to respond to development requests may result in the inability to process your application:
    - Application will be rejected, and you will be request to submit a new application with potential impacts to the originally requested effective date
- For more information, review the Top development reasons article (JH)

Processing Timeframes: PECOS Applications

- Processing timeframes may vary:
  - Refer to CMS-855 enrollment application processing timeframes (JH)

Type of enrollment	PECOS: No site visit, development, and/or fingerprints	PECOS: Site visit, development, and/or fingerprints required
Initial enrollment Change of information	• 95% completed within 15 calendar days of receipt • 100% completed within 50 calendar days of receipt	• 95% completed within 50 calendar days of receipt • 100% completed within 85 calendar days of receipt
Revalidation	• 80% completed within 15 calendar days of receipt • 100% completed within 50 calendar days of receipt	• 80% completed within 50 calendar days of receipt • 100% completed within 85 calendar days of receipt

Processing Timeframes: Paper Applications

- Processing timeframes may vary:
  - Refer to CMS-855 enrollment application processing timeframes (JH)

Type of enrollment	Paper: No site visit, development, and/or fingerprints	Paper: Site visit, development, and/or fingerprints required
Initial enrollment Change of information	• 95% completed within 30 calendar days of receipt • 100% completed within 65 calendar days of receipt	• 95% completed within 65 calendar days of receipt • 100% completed within 100 calendar days of receipt
Revalidation	• 80% completed within 30 calendar days of receipt • 100% completed within 65 calendar days of receipt	• 80% completed within 65 calendar days of receipt • 100% completed within 100 calendar days of receipt

Billing as an REH

NOVITAS
SOLUTIONS

IHS REH Billing

- Claims submitted on the UB-04 and/or 837I equivalent
- Outpatient bill:
  - TOB will always be a 13X or 14X:
    - Revenue Code 0510:
      - Appropriate HCPCS
  - Inpatient claims are not billable as an REH
- Reimbursement is under the All-Inclusive Rate (AIR) as IHS REH services:
  - Services that are not under the definition of an IHS REH service, such as the following:
    - Ambulance services if REH owned and operated would be reimbursed under the ambulance fee schedule
    - Post-hospital care SNF services are reimbursed under the SNF PPS

IHS REH Monthly Facility Payment

- IHS REH facilities will receive an additional facility payment:
  - Payments received in twelve monthly installments
  - Must keep detailed information of how payments are used:
    - Be available if CMS asked for information
  - Monthly facility payment is updated annually
  - Sequestration applies
- References:
  - 2024 updates:
    - Change Request (CR) 13457 - January 2024 Annual Rural Emergency Hospital (REH) Monthly Facility Payment
    - Rural Emergency Hospital Fact Sheet

Key Takeaways

- Gained a better understanding of enrolling as an REH
- Reviewed eligibility, billing and reimbursement of an REH

Join Our Novitas eNews Email List!

- Receive current updates directly via email:
  - Part A and Part B News
  - Issued weekly
  - CMS MLN Connects issued Thursdays
- Subscribing is quick and easy:
  - Click the Join E-Mail List from our website tool bar
- Didn't receive verification or stopped receiving email notifications?
  - Follow these simple steps to allow emails

IHS Contact Information

- Visit our websites:
  - www.novitas-solutions.com
- Call our Customer Contact Center:
  - JH: 1-855-252-8782
- Gail Atnip
  Education Specialist, Provider Outreach and Education
  Gail.Atnip@novitas-solutions.com
  214-356-4210
- Kim Robinson
  Education Specialist, Provider Outreach and Education
  Kim.Robinson@novitas-solutions.com
  214-399-0444
- Stephanie Portzline
  Manager Provider Engagement
  Stephanie.Portzline@novitas-solutions.com