

3.8.1 Scope Of Chapter

Medicare cannot generally pay for hospital or medical services furnished outside the United States except for certain care in qualified Canadian or Mexican hospitals. All medical claims for services received in foreign countries other than Canada and Mexico must be denied. This chapter describes the health insurance services furnished outside the U.S. that are reimbursable under the Medicare program. In addition, this chapter discusses claims processing for both hospital and medical insurance claims.

Section 7(d) (4) of the Railroad Retirement Act provides for the payment by the RRB of covered hospital services furnished in Canadian hospitals. The full text of section 7(d) (4) is as follows:

4) The rights of individuals described in subdivision (2) of this subsection to have payment made on their behalf for the services referred to in subdivision (1) but provided in shall be the same as those of individuals to whom section [U.S.C.] and part A of title XVIII [U.S.C. et seq.] of the Social Security Act apply, and this subdivision shall be administered by the Board as if the provisions of section and part A of title XVIII of the Social Security Act were applicable, as if references to the Secretary of Health and Human Services were to the Board, as if references to the Federal Hospital Insurance Trust Fund were to the Railroad Retirement Account, as if references to the United States or a State included or a subdivision thereof, and as if the provisions of sections 1862 (a)(4), 1863, 1864, 1868, 1869, 1874 (b), and 1875 [U.S.C. [\(a\)\(4\)](#), , , , [\(b\)](#),] were not included in such title. The payments for services herein provided for in shall be made from the Railroad Retirement Account (in accordance with, and subject to, the conditions applicable under subsection (b) of this section, in making payment of other benefits) to the hospital, extended care facility, or home health agency providing such services in to individuals to whom subdivision (2) of this subsection applies, but only to the extent that the amount of payments for services otherwise hereunder provided for an individual exceeds the amount payable for like services provided pursuant to the law in effect in the place in where such services are furnished. For the purposes of section of this title, any overpayment under this subdivision shall be treated as if it were an overpayment of an annuity.

Section 7(d)(4) of the Railroad Retirement Act (45 U.S.C. § 231f (d)(4)) provides that qualified railroad retirement beneficiaries who could be entitled to hospital insurance benefits if those services were provided in the United States have the same entitlement even though such services were provided in Canada. Section 7(d)(1) of the Railroad Retirement Act (45 U.S.C. § 231f (d)(1)) provides the Board with the same authority to determine the rights of qualified railroad retirement beneficiaries with regard to their entitlement to hospital insurance benefits as the Secretary of Health and Human Services has with respect to individuals entitled to hospital insurance benefits under section 226 of the Social Security Act. Section 7(d) (4) also provides that “The

payment for services herein provided for in Canada shall be made from the Railroad Retirement Account....”

3.8.2 Background

QRRBs are entitled to Medicare benefits under both the Railroad Retirement Act (RRA) and the Social Security Act. Since the inception of the Medicare program, the RRA has guaranteed that QRRBs receive **hospital** insurance benefits for covered services furnished in Canada, as well as in the United States. Before 1973, Social Security beneficiaries who were U.S. residents were limited to certain emergency inpatient care furnished in a more accessible Canadian or Mexican hospital. In 1973, the SS Act was expanded to include:

1. inpatient hospital care furnished in Canada or Mexico received by U.S. border residents regardless of whether an emergency exists, and
2. emergency inpatient hospital care required by a beneficiary traveling between Alaska and another State.

In addition, the SS Act covers physician and ambulance services furnished in connection with a covered foreign hospitalization. Payment may not be made for any other Part B medical and other health services, including outpatient services, furnished outside the United States.

The term “United States” means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa. It also includes the territorial waters adjoining these entities. This means the 3-mile limit off the shores of most of the United States constitutes American territory. In the case of Texas and Florida, the limit extends into the Gulf of Mexico within 9 miles (three leagues) off the shores of these states. If a ship or aircraft, even of American registry, is not within or above the land area or territorial waters of the United States, it is not considered to be within an American territory.

Because physician and ambulance services furnished in connection with a covered foreign hospitalization are covered under the SS Act and not the RRA, it is more advantageous for QRRBs to have their claims considered under the SS Act if Part B benefits are involved. SSA has delegated to the RRB the authority to make entitlement determinations under the SS Act for QRRBs claiming Part B benefits for services furnished in Canada.

The RRB forwards claims for inpatient connected services received in Mexico to the CMS Regional office. Since other services in Mexico are not covered, those claims are sent to the Palmetto GBA Dallas office for denial.

3.8.3 Summary Of Hospital Insurance (Part A) Benefits Outside The U.S

Under the Railroad Retirement Act, payment can be made to any railroad retirement beneficiary for covered **hospital** insurance services furnished by a qualified Canadian hospital. Payment may be made for all covered hospital insurance services received anywhere in Canada regardless of where the beneficiary lives.

In Mexico, inpatient **hospital** services are covered under the following situations:

1. an emergency occurs in the U.S. and the Mexican hospital is closer than the nearest U.S. hospital equipped to deal with the injury or illness.
2. A U.S. resident receives services in a Mexican hospital which is closer to or substantially more accessible to his or her residence than the nearest hospital within the U.S., regardless of whether or not an emergency exists.

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

3.8.4 Summary Of Medical Insurance (Part B) Benefits Outside The U.S

Medical insurance benefits are limited to necessary physician and ambulance services furnished in connection with three specific situations.

Those situations are:

1. an emergency occurs in the U.S. and a Canadian or Mexican hospital is closer than the nearest U.S. hospital equipped to deal with the injury or illness.
2. a U.S. resident receives services in a Canadian or Mexican hospital which is closer to or substantially more accessible to his or her residence than the nearest hospital within the U.S., regardless of whether or not an emergency exists, or
3. a medical emergency occurs within Canada which requires admittance to a Canadian hospital while the beneficiary is traveling without unreasonable delay and by the most direct route between Alaska and another State. This provision does not apply when a beneficiary is vacationing in Canada.

Please note that medical insurance benefits are limited to physician and ambulance services furnished in connection with a covered foreign hospitalization. This means these services are covered both during the time period immediately before the beneficiary is actually admitted to the foreign hospital and during the covered foreign hospitalization itself. Payment may not be made for any other Part B medical services, including outpatient services, furnished outside the United States.

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.

3.8.4.1 Medicare Services Received Aboard a Ship

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.

The following services furnished aboard a ship are covered:

- Emergency and nonemergency services furnished by a physician or supplier aboard a vessel are covered when the ship is within the territorial waters of the United States.
- Emergency services furnished by a physician or supplier aboard a vessel are covered when the services are rendered while the ship is within the territorial waters of Canada (while the individual was traveling, by the most direct route and without unreasonable delay between Alaska and another State) and the emergency services are furnished in connection with a covered foreign hospitalization in Canada, including the day the patient is admitted to the Canadian hospital.

3.8.5 Chronic Care Services In Canada

Hospital insurance claims from beneficiaries living in Canada sometimes include claims for "chronic care" services. The term "chronic care" refers to a level of care lower than acute inpatient hospital care and significantly higher than custodial care. For purposes of claims processing, always consider a claim for chronic care services to be the same as a claim for skilled nursing services.

Chronic care services may be provided in one of two locales:

1. **Chronic Care Wing of a Public General Hospital.**

Some public general hospitals in Canada set up chronic care wings to make better use of available hospital space, especially in less populous areas. Though the full range of acute treatment services is available (surgery, x-ray, etc.), chronic care patients have less need for them. Chronic care patients receive regular skilled nursing care daily and medical care when needed. The Canadian provincial plans pay most of the cost of chronic care, leaving the patient responsible for a smaller co-payment. (The co-payment in 2007 was

approximately \$51.00 a day.) The patients' proportionate share of the cost generally increases the longer he or she stays in the chronic care wing. Patients usually leave the chronic care wing when space can be found for them in skilled nursing facilities.

2. Public Chronic Hospitals.

Patients are admitted to public chronic hospitals when no chronic wing is attached to the public general hospital. The level of care provided in the public chronic hospital is the same as that provided in a chronic wing of a public general hospital.

Chronic care facilities in Canada developed in response to a shortage of skilled nursing facilities. Today a large portion of the patients in skilled nursing facilities are transferred there from chronic care facilities. Likewise, a large portion of the patients in chronic care facilities are awaiting transfer to a skilled nursing facility. In most cases, skilled nursing facilities are smaller, less institutional, and have more comfortable accommodations than chronic care facilities. The actual care provided to patients in chronic care facilities versus patients in skilled nursing facilities is identical.

3.8.5.1 Alternative Level Of Care Services In Canada

On July 1, 2009 all acute and post-acute hospitals in Ontario began using a standardized Provincial Alternate Level of Care (ALC) Definition to designate patients as ALC. The definition applies to all patient populations waiting in all patient care beds in an acute or post-acute care hospital in Ontario.

Definition:

When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this type of care setting, the patient must be designated Alternate Level of Care (ALC) at that time by the physician or his/her delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination (or when the patient's needs or condition changes and the designation of ALC no longer applies).

This does not apply to patients who are:

- waiting at home.
- waiting in an acute care bed/service for another acute care bed/service (e.g. surgical bed to a medical bed).
- waiting in a tertiary acute care hospital bed for transfer to a non tertiary acute care hospital bed (e.g. repatriation to community hospital).

MS Examiner Actions:

Medicare generally covers 3 days to find a bed after discharge as administrative days. RRB will pay up to 3 days after the beneficiary's discharge to a continuing care facility. Only the co-payment portion of the charge, after the deductible, has been met will be reimbursed by the RRB.

3.8.6 Role Of Medicare Section (MS)

Under the RRA, the RRB administers the hospital insurance part of the Medicare program for QRRBs who receive services in Canada. Operations' Medicare Section (MS) acts as a fiscal intermediary to process claims for payment. Its functions include: coverage determinations, applying the deductible and coinsurance amounts, and determining whether all conditions of payment are met. The MS supervisor and designated claims specialist are authorized to certify payment or denial of Canadian hospital insurance claims.

3.8.7 Definition Of Terms Used In Claims Process

Below is a list of terms and their definition commonly used in the claims process.

- Application - Every beneficiary living in Canada who is enrolled for hospital insurance coverage (HI) is provided with a Form RB-104 describing HI benefits. An application, Form AA-104, must be filed for reimbursement of HI services furnished in Canada. To claim payment, the beneficiary returns a completed Form AA-104 with paid bills attached, and in some cases, a doctor's statement indicating that the services were medically necessary.
- Assignment - A beneficiary may, if he or she wishes, assign the payment due to the provider. An assignment must be a written request signed by or on behalf of the beneficiary requesting that payment on his or her behalf be made to the provider.
- Benefit Days for Reimbursement and Utilization Purposes - The number of days of care charged to a beneficiary for inpatient hospital services will always be in units of full days. In counting inpatient days for reimbursement purposes and determining the total number of days utilized by the beneficiary, either the day of admittance or the day of discharge is counted. In the Province of Ontario, the day of admission is not counted but the day of discharge is counted. Some provinces may be operating under a Canadian government ruling of January 1, 1968, which required hospitals to "charge for date of admission but not for date of discharge." The MS will certify payment for either the day of admission or for day of discharge. If admission and discharge occur on the same day, the examiner will count one inpatient day for reimbursement purposes.
- Benefit Period - A benefit period is a period of time measuring a beneficiary's use of hospital insurance benefits. It begins on the first day a bed patient receives services in a hospital. It ends after a person has been out of the hospital or skilled nursing facility for at least 60 consecutive days.

- Canadian Provincial Plan - Canada's national health insurance program, which is also often referred to as "Medicare", is designed to ensure that all residents have reasonable access to medically necessary hospital and physician services, on a prepaid basis. Instead of having a single national plan, Canada has a national program that is composed of 13 interlocking provincial and territorial health insurance plans (i.e. Canadian Provincial Plans), all of which share certain common features and basic standards of coverage. Medicare payments made by the RRB are reduced by the amount of payment made for the same services by the Canadian Provincial Plan.
- Chronic Care - Chronic care is a term used in Canada to describe an intermediate level of care similar to skilled nursing services in the United States.
- Doctor's Certificate - A doctor's certificate is a statement confirming that the services furnished were medically necessary. It is required as follows:
 1. If no part of the charges for the services were payable under a provincial hospital plan.
 2. If accommodations more expensive than a semiprivate room are furnished, e.g., private room or intensive care facilities, reimbursement of the difference between the customary charges for the accommodations furnished and the customary charges for semiprivate accommodations may be made only if they are considered medically necessary. The more expensive accommodations will ordinarily be considered medically necessary only when the patient's condition required it for his or her own health or for that of others.
- Exchange Rate - The price or sum per unit at which the currency of one country is exchanged for currency of another country. The MS uses the exchange rate to convert the reimbursable amount from Canadian dollars into U.S. dollars.
- Excluded Services - These are services excluded from coverage under the Medicare program. These exclusions apply to domestic and foreign care. They include private nursing care, personal comfort items and custodial care.
- Inpatient Hospital Coinsurance - The beneficiary is responsible for a daily coinsurance amount of one-fourth of the inpatient hospital deductible for the 61st through the 90th days of inpatient hospital services used during each benefit period. Also, the beneficiary is responsible for a daily coinsurance amount of one-half of the inpatient hospital deductible for each of the lifetime reserve days used in a benefit period.
- Inpatient Hospital Deductible - The amount a beneficiary is responsible for paying before the Medicare program starts paying for inpatient hospital service in each benefit period.

- Inpatient Hospital Services - When a beneficiary has been admitted to a hospital for treatment of an illness or injury, hospital insurance can pay for most of the items and services that are furnished. Inpatient hospital services include: room and board, regular nursing care, drugs, laboratory tests and use of hospital facilities. For more information on services covered under hospital insurance, see RCM Chapter 3.1.
- Lifetime Reserve Days - A beneficiary can use an additional 60 inpatient hospital days after 90 days have been used in a benefit period.
- Post Hospital Home Health Services - When an individual needs skilled health services on a part-time basis after treatment in a hospital or skilled nursing facility, hospital insurance can pay for home health care provided at home. Medicare can pay for: part-time skilled nursing care, physical therapy, speech therapy and occupational therapy. If home health services are covered under Medicare, a supplemental questionnaire may be needed to determine what type of services were received.
- Proof of Services Received - General - The claimant must submit documentary proof that he or she received covered services for which reimbursement is being claimed. As proof, the beneficiary may submit a bill. The bill must show payment has been made for such services or it must be accompanied by an assignment indicating that the beneficiary wishes payments due for covered services paid directly to the provider furnishing such services. Where a receipted bill carries a notation that payment was by promissory note, such a receipt is acceptable as proof of payment.
- Promissory Note - A promissory note is a written promise to pay at a fixed or determinable future time a sum of money to a specific individual or to bearer.

If a receipted bill carries a notation that payment was by promissory note (or the beneficiary indicates that a promissory note was given as payment) assume an unconditional giving and acceptance of the note as payment in the absence of evidence to the contrary.

The fact that the beneficiary paid his or her hospital bill by a promissory note is immaterial. It is also immaterial that the hospital endorsed or cosigned the promissory note.

- Qualification Requirements for Providers of Service - Where the requirements for provincial approval of hospitals or nursing facilities are substantially the same as the requirements for participation in the HI program, the certified Canadian providers are deemed to be eligible for participation in the Medicare program. We do not require a certification to that effect from the provincial agency nor do we determine that the providers of services do, in fact, meet all of the requirements for participation. Similarly, if a hospital is accredited by the Canadian Council for Accreditation of Hospitals, we deem the hospital to meet all of the requirements for participation except the requirement of utilization review.

Where Western Benefits Administration of Ontario, Canada certifies that the provider of services for which reimbursement is claimed, is a hospital, skilled nursing facility, or home health agency, as those items are defined in Section 1861 of the SS Act, assume that the requirements for participation have been met.

- Receipted Bill - A receipted bill is a written acknowledgement by the person or organization furnishing the covered services that all or part of the bill has been paid. The receipted bill must show the beneficiary's name and the amount paid. Acceptable proof that the bill was paid is the original receipted bill or a certified copy of such bill. It should show "Received Payment," "Paid in Full," "Paid" or a phrase with the same meaning with the initials or signature of the person receiving the payment.
- Skilled Nursing Coinsurance - The beneficiary is responsible for a daily coinsurance amount of one-eighth of the inpatient hospital deductible for the 21st through the 100th day of skilled nursing services used during each benefit period.
- Skilled Nursing Services - When a beneficiary no longer needs all the services that only a hospital can provide, but still requires skilled nursing or rehabilitation services, hospital insurance can pay for skilled nursing services provided in a qualified skilled nursing facility. In Canada, such services may also be provided in a public chronic hospital or in the chronic care wing of a public general hospital. These services include room and board, regular nursing services, rehabilitation services, drugs and medical supplies. See RCM 3.1 for a discussion of the conditions that must be met before skilled nursing services are covered under the hospital insurance program.

3.8.8 Amount Of Benefits

Hospital benefits for services provided in Canada are reduced by the greater of the following:

- The amount paid (or which would have been paid upon application) under a Canadian provincial health care plan, or
- The total of the deductible and coinsurance amounts (converted to Canadian funds).

Apply the above reduction criteria if the beneficiary did not receive payment under a provincial plan because he or she failed to apply for it. Do not make a reduction in the payment of benefits if the beneficiary had an option to participate in a provincial plan but elected not to do so.

Compute each type of service separately, i.e., inpatient hospital care, skilled nursing care, and home health service. The same deductible and coinsurance amounts apply to both domestic and foreign hospital insurance services.

3.8.9 Review Of Incoming Claims Material

An application must be filed within the regular time limit established for all Medicare claims. The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010. Under PPACA, claims starting January 1, 2010, must be filed within one year of the date of service.

Review the Form AA-104 for completeness. If the form is not completed properly, return it to the applicant. Compare the Form AA-104 with the doctor's statement, if any, and reconcile any discrepancies with the beneficiary. When private accommodations are claimed and the beneficiary has not already submitted a doctor's statement of medical necessity, request one.

If the bill does not indicate that it was paid, or a receipted bill was not submitted, inform the claimant that reimbursement cannot be made unless a receipted bill or a bill with an assignment of benefits to the provider is received.

If there is a discrepancy between the amount alleged by the claimant and the amount shown on the receipted bill, reconcile it before forwarding the claims material to WBA.

3.8.10 Role Of Western Benefits Association Of Ontario, Canada

The RRB has designated Western Benefits Association (WBA) of Ontario, Canada to act as its agent in Canada. This organization provides the RRB with the information required to make a reimbursement determination. WBA represents the RRB as an agent and advisor.

In requesting certification of hospital insurance services furnished in Canada, the Medicare Section refers Form AA-104, receipted bills other statements, and Form G-760 to WBA. WBA takes the following actions:

1. Establishes that the services were received;
2. Verifies the total charges;
3. Verifies the amount payable under the Canadian provincial health plan;
4. Verifies the amount paid by the beneficiary;
5. Completes Form G-760 and certifies:
 - a. That the services were provided to the beneficiary;
 - b. That the amount charged for services are reasonable costs, with appropriate exceptions listed in "Remarks;"
 - c. That the services are covered by the Medicare program with appropriate exceptions listed in "Remarks;" and

- d. That the provider of services is a qualified participant.

When a question arises about any WBA determination, contact them to reconcile the difference. If WBA finds that the provider is not a qualified participant, deny the claim.

3.8.11 Obtaining Certification From WBA

Refer Form AA-104, all receipted bills, except those for Part B services only (a bill may be received for both Part A and Part B services), and Form G-760 to WBA for certification if the services furnished are covered under the Medicare program and the beneficiary is a QRRB. Prepare the referral package as follows:

1. Assemble the Form AA-104 and all attachments including correspondence that reconciles any discrepancy.
2. Prepare Form G-760. Enter the beneficiary's name, RRB claim number, Medicare claim number (if different) and your signature on the Form G-760. WBA will complete the "Certification," including the appropriate dates in item 1.
3. Fax Form G-760, Form AA-104, the receipted bill(s), doctor's statement, etc. to WBA.

If accommodations more expensive than a semiprivate room are claimed and were not certified to be medically necessary, request WBA to determine the rate for a semiprivate room and to base its determination of reimbursable charges on that rate. Also, raise any other questions about the claim or bill that need clarification. These questions should be asked in the "Remarks" section of Form G-760. For example, if the daily rate on the hospital bill appears excessive, question whether it includes the cost of a private room.

4. Maintain the original forms until the completed Form G-760 is returned by WBA. Trace for the completed Form G-760 using the following schedule:
 - Initial request: 45 days
 - Second request: 30 days
 - Third request: 14 days

The third trace should be made by telephone call to WBA.

3.8.12 Using Prior Utilization Data

When the claims specialist releases Form G-760 to WBA, the claims specialist will also review the Common Working File (CWF) to obtain Part A and/or Part B utilization information. Hospital services received in the U.S. are considered along with services

received in Canada to determine the amount payable. For example, the benefit period, deductible and coinsurance amounts may be affected.

3.8.13 Who May Receive Payment

Payment of hospital insurance benefits is to be made as follows:

1. The individual who received the services if such individual paid for the services and submits documentary proof that such payment was made, or
2. The provider of services if the beneficiary makes an assignment.

3.8.14 Examples Of Computation Of HI Benefits

Here are some examples showing the computation of HI benefits for services received in Canada. The figures used in the following examples are not actual figures. If payment cannot be made for a particular day, do not count the day as a day of utilization, e.g., a person is hospitalized in a standard ward room and the Canadian provincial plan paid all charges in full. For more information, refer to Part 3 of the Intermediary Manual, section 3107.

- A. Inpatient Hospital - Example - Mr. Jacobs was hospitalized for 90 days in a two-bed room. The daily rate was \$90. The Canadian provincial plan paid the daily rate of \$80 for a standard ward bed. The total cost of services covered under the RRA before exclusion is \$8,100 (90 days x \$90 full daily rate). The \$8,100 total charge must be reduced by the amount paid under the Canadian provincial plan or the amount of the deductible and coinsurance adjusted to Canadian funds, which is more. The amount paid by the Canadian provincial plan is \$7,200. The deductible of \$124 plus the coinsurance amount of \$930 (\$31 x 30 days) is \$1,054. This amount adjusted to Canadian funds (\$1,054 x \$1.07, a hypothetical exchange rate as of the date of the hospital bill) is \$1,127.78. Therefore, we deduct \$7,200 paid under the Canadian provincial plan from the total of \$8,100. This leaves \$900 in Canadian funds to be paid under the RR Act. This amount must be converted to U.S. funds as of the date of payment. \$900 multiplied by a hypothetical U.S. exchange rate of .9346 is \$841.12. This is the amount payable.
- B. Skilled Nursing Care - Example - Mr. Bacon was in a covered nursing home for 100 days. The daily rate was \$30. The Canadian provincial plan pays for no part of this skilled nursing service. The total cost of the skilled nursing services was \$3,000 (100 days x \$30). The coinsurance amount is \$1,326.80 (80 days x \$15.50 x \$1.07, a hypothetical Canadian exchange rate). The total charge for the skilled nursing services must be reduced by the amount paid under the Canadian provincial plan or the coinsurance amount, whichever is greater. Therefore, the amount payable in Canadian funds is \$1,673.20 (\$3,000 - \$1,326.80). In converting the amount payable to U.S. funds, \$1,673.20 is

multiplied by .9346, a hypothetical U.S. exchange rate. The amount payable in U.S. funds is \$1,563.77.

- C. Home Health - Example - Mr. Corley received 100 home health visits in a 1-year period. The home health visits were \$8 each. The Canadian provincial plan paid no benefits. The total cost of the home health services is \$800. There is no deductible or coinsurance for home health services. Therefore, the amount payable in Canadian funds is \$800. This amount must be converted to U.S. funds as of the date of payment. Do this by multiplying \$800 by the U.S. exchange rate on the date the bill was paid ($\$800 \times .9346$, a hypothetical U.S. exchange rate, is \$747.68). The amount payable in U.S. funds is \$747.68.
- D. Inpatient Lifetime Reserve Hospital Days - Example - Mrs. Evans was hospitalized a number of times in the same benefit period and used up her 90 days. Before a new benefit period started, she again was hospitalized. Mrs. Evans decided to use her 60 lifetime reserve days. She was hospitalized in a two-bed room. The daily rate was \$90. The Canadian provincial plan paid the daily rate of \$80 for a standard ward bed. The total cost of services covered under the RRA before exclusions is \$5,400 ($90 \text{ full daily rate} \times 60 \text{ days}$). The \$5,400 is reduced by the amount paid or the amount of the coinsurance adjusted to Canadian funds, whichever is the greater amount. The amount paid by the Canadian provincial plan is \$4,800; the coinsurance amount is \$3,720 ($\$62 \times 60 \text{ days}$). The coinsurance amount adjusted to Canadian funds is \$3,980.40 ($\$3,720 \times \1.07 , a hypothetical exchange rate). Therefore, \$4,800 paid under the Canadian provincial plan is deducted from the cost of \$5,400. This leaves \$600 in Canadian funds to be paid under the RRA. This amount is converted to U.S. funds as of the date the bill is paid. $\$600 \times .9346$, a hypothetical U.S. exchange rate, is \$560.76. When this is paid, Mrs. Evans 60 lifetime reserve days will have been exhausted.

NOTE: RRB asks the beneficiary if (s)he wants to use lifetime reserve days or keep them for the future.

- E. New Benefit Period – Example - Mr. Halbert had a heart attack and was admitted to the Douglas Memorial Hospital in Ontario, Canada on May 20, 2008. He was released on June 2, 2008 and was transferred to a skilled nursing facility (SNF). He was discharged from the SNF on June 23. Fifteen days later on July 8, Mr. Halbert suffered a stroke and was hospitalized from July 8, 2008 through August 28, 2008. He is considered to still be within his first benefit period because 60 days had not elapsed since his last hospitalization or discharge from a SNF. Mr. Halbert had a relapse and was re-admitted on November 24. He was discharged from the SNF on December 1, 2008. This is considered a new benefit period because more than 60 days elapsed from the date of his last hospitalization or discharge from a SNF (August 29 through November 23).
- F. Acute Level of Care – Example – Mrs. Williams was hospitalized after suffering severe injuries from a car accident. After a 10-day stay in the hospital, Mrs.

Williams was to be transferred to a skilled nursing facility. However, she could not be immediately transferred to the facility. She remained at the hospital for an additional seven days until a bed was available at the skilled nursing facility. Since Mrs. Williams no longer required the level of care normally provided in a hospital, her last seven days in the hospital were billed as ALC (Alternate Level of Care). She submits the bill of \$2,500 to the RRB for payment. RRB will only reimburse her the co-pay for three of the days (the maximum).

3.8.15 Selecting Payee For Claims After Death

If the beneficiary who received the service dies, claims for unpaid benefits are paid as follows:

A. Bill Was Paid - Pay in the following order of priority:

- The person or persons who paid the bill.
- The legal representative of the estate if the bill was paid by the deceased enrollee or from funds from his or her estate. When the estate has already been closed, or when there may be an indefinite delay in the appointment of a legal representative, payment may be made to a surviving relative in the priority order listed below.
- The surviving spouse who was either living in the same household as the enrollee or was entitled to monthly SS or RR benefits (based on the same earnings record) for the month of his or her death.
- Child or children of the enrollee who were entitled to monthly SS or RR benefits (based on the same earnings record) for the month of his or her death.
- Parent or parents of the enrollee who were entitled to monthly SS or RR benefits (based on the same earnings record) for the month of his or her death.
- Surviving spouse who was not either living in the same household as the enrollee or was not entitled to monthly SS or RR benefits (based on the same earnings record) for the month of his or her death.
- Child or children of the enrollee who were not entitled to monthly SS or RR benefits (based on the same earnings record) for the month of his or her death.
- Parent or parents of the enrollee who were not entitled to monthly SS or RR benefits (based on the same earnings record) for the month of his or her death.

- Legal representative of the estate of the enrollee if the bill was paid by another person who is now deceased and no relative as described above exists.

Documentary evidence must be submitted to support the entitled person's claim for benefits (i.e., proof of relationship, proof of payment, or proof of appointment).

- B. Bill Was Not Paid - Pay to the provider of services if the provider accepts an assignment.

If no person survives who meets the above requirements, the benefit cannot be paid.

3.8.16 Preparation Of Award Through SURPASS; Completion of Form G-730

- A. Instructional Memorandum No. 07-02 containing instructions for making Canadian Part A benefit payments is no longer accessible through PRISM. A paper copy is available in Policy & Systems until IM 07-02 can be incorporated into this section.
- B. Use Form G-730 to document payment of the claim and the utilization of HI services furnished in Canada. See RCM 3.8, Appendix A for instructions on the preparation and certification of this form.

Because the U.S. foreign exchange rate for a Canadian dollar fluctuates, convert the reimbursable amount into U.S. funds as of the date of the hospital bill was paid and pay the converted amount. If the exact date of payment is not available, use the exchange rate in effect on the billing date. The Medicare Section maintains a listing of exchange rates for this purpose. There are some non-payment situations where an award form should be completed but no utilization charged. e.g., physician refuses to make a required certification or the provider fails to submit needed information.

3.8.17 Completion Of Award Letter

Form RL-340 or Form RL-341 is the award letter used to notify a Canadian beneficiary of entitlement to reimbursement for HI services in Canada. Award letter RL-340 is used when reimbursement will be paid to the beneficiary. Award letter RL-341 is used in assignment cases when reimbursement will be paid to the provider. The letter is released by the authorizer when the Canadian payment has been authorized on SURPASS. Complete the award letter carefully to show all the details. It is used as a record of HI services in Canada.

Complete Form RL-340 or Form RL-341 using RRAILS. Use the data shown on the completed Form G-730 to complete the form.

- A. Heading - The beneficiary's name and address are prefilled. Type in the salutation.

- B. Paragraph 1 - In the first line, enter the Net Amount Paid shown in Item 19 of the Form G-730. Enter the type of service(s), dates covered by the bill and number of health visits included, as shown in Item 6 of the Form G-730. If an RL-341 is being prepared, enter the name of the hospital in the first sentence.
- C. Paragraph 2 - List the exceptions and amounts shown in Items 8 (amount paid by Canadian provincial plan), item 9 (deductible and coinsurance amounts), and item 10 (non-covered services) of the Form G-730.
- D. Paragraph 3 - Enter the number of days or visits used on this bill, used to date, and remaining, as shown in Item 6 of the Form G-730 for each type of service.
- E. Checking RL-340 and RL-341 - Check the correctness of the data entered on the award letter.
- F. Disposition - Route the original and 2 copies of the RL-340 or RL-341, with the Form G-730 and all related documentation to the authorizer. The authorizer will date the original letter and the 2 copies, and release the original letter upon authorizing the SURPASS award. The authorizer will also route a copy of the award letter with copies of all other documents to be imaged. The other copy along with the originals and/or copies of all other documents are to be filed in the Foreign Claims Voucher Book.

3.8.19 Processing Denials

- A. Reasons for Denials - Deny the claim without referral to WBA if the beneficiary does not submit the necessary evidence, or claims only non-covered services. Some examples of non-covered services are:
1. Private nurse, comfort items, etc.
 2. Inpatient hospital services when the cost is less than the deductible.
 3. Skilled nursing services (SNF) when:
 - Beneficiary did not have a qualifying 3-day hospital stay;
 - Beneficiary did not enter SNF or chronic care facility within 30 days after release from hospital;
 - Nursing care had no relationship to condition requiring hospitalization; etc.
 4. Home health services were not provided by an agency participating in Medicare.

After verification of the services by WBA, deny the claim if:

1. A. U.S. intermediary has already paid HI benefits on the claim.
2. The services are not covered.
3. The charges are less than deductible.

NOTE:

A beneficiary has 120 days to file a re-determination request on all Medicare claims.

- B. Disposition of Claims - Prepare an original and 2 copies of the denial letter. Be sure to include the standard explanation of the beneficiary's rights to reconsideration and appeal in the letter. Close out the entry in the Foreign Claims Voucher Book, and route all copies of the letter and all related documents to authorization.

If covered services are involved but the charges are less than the deductible, or the beneficiary does not submit necessary evidence, prepare a "dummy" Form G-730 as described in RCM 3.8.20.

The copies of the letter will be distributed as follows:

- Original - Claimant; the original bills and receipts should be included.
- Copy -To imaging along with copies of the claim and related documentation, i.e. bills and receipts.
- Copy - Foreign Claims Voucher Book along with copies of the claim and related documentation, i.e. bills and receipts.

3.8.20 Report To CMS Of Utilization

HI services furnished in Canada are charged against a beneficiary's utilization record in the same manner as services furnished in the U.S. Form G-730 is used to record utilization information and is sent to the Centers for Medicare and Medicaid Services (CMS). Form G-730 is also used when the claim is not payable but the services are chargeable against the beneficiary's utilization record. The Medicare Section will send a "dummy" Form G-730 to CMS with the words "No Amount Payable" in the remarks section of the form.

Health Enterprises is no longer the intermediary that processes Forms G-730 to update the Common Working File (CWF). All Forms G-730 are to be sent to CMS via email. After the case is complete, the authorizer will encrypt the Form G-730 Word document, attach it to the email and send it to CMS at the following address:

.Wolfsheimer@cms.hhs.

Richard Wolfsheimer is our contact at CMS for processing Forms G-730. His telephone number is (410) 786-6160.

The authorizer should follow this email with a second email to Richard Wolfsheimer providing him the password to open the encrypted file. The same password will be used for all subsequent Forms G-730 encrypted and sent to CMS.

3.8.25 Introduction – Part B Services in Canada

Beginning in 1973, the Social Security Act provides benefits for certain Part B services furnished in Canada. Part B covers physician and ambulance services furnished in connection with and during specific hospital stays. The three situations are:

1. An emergency occurs in the U.S. and the Canadian hospital is closer than the nearest U.S. hospital.
2. Inpatient hospital services are furnished in a Canadian hospital which is closer to, or substantially more accessible to the beneficiary's U.S. residence than the nearest U.S. hospital which can provide adequate care, regardless of whether or not an emergency exists.
3. An emergency occurs in Canada while the beneficiary is traveling without unreasonable delay and by the most direct route between Alaska and another State.

Under this provision payment can be made for the following Part B services:

1. Physicians' services rendered to the beneficiary while he or she is an inpatient.
2. Physicians' services rendered to the beneficiary outside the hospital on the day of his or her admission as an inpatient, provided the services were for the same condition that required emergency treatment. Please note that claims for emergency room visits are not payable if there is no accompanying hospital stay.
3. Ambulance services, where necessary, for the trip to the hospital in connection with the beneficiary's hospitalization.

Even though the hospital stay of a QRRB is covered under the RRA, Part B benefits are payable only when the hospitalization is covered under the SS Act. CMS has authorized the RRB to make coverage determinations under the SS Act for QRRBs claiming Part B benefits.

3.8.26 Claims Development

- A. General - Part B claims may be received from Palmetto GBA, directly from the beneficiary or indirectly through RRB field offices. A claim should be made on Form CMS-1500. (Claims submitted using obsolete Forms G-740s or HCFA-

1500 are also acceptable.) The claim must be filed within the regular time limit established by law. Enter each incoming claim in the foreign Part B log book.

Each claim must include the beneficiary's residence, where the services were rendered, the type of services, and the nature of the illness or injury. If the claim lacks sufficient information to make a coverage decision, request the appropriate district office to develop the required information. If a claim for hospital insurance benefits has not been filed, have the district office secure a completed Form AA-104. Wait for the certification from WBA before making a determination on the Part B claim. WBA will determine whether the hospital is a "qualified" institution and whether benefits have already been paid by CMS.

B. Coverage Determination - In determining whether Part B benefits are payable, the Medicare Section claims specialist first determines whether Part A hospital benefits are payable under the SS Act. The claims specialist applies the provision of the SS Act regarding:

- accessibility of the Canadian hospital,
- residency requirement,
- Canadian travel requirements, (Use MapQuest or a similar application to determine if the beneficiary used the shortest practicable route traveling between Alaska and another state.
- whether physician and ambulance services furnished in Canada were furnished in connection with covered inpatient services, and
- whether the claim was filed within the time limit.

3.8.27 Emergency Hospital Admissions

A. Emergency Provision - An emergency will be considered to have occurred within the United States if the individual was physically present in the United States when the need for emergency inpatient hospital services arose and the individual's reason for departure from the United States was to obtain treatment at the foreign hospital. Thus, a person who becomes ill while enroute to a foreign country by ship or airplane and receives hospital services in the foreign country does not qualify to have payment made for these services.

The emergency requirement will be established based upon the statement of the physician who attended the patient at the hospital. The statement must describe the nature of the emergency, furnish any relevant clinical information about the patient's condition, and also state that the services rendered were required as emergency services. The statement must include the date when, in the physician's judgment, the emergency ceased. Photocopies of hospital records can be used to substantiate the emergency nature of the situation.

B. Accessibility Determination.

1. Emergency Occurs Within the U.S. - If the emergency occurred within the U.S. determine from the criteria below whether the patient was admitted to the nearest or most accessible hospital from the site of the emergency.

a. Participating Hospital 15 or Fewer Miles Farther From the Location of the Emergency Than the Admitting Canadian Hospital.

If the distance from the location of the emergency to the nearest participating hospital with available beds or adequate emergency facilities is 15 or fewer miles greater than is the distance to the admitting Canadian hospital, accessibility is provisionally not met, but there must be a physician review to determine whether the nature of the emergency required immediate transportation to the Canadian hospital.

If the review indicates that the nature of the emergency would have allowed the additional transportation time needed to take the patient without hazard to the U.S. hospital, the accessibility requirement shall be deemed not met unless evidence established the necessity for taking the patient to the Canadian hospital e.g., unusual medical circumstances; needed equipment and/or personnel unavailable in the U.S. hospital.

Factors involving selection of a hospital which reflect the personal preference of the individual or physician does not have staff privileges at the participating hospital, nearness to beneficiary's residence, religious affiliation, presence of previous medical records at the nonparticipating hospital, cost, type of accommodations available, etc. are not considered in the accessibility determination.

b. Participating Hospital More than 15 Miles Farther from the Location of the Emergency than the Admitting Nonparticipating Hospital.

If the nearest participating hospital is more than 15 miles farther from the location of the emergency than is the admitting nonparticipating hospital the accessibility requirements shall be deemed met.

Request the field office to secure a statement from the beneficiary describing the circumstances of the illness or injury, when the emergency occurred and why the Canadian hospital was chosen. Ask the field office to determine the distances between the emergency site and:

- the closest U.S. hospital,

- the Canadian hospital that admitted the beneficiary.
2. Emergency Occurred In Canada - If the emergency occurred while the beneficiary was traveling in Canada between Alaska and another State, the accessibility requirement is considered met where the emergency occurred more than 15 miles from the U.S. border and the other Canadian travel provisions are met. If the emergency occurred within 15 miles of the U.S. border, apply the accessibility criteria described in B. 1. above.
- C. "Canadian Travel" Provision - An emergency will be considered to have occurred while the beneficiary was traveling without unreasonable delay and by the most direct route between Alaska and another State if the emergency occurred while the beneficiary was enroute between Alaska and another border State by the shortest practicable route, or while making a necessary stopover in connection with such travel. To make this determination, secure a detailed itinerary from the beneficiary and apply the criteria below. The examiner may also use MapQuest or a similar application to determine the shortest practicable route possible.
1. Shortest Practicable Route - Ordinarily the "shortest practicable route" is the one that results in the least travel in Canada, between the point of entry into Canada and the intended point of departure. The amount of travel in the United States 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 would result in a savings of time or was necessary because of road or weather conditions, the age, health, or physical condition of the traveler, to make suitable travel arrangements, obtain acceptable accommodations, etc.

However, the individual would be considered to have deviated from the "shortest practicable route" if the detour was unrelated to the purpose of reaching his or her destination (e.g., for the principal purpose of sightseeing or vacationing).
 2. Necessary Stopover - The term "necessary stopover" means (a) a routine stopover for rest, food, or servicing of the travel vehicle, and (b) a non-routine stopover (even though of significant duration) caused by 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.

3.8.28 Services Furnished In Canadian Hospital Nearest To Beneficiary's U.S. Residence

In determining whether a U.S. border resident can qualify for Part B benefits, two criteria must be established: the beneficiary's "residence" and the accessibility of the Canadian hospital.

- A. Residence - "Residence" means the beneficiary's fixed and permanent home to which he or she intends to return whenever he or she is away or a dwelling where the beneficiary periodically spends some time (e.g., a summer home).

Residence will normally be determined from the address listed on the claim form.

- B. Accessibility - The accessibility requirement will be deemed met if the Canadian hospital is closer to the beneficiary's U.S. residence than is the closest U.S. participating hospital. If the Canadian hospital is farther from the beneficiary's residence than is a U.S. participating hospital, accessibility will not be met unless the facts show that the U.S. hospital had no bed available, would not accept the patient, did not have the necessary equipment or personnel, or was inaccessible for some other reason.

The personal preference of the beneficiary, his or her physician, or others in the selection of a hospital, the type of accommodations available, or the non-availability of staff privileges to the attending physician are not considered in determining whether a Canadian hospital is more accessible than a participating hospital.

Request the field office to determine the distances between the beneficiary's residence and:

- the closest U.S. hospital,
- The Canadian hospital that admitted the beneficiary.

If the admitting Canadian hospital is farther than the closest U.S. hospital, ask the field office to secure a statement from the beneficiary explaining why the Canadian hospital was chosen.

3.8.29 Disposition Of Part B Claims

- A. Claim Meets Coverage Requirements - Prepare a letter to Palmetto GBA authorizing payment of the Part B claim. Briefly explain the basis for the favorable determination. Use the letter as a transmittal for the Part B claim, related material, and copy of the Form AA-104. Address all correspondence to:

Octavia Huff
Palmetto GBA
Post Office Box 1066
Augusta, Georgia 30999-001

Her telephone number is (706) 855-3382.

Route the letter and all related documents to the authorizer. The authorizer will date the letter and all copies, and release the original letter upon authorizing the

determination. The authorizer will also route a copy of the letter with copies of all other documents to be imaged. The other copy along with the originals and/or copies of all other documents are to be filed in the Canadian Voucher Book.

- B. Claim Does Not Meet coverage Requirements - Prepare a letter to the beneficiary (with a copy to Palmetto GBA if they referred the claim to us.) Explain the coverage requirements and include the Medicare appeals paragraph.

Route the letter and all related documents to the authorizer. The authorizer will date the letter and all copies, and release the original letter upon authorizing the determination. The authorizer will also route a copy of the letter with copies of all other documents to be imaged. The other copy along with the originals and/or copies of all other documents are to be filed in the Canadian Voucher Book.

If the beneficiary protests the denial, consult with your supervisor.

NOTE:

A beneficiary has 120 days to file a re-determination request on all Medicare claims.

3.8.35 Medicare Benefits In Mexico

Claims for Medicare services furnished in Mexico are handled by the Centers for Medicare & Medicaid Services (CMS). When a claim for inpatient hospital benefits is received, the Medicare Section claims specialist forwards it to the appropriate regional office of CMS. The CMS regional office makes the coverage determination and:

- sends the Part B claim to Palmetto GBA for payment, or
- prepares and releases a denial letter.

The claims specialist answers general questions about Mexican coverage.

All claims for inpatient hospital services furnished in Mexico are sent to the appropriate CMS regional office. Claims for other services furnished in Mexico should be forwarded to Palmetto GBA in Augusta, Georgia. The geographic location of the hospital furnishing the inpatient services determines which regional office handles the claim. If the examiner cannot determine the Mexican state the hospital is located in from any of the documentation provided, he or she can use Google or MapQuest to assist in making a determination.

The following is a listing of all 31 Mexican states: Aguascalientes, Baja California, Baja California Sur, Campeche, Chiapas, Chihuahua, Coahuila de Zaragoza, Colima, Durango, Guanajuato, Guerrero, Hidalgo, Jalisco, Mexico, Michoacan de Ocampo, Morelos, Nayarit, Nuevo Leon, Oaxaca, Puebla, Queretaro de Arteaga, Quintana Roo, San Luis Potosi, Sinaloa, Sonora, Tabasco, Tamaulipas, Tlaxcala, Veracruz-Llave, Yucatan, Zacatecas

State	Regional Office
Baja California (B.C.) Nayarit (NAY.) Sinaloa (SIN.) Sonora (SON.)	Centers for Medicare & Medicaid Services Regional Office – Region 9 90 Seventh St, Suite 5-300 (5W) San Francisco, CA 94103-6706
All Others	Centers for Medicare & Medicaid Services Regional Office –Region 6 1301 Young St., Suite 714 Dallas, TX 75202

Appendices

Appendix A - Form G-730, Determination of Award

Form G-730 (6-86) - Determination of Award - Hospital Insurance Benefits for Services in Canada. If benefits are payable for more than one type of service (e.g. inpatient hospital, chronic care, home health, or skilled nursing facility), a Form G-730 should be prepared for each type of service.

Use

Used by the Medicare Section to reimburse a QRRB for HI services received in Canada.

Completion

Item	Entry
1	Enter the beneficiary's RRB claim number, including payee symbol (if any), claim number prefix.
2	Enter the employee' SS number.
3	Enter the beneficiary's pseudo number, if there is one.
4	Enter the name of the beneficiary who received the hospital insurance services.

5	Enter the beginning date of the benefit period. This is the first day the beneficiary received covered services in the current benefit period.
6	<p>Check the box to indicate the type of service. If there is inpatient hospital and some other type of service on the same bill, prepare a separate Form G-730 for each type of service.</p> <p>Enter the dates covered by the bill unless the bill covers services before the effective date of coverage. In the latter event, enter only the period covered by the bill beginning with the effective date of coverage. Enter the number of days used or visits made and the number of days or visits remaining.</p>
7	Enter the total charges (in Canadian funds) for the services provided to the beneficiary during the period covered. This may include services not covered under the RRA. This should be the total charges as shown in item 1 of the Form G-760 completed by Western Benefits Association (WBA) unless the bill covers services before the effective date of coverage. In the latter event, enter only the total charges for the period beginning with the effective date of coverage.
8	Enter the amount (in Canadian funds) payable to the provider under the Canadian provincial plan. This is the amount shown in item 2 of the Form G-760 completed by WBA unless the bill covers services before the effective date of coverage. In the latter event, enter only the total charges for the period beginning with the effective date of coverage. If none, leave this item blank.
9	Add the deductible and/or the coinsurance together, if applicable, divide that amount by the exchange rate and enter the total amount as converted to Canadian funds as of the date(s) the bill(s) was(were) processed paid in the "\$" field. Enter the amount by which item 9 exceeds item 8 in the column next to the arrow. If item 8 is greater, enter 0.
10	List the type of services not covered and the cost in Canadian funds of each type and enter the total in Canadian funds in the "\$" column. This information will be listed as exceptions under "Remarks" of the completed Form G-760. If none, leave this item blank.
11	Enter the amount of Canadian funds previously paid for the services covered by the bill as listed in item 6 of the Form G-730. This is the amount of Canadian funds shown in item 14 of any previous Form G-730 completed for the same services. If none, leave this item blank.
12	Enter the unpaid amount of Canadian funds for the services covered by the bill as listed in item 6 of the Form G-730.

13	Add items 8 through 12 and enter the total here.
14	Subtract the total shown in item 13 from the total charges shown in item 7. Enter the result here.
15	Under date, enter the date the bill was paid. Under U.S., enter the exchange rate for the Canadian dollar.
16	Multiply the amount in item 14 by the exchange rate in item 15 and enter the result here.
17	Use this item to include any additional information that would be useful in explaining the award.
18	Enter the name and address of the payee. Follow the rules in RCM 8.1, Appendix A, except do not use a group mark.
19	Under "Net Amount Paid," enter, in U.S. funds, the total amount to be paid to the payee in item 16.

Signature And Disposition

The Medicare Section specialist signs his or her name and enters the date on which he or she completed the form. The authorizer will sign his or her name and enter the date on which he or she authorized the completed Form G-730.

Route the completed Form G-730 with all related documents to the authorizer. Once the authorizer has authorized the Form G-730 and related SURPASS award (if any), a copy of the Form G-730 and related documentation will be routed for imaging, and a copy will be filed in the Foreign Claims Voucher Book. The original Form G-730 will be sent to CMS as an encrypted document via an email. Refer to section 3.8.20 for further information.