Military Treatment Facility Claims for Emergency Hospital Services
CMS Approval Checklist

At the time of the emergency, was the BENEFICIARY:	YES	NO
1. Already an inpatient in a hospital? If Yes, **STOP**. This claim cannot be paid. If No, skip to #3.	☐	☐
2. Admitted to the hospital on an emergency basis? If Yes, go to #3. If No, **STOP**. This claim cannot be paid.	☐	☐
3. Able to be safely discharged or transferred to a participating hospital or other institution? If No, go to #4. If Yes, **STOP**. This claim cannot be paid.	☐	☐
4. Eligible for Medicare Fee For Service (FFS) Part A? If No, **CAUTION.** No Part A payment can be made.	☐	☐
5. Eligible for Medicare FFS Part B? If No, **CAUTION.** No Part B payment can be made.	☐	☐
6. Covered by Medicare as a secondary payer? **ACTION: If primary payer remittance or denial not attached, return claim to provider.**	☐	☐
7. Retired or active duty military personnel (other than a veteran) or an eligible dependent? If Yes, **STOP**. This claim cannot be paid.	☐	☐

When the beneficiary received service, was the PROVIDER:	YES	NO
1. Located in the United States (i.e., the 50 states, the District of Columbia, Puerto Rico, the US Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands)? If No, **STOP**. You must follow the rules for foreign & shipboard claims.	☐	☐
2. A Military Treatment Facility owned and operated by the US Government? If No, **STOP**. This form applies only to Military Treatment Facilities.	☐	☐
3. Operating under a current, CMS-approved election to bill Medicare for the calendar year in which the service occurred? For Hospital-submitted claims: If Yes, go to #4. If No, **STOP**. This claim cannot be processed. Contact the MTF to request an election to bill. If MTF declines, contact CMS. For Beneficiary-submitted claims: If Yes, contact CMS. The beneficiary should not have received a bill without a denial from Medicare. If No, **STOP**. Contact the MTF to request an election to bill.	☐	☐
4. Located in a rural area? If Yes, go to #5. If No, skip to #10.	☐	☐
5. Located closer to the site of the emergency than the nearest appropriate Medicare participating hospital? If Yes, skip to next section. If No, go to #6.	☐	☐
6. Deemed most accessible due to the transportation facilities available? If Yes, skip to next section. If No, go to #7. **ACTION: Attach explanation.**	☐	☐
7. Deemed most accessible due to the quality of the roads? If Yes, skip to next section. If No, go to #8. **ACTION: Attach explanation.**	☐	☐
8. Deemed most accessible due to lack of beds available at the closest participating hospital? If Yes, skip to next section. If No, go to #9.	☐	☐
9. Deemed most accessible due to extenuating circumstances preventing or prolonging the beneficiary's ability to access the closest participating hospital? Note: Extenuating circumstances does **not** include personal preference, proximity to beneficiary's residence, presence of medical records, etc. If Yes, skip to next section. If No, **STOP**. This claim cannot be paid. **ACTION: Attach explanation.**	☐	☐
10. Deemed most accessible based on "clear and convincing evidence" that there was a **medical or practical need** to use the non-participating hospital? Note: Examples of practical needs may be chronic high traffic areas or 911 dispatched beneficiary to non-participating hospital. If Yes, skip to next section. If No, **STOP**. This claim cannot be paid. **ACTION: Attach explanation**.	☐	☐

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Were the SERVICES the provider rendered to the beneficiary:	**YES**	**NO**
1. Emergency services as defined in 42 CFR § 424.101 and as described in the policy stated in Pub. 100-04, Chapter 32, § 350.11.5? If No, **STOP**. This claim cannot be paid.	☐	☐
2. Inpatient or outpatient hospital? If No, **STOP**. This form is only used for MTF hospital emergency claims.	☐	☐
3. Covered services (except custodial care) that Medicare would pay for if rendered by a participating provider? This includes meeting any medical necessity requirements as defined in Pub. 100-04, Chapter 32, §350.11.5. If No or if custodial care, **STOP**. This claim cannot be paid.	☐	☐

Was the CLAIM:	**YES**	**NO**
1. Appropriately billed on a Form CMS-1450/UB-04 or electronic equivalent with the statement "hospital filed emergency admission" in FL 80?	☐	☐
2. Received by the MAC within ONE YEAR of the date of service? If No, **STOP**. This claim cannot be paid. **ACTION: If applying or requesting a timely filing exception, attach a justification.**	☐	☐
3. Submitted with additional records properly documented on a CMS-1771 or other supporting medical information which meets ALL of the following criteria:		
a. Describes the nature of the emergency, specifying why treatment at the most accessible hospital was necessary and stating the services were necessary to prevent death or serious impairment of the beneficiary	☐	☐
b. Establishes that the conditions at 42 CFR 424.103(a) are met, i.e. normally covered services, non-par hospital election to bill in effect, emergency did not occur during inpatient stay, beneficiary could not be safely transferred, and states the non-part hospital was most accessible available and equipped to furnish service.	☐	☐
c. States when the emergency ended (for inpatient services, it is the earliest date the beneficiary could be discharged or transferred safely)	☐	☐
ACTION: Please provide a high level summary of the information received that satisfies each of the required criteria.		

Claim Payment Calculation:	
1. Enter the total amount billed.	$
2. Total non-covered charges.	$
3. Total reasonable/customary charge amount. (Amount #1 minus Amount #2)	$
4. Calculation of Allowed Amount: Use the amount in #5 to calculate as indicated below. <u>Hospital-submitted claims</u>: For inpatient services, allow 100% reasonable charges. For outpatient services, allow 85% of customary charges for covered services minus deductible and coinsurance. <u>Beneficiary-submitted claims</u>: For inpatient services, to determine the allowed amount for accommodation charges, subtract non-covered accommodation charges from the total accommodation charges then subtract deductible & coinsurance. Multiply remainder by 60%. To determine the allowed amount for ancillary charges, subtract non-covered ancillary charges then subtract deductible & coinsurance. Multiply remainder by 80%. Add allowed amounts for accommodation and ancillary charges. For outpatient services, subtract Part B deductible (if any) from total covered charges. Multiply remainder by 80%.	$
5. Less deductible, coinsurance, and any other adjustment amount(s), e.g. sequestration. (Note: Do not subtract amounts already deducted in a prior step.)	$
6. Total Payment Amount	$