Migrant Hospitalization Program

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service
Health Services Administration
Bureau of Community Health Services
Office of Migrant Health
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BCHS

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Summary and Program Objectives

The Bureau of Community Health Services' hospitalization program for migrants provides inpatient hospital services including inpatient medical services for migrant agricultural workers and their dependents through selected migrant health projects. Projects chosen to participate are limited to those which provide comprehensive, full-time medical services on a year round basis, and which have no other source of hospitalization support. These projects certify the eligibility of patients for care under the program and refer the patients to a participating hospital.

The participating hospitals are reimbursed for services by the Office of Direct Reimbursement (ODR) Health Care Financing Administration on a predetermined all inclusive per diem rate. The rates of reimbursement are based on the participating hospital's costs or charges whichever are lower. Two rates of payment are available to pay for covered services provided by a participating hospital. One rate applies to newborn nursery inpatients and the other applies to all other inpatients.

Physicians who are not employed full time by the project and who serve as attending physicians, as well as other physicians required by the patient's condition, are reimbursed for inpatient hospital medical services provided to eligible recipients using the Relative Value Studies of the California Medical Association and the Relative Value Guide of the American Society of Anesthesiologists.

The primary objective of the program is to provide inpatient hospital services to migrants who have no other means to obtain hospital care. The hospitalization program is aimed at the efficient and effective use of high cost inpatient care as a supplemental service available to comprehensive ambulatory care projects serving migrants and their dependents.

In fiscal year 1978 a new program initiative was authorized entitled *High Risk Maternity and Newborn Infant Care Program for Migrants.* Federal funds were made available to provide for the identification and care of the "high risk" migrant mother and infant in order to reduce to the extent possible morbidity and mortality rates for both mothers and infants. Selected participating projects have been identified as serving in county populations with a statistically high infant mortality rate. The available funds will be used to pay for the hospitalization of this "high risk" caseload utilizing the established procedures of the Migrant Hospitalization Program.

Revisions in this reissue of the Migrant Hospitalization Manual

NOTE: A number of changes and corrections have been incorporated into the manual, the most significant of these being itemized below. However, a careful reading of this manual is recommended so that any questions you may have can be brought to our attention (see last section). The previous issuance of this manual was dated January 1, 1977.

All Sections

All references to the Bureau of Health Insurance, SSA, have been changed to conform with the organizational structure of the new Health Care Financing Administration (HCFA). Note that also affected is the designation of certain forms used in this program.

Additionally, HCFA will accomplish internal reorganization of various units during fiscal year 1979. Therefore, references in this revision of the Migrant Hospitalization Manual to these internal units should be considered as interim designations until final designations are announced and published.

Section 110.2

Paragraph five notes minor changes in hospital outpatient benefits.

Section 110.4

Note revision in hospital utilization review requirements.

Section 110.7, c.

Current regulations on sterilization and hysterectomies are set forth.

Section 110.7, d.

Current regulations on abortions are set forth.

Section 110.8

Item h., excluded from covered benefits is air ambulance or other nonsurface emergency transportation.

Section 120

Note new Section 120.3 on admission control procedures adopted by the Office of Direct Reimbursement, HCFA.

Section 270.2

This new Section describes the conditions under which a limited hospital outpatient benefit is available.

Section 340

Note the time limit of 1 year for filing bills for services to migrant beneficiaries.

Section 360

Uniform Bill, UB 16, will replace Uniform Bill, UB 14, and instructions are revised accordingly.

Section 370

Revisions of Sections A, and B, clarify reimbursement of professional services to program beneficiaries.

Section 400

Exhibit II is a modified contract form which must be executed by those projects which participate in the High Risk Maternity and Newborn Infant Care Program. All projects participating in the basic Migrant Hospitalization Program (MHP) will continue to execute the form shown in Exhibit I.

The form *Conditions of Participation for Migrant Health Projects* is redesignated as Exhibit III and is mandatory for all MHP project participants, including the "high risk" program.

Section 100: COVERAGE AND REIMBURSEMENT

110 COVERAGE OF SERVICES

110.1 General

The benefits provided to eligible migrant workers or their dependents under this program will parallel in most respects those of the Medicare program.

The most obvious exceptions are the absence of deductibles and coinsurance features and the limitation of 30 days per benefit period. It should also be noted that all benefit payments, hospital and professional, are limited to beneficiaries who are hospital inpatients whose hospital stay meets all the conditions for coverage under the Migrant Hospitalization Program.

110.2 Hospital Services

a. Benefit Period: Once a determination of eligibility has been made, the patient is entitled to up to thirty (30) days of inpatient hospital care in each benefit period. A benefit period begins on the date of admission to a participating provider of migrant hospital services and ends sixty (60) days after the patient's discharge from any hospital.

b. Covered Days: The first day of a hospital stay, regardless of the time of admission prior to midnight, will count as a full inpatient day for determining the migrant patient's length of stay.

The day of discharge (or death), regardless of the time, is not counted.

NOTE: When a patient is transferred to a non-participating hospital for continued covered care this rule, for claim payment purposes, will continue to apply. Thus, the day of transfer will be a day of discharge for the participating hospital and a day of admission for the second hospital. And the reverse will apply if the patient is returned to the participating hospital. However, when admission and transfer take place on the same day, a day's claim payment may be made to each institution, even though only one day is counted against the patient's benefit period.

When admission and discharge (or death) take place on the same day, this will count as one day for both payment and benefit period purposes.

This program does not provide hospital outpatient benefits except in very limited situations. (See Section 270.2.)

Additionally, benefit payments under this program can be made for both obstetrical procedures and nursery charges for newborn infants. If the newborn infant is kept in the hospital after discharge of the mother, a new identification number for the infant—who becomes a new beneficiary—will be established by the participating migrant health project. Benefit days for the infant will be counted from the date of the mother's discharge and all claims will be handled as if the newborn patient had been admitted under regular procedures. However, if the newborn infant is moved to a non-participating hospital, benefit days will be counted from the day of transfer, even though the mother may still be hospitalized in the participating hospital.

When a newborn requires intensive or specialized care which cannot be provided in the nursery, the participating hospital may bill separately for the newborn. The infant should be assigned a separate identification number by the local migrant health project. The hospital *must* include the mother's name, identification number and date of admission on the bill (UB 16) submitted for the infant. (See Section 360)

Coverage for the infant requiring special care begins on the day the infant is transferred from regular nursery care to special nursery care. If special care is required from birth, the date of birth is the first covered day for the infant.

The care provided to migrant beneficiaries must be in a semi-private room—2-, 3-, 4-bed rooms—or in a private room if medically necessary. Where the provider's bed complement consists of only ward accommodations, such facilities will be acceptable.

110.3 Covered Services

In addition to semi-private room accommodations covered services include:

a. Coronary and intensive care
b. General nursing services (excluding private duty nurses)
c. Anesthetist services when provided by a hospital employee or by certain individuals who have payment arrangements with the hospital
d. Medical social services
e. Drugs and biologicals favorably evaluated and included in or approved for inclusion in the *U.S. Pharmacopeia, National Formulary*, or *U.S. Homeopathic Pharmacepeia* or approved by the appropriate hospital committee for use in the hospital.
f. Supplies, appliances, and equipment for use in the hospital. (Prosthetic devices and disposable supplies which the patient needs to leave the hospital are also covered i.e., pacemaker, colostomy bag, etc.)
g. Laboratory and radiology services
h. Rehabilitation services (i.e., physical therapy, occupational therapy, and speech therapy—but only where such services are ancillary to acute hospital care)
i. All other diagnostic and therapeutic services normally furnished to inpatients of the admitting hospital
j. Delivery rooms and nursery for newborns
k. Ambulance service but only when ambulance service is required to transfer a patient from a participating hospital to another hospital for admission or to return the patient to a participating hospital.

110.4 Utilization Review

Program patients must be reviewed in the same manner as Title XVIII (Medicare) patients as provided for in regulations pursuant to Section 1861(k) Utilization Review, of the Social Security Act. Where a Professional Standards Review Organization (PSRO) has been established and has assumed review in the facility, as provided for in regulations pursuant to Title XI of the Social Security Act, review should be performed in the manner established by the PSRO for Medicare patients.

110.5 Professional Services

In addition to institutional services of the admitting hospital, the program will also provide benefits for professional services while the beneficiary is an inpatient. The professional services are primarily expected to be physician services, performed by a doctor of:

a. medicine or osteopathy (including osteopathic practitioner) legally authorized to practice by the State in which he performs this function;
b. podiatry (chiropody) with respect to those functions which he is legally authorized to perform in the State in which he performs them;
c. dental surgery or dental medicine with the State authorization to practice, but only for surgery related to the jaw or any structure contiguous to the jaw or any facial bones.

NOTE: Only a doctor of medicine (including osteopathy in States where so authorized) may normally act as attending physician of record for purposes of admission, certification, and recertification. (When permitted by State law, a doctor of dental medicine may also admit, certify, and recertify when the admission is for services outlined in 110.3.)

110.6 Transfers to Non-participating Hospitals

Benefit payments can be made only when a migrant patient has had eligibility established by a *participating* migrant health project and has been admitted to a *participating* hospital (see exception to the admission requirement in Section 270). The program, however, does recognize that some participating hospitals may not be able to provide the range of services necessary for the medically appropriate treatment of a migrant patient. Should such a situation arise, it will then be necessary to transfer the patient to a non-participating hospital.

In the event the attending physician of record has staff privileges at the second hospital, it is possible that he will continue as the attending physician in the second hospital. When a physician on the staff of the migrant project or the attending physician of record at the participating hospital is unable to perform as attending physician, then the non-participating hospital will be expected to designate an attending physician from its staff or house register.

In addition to providing the project with a notification of transfer, the participating hospital will forward such medical records as are required by the non-participating hospital.

The hospital accepting the transfer patient will use THE SAME PATIENT IDENTIFICATION NUMBER ESTABLISHED BY THE MIGRANT PROJECT AND USED BY THE PARTICIPATING HOSPITAL IN ALL ITS DOCUMENTATION AND RECORDS.

At the time of the transfer, the project will notify the non-participating hospital as to the number of days available in the patient's benefit period.

Upon the patient's discharge, death, or exhaustion of benefit period days, the non-participating hospital will forward a completed claim package to the participating hospital for review and transmittal to the Office of Direct Reimbursement. *The non-participating hospital will be identified by a change in the participating hospital's identification code suffix from "W" to "T"* (see Section 230).

NOTE: This claim package *must* include completed claim forms for *both* hospital and professional services. Claims for professional services—which must itemize and describe all procedures (see Section 370)—will *not* be paid unless submitted by the participating hospital in combination with a claim for inpatient hospital services. In this program THE PARTICIPATING HOSPITAL IS THE CONTROL POINT FOR ALL TRANSFER CLAIM SUBMITTALS, HOSPITAL AND PROFESSIONAL.

110.7 Limitations

a. Psychiatric Care: Benefit payments may be made only for active psychiatric care. To be considered active psychiatric care, the services must be:

1. provided under an individual plan of treatment or diagnostic plan,
2. reasonably expected to improve the patient's condition, or for the purposes of diagnosis, and
3. supervised and evaluated by a physician.

Benefit payments will be made only to those hospitals which have qualified staff and facilities to provide active psychiatric care except where interim treatment for control of aberrant behavior is indicated, pending transfer to an appropriate institution.

b. Rehabilitation Services: Admissions for the sole purpose of receiving rehabilitation (physical, occupational, and speech therapy) are not covered. A hospital stay cannot be continued for the sole purpose of receiving rehabilitation services. To be covered, rehabilitation services must be:

1. related to the diagnosis for which medical or surgical treatment is being rendered,

2. rendered under a physician's plan of treatment and determined by the physician to be reasonable and medically necessary, or
3. restorative or for purposes of teaching a maintenance program.

c. Sterilizations and Hysterectomies: DHHS has amended Public Health Service Regulations (42 CFR Part 50) with regard to Federal Financial Participation (FFP) in expenditures for sterilizations and hysterectomies, effective February 6, 1979, as follows:

Title 42—Public Health

CHAPTER I—PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

SUBCHAPTER D—GRANTS

PART 50—POLICIES OF GENERAL APPLICABILITY

Provision of Sterilization in Federally Assisted Programs of the Public Health Service

AGENCY: Public Health Service.

ACTION: Final rules.

SUMMARY: The Department is promulgating new rules to govern expenditures for sterilizations provided under various Department programs. Three parallel sets of regulations are being issued. This set applies to programs of Federal financial assistance administered by the Public Health Service; the other two sets, which appear in this issue of the FEDERAL REGISTER, apply to the progams administered under title XIX of the Social Security Act and the social services programs administered by the Administration for Public Services of the Office of Human Development Services. The rules are being revised at this time because the recent decision in *Relf* v. *Weinberger,* C.A. No. 74-1797 (D.C. Cir. 1977) resolved questions as to the scope to the Department's authority to regulate in this area. Based on its experience under the rules which currently apply to sterilizations under the Federal programs and the public comment received during rulemaking, the rules below establish new rules applicable to sterilizations.

EFFECTIVE DATE: These rules are effective February 6, 1979.

Subpart B of 42 CFR Part 50 is revised to read as follows:

Subpart B—Sterilization of Persons in Federally Assisted Family Planning Projects

Sec.

AUTHORITY: Sec. 215, Public Health Service Act, as amended (42 U.S.C. 216).

Subpart B—Sterilization of Persons in Federally Assisted Family Planning Projects

§ 50.201 Applicability.

The provisions of this subpart are applicable to programs or projects for health services which are supported in whole or in part by Federal financial assistance, whether by grant or contract, administered by the Public Health Service.

§ 50.202 Definitions.

As used in this subpart:

"Arrange for" means to make arrangements (other than mere referral of an individual to, or the mere making of an appointment for him or her with, another health care provider) for the performance of a medical procedure on an individual by a health care provider other than the program or project.

"Hysterectomy" means a medical procedure or operation for the purpose of removing the uterus.

"Institutionalized individual" means an individual who is (1) involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or (2) confined, under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness.

"Mentally incompetent individual" means an individual who has been declared mentally incompetent by a Federal, State, or local court of competent jurisdiction for any purpose unless he or she has been declared competent for purposes which include the ability to consent to sterilization.

"Public Health Service" means the Health Services Administration, Health Resources Administration, National Institutes of Health, Center for Disease Control, Alcohol, Drug Abuse and Mental Health Administration and all of their constituent agencies.

The "Secretary" means the Secretary of Health, Education, and Welfare and any other officer or employee of the Department of Health, Education, and Welfare to whom the authority involved has been delegated.

"Sterilization" means any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing.

§ 50.203 Sterilization of a mentally competent individual aged 21 or older.

Programs or projects to which this subpart applies shall perform or arrange for the performance of sterilization of an individual only if the following requirements have been met:

(a) The individual is at least 21 years old at the time consent is obtained.

(b) The individual is not a mentally incompetent individual.

(c) The individual has voluntarily given his or her informed consent in accordance with the procedures of § 50.204 of this subpart.

(d) At least 30 days but not more than 180 days have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of premature delivery or emergency abdominal surgery, if at least 72 hours have passed after he or she gave informed consent to sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

§ 50.204 Informed consent requirement.

Informed consent does not exist unless a consent form is completed voluntarily and in accordance with all the requirements of this section and § 50.205 of this subpart.

(a) A person who obtains informed consent for a sterilization procedure must offer to answer any questions the individual to be sterilized may have concerning the procedure, provide a copy of the consent form, and provide orally all of the following information or advice to the individual

who is to be sterilized:

(1) Advice that the individual is free to withhold or withdraw consent to the procedure any time before the sterilization without affecting his or her right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled:

(2) A description of available alternative methods of family planning and birth control;

(3) Advice that the sterilization procedure is considered to be irreversible;

(4) A thorough explanation of the specific sterilization procedure to be performed;

(5) A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used;

(6) A full description of the benefits or advantages that may be expected as a result of the sterilization; and

(7) Advice that the sterilization will not be performed for at least 30 days except under the circumstances specified in § 50.203(d) of this subpart.

(b) An interpreter must be provided to assist the individual to be sterilized if he or she does not understand the language used on the consent form or the language used by the person obtaining the consent.

(c) Suitable arrangements must be made to insure that the information specified in paragraph (a) of this section is effectively communicated to any individual to be sterilized who is blind, deaf or otherwise handicapped.

(d) A witness chosen by the individual to be sterilized may be present when consent is obtained.

(e) Informed consent may not be obtained while the individual to be sterilized is:

(1) In labor or childbirth;

(2) Seeking to obtain or obtaining an abortion; or

(3) Under the influence of alcohol or other substances that affect the individual's state of awareness.

(f) Any requirement of State and local law for obtaining consent, except one of spousal consent, must be followed.

§ 50.205 Consent form requirements.

(a) *Required consent form.* The consent form appended to this subpart or another consent form approved by the Secretary must be used.

(b) *Required signatures.* The consent form must be signed and dated by:

(1) The individual to be sterilized; and

(2) The interpreter, if one is provided; and

(3) The person who obtains the consent; and

(4) The physician who will perform the sterilization procedure.

(c) *Required certifications.* (1) The person obtaining the consent must certify by signing the consent form that: (i) before the individual to be sterilized signed the consent form, he or she advised the individual to be sterilized that no Federal benefits may be withdrawn because of the decision not to be sterilized, (ii) he or she explained orally the requirements for informed consent as set forth on the consent form, and (iii) to the best of his or her knowledge and belief, the individual to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized.

(2) The physician performing the sterilization must certify by signing the consent form, that: (i) shortly before the performance of the sterilization, he or she advised the individual to be sterilized that no Federal benefits may be withdrawn because of the decision not to be sterilized, (ii) he or she explained orally the requirements for informed consent as set forth on the consent form, and (iii) to the best of his or her knowledge and belief, the individual to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized. Except in the case of premature delivery or emergency abdominal surgery, the physician must further certify that at least 30 days have passed between the date of the individual's signature on the consent form and the date upon which the sterilization was performed. If premature delivery occurs or emergency abdominal surgery is required within the 30-day period, the physician must certify that the sterilization was performed less than 30 days but not less than 72 hours after the date of the individual's signature on the consent form because of premature delivery or emergency abdominal surgery, as applicable. In the case of premature delivery, the physician must also state the expected date of delivery. In the case of emergency abdominal surgery, the physician must describe the emergency.

(3) If an interpreter is provided, the interpreter must certify that he or she translated the information and advice presented orally, read the consent form and explained its contents and to the best of the interpreter's knowledge and belief, the individual to be sterilized understood what the interpreter told him or her.

§ 50.206 Sterilization of a mentally incompetent individual or of an institutionalized individual.

Programs or projects to which this subpart applies shall not perform or arrange for the performance of a sterilization of any mentally incompetent individual or institutionalized individual.

§ 50.207 Sterilization by hysterectomy.

(a) Programs or projects to which this subpart applies shall not perform or arrange for the performance of any hysterectomy solely for the purpose of rendering an individual permanently incapable of reproducing or where, if there is more than one purpose to the procedure, the hysterectomy would not be performed but for the purpose of rendering the individual permanently incapable of reproducing.

(b) Programs or projects to which this subpart applies may perform or arrange for the performance of a hysterectomy not covered by paragraph (a) of this section only if:

(1) The person who secures the authorization to perform the hysterectomy has informed the individual and her representative, if any, orally and in writing, that the hysterectomy will render her permanently incapable of reproducing; and

(2) The individual or her representative, if any, has signed a written acknowledgment of receipt of that information.

§ 50.208 Program or project requirements.

(a) A program or project must, with respect to any sterilization procedure or hysterectomy it performs or arranges, meet all requirements of this subpart.

(b) The program or project shall maintain sufficient records and documentation to assure compliance with these regulations, and must retain such data for at least 3 years.

(c) The program or project shall submit other reports as required and when requested by the Secretary.

§ 50.209 Use of Federal financial assistance.

(a) Federal financial assistance adminstered by the Public Health Service may not be used for expenditures for sterilization procedures unless the consent form appended to this section or another form approved by the Secretary is used.

(b) A program or project shall not use Federal financial assistance for any sterilization or hysterectomy without first receiving documentation showing that the requirements of this subpart have been met. Documentation includes consent forms, and acknowledgments of receipt of hysterectomy information.

§ 50.210 Review of regulation.

The Secretary will request public comment on the operation of the pro-

visions of this subpart not later than 3 years after their effective date.

APPENDIX: REQUIRED CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from ———— (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a ————. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on — (day), ———— (month), —— (year).

I, ————, hereby consent of my own free will to be sterilized by ———— by a method called ————. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health, Education, and Welfare or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

Signature ————————————
Date:————————————
(Month, day, year)

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)
Black (not of Hispanic origin) ————
Hispanic ————
Asian or Pacific Islander ————
American Indian or Alaskan native ————
White (not of Hispanic origin) ————

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in ———— language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Interpreter ————————————
Date ————————————

STATE OF PERSON OBTAINING CONSENT

Before ———— (name of individual), signed the consent form, I explained to him/her the nature of the sterilization operation ————, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

Signature of person obtaining consent ——
Date ————————————
Facility ————————————
Address ————————————

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon ———— (name of individual to be sterilized), on ———— (date of sterilization), ———— (operation), I explained to him/her the nature of the sterilization operation ———— (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(*Instructions for use of alternative final paragraphs:* Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

☐ Premature delivery
Individual's expected date of delivery: ——
☐ Emergency abdominal surgery:
(Describe circumstances): ————————

Physician ————————————
Date ————————————

YOUR STERILIZATION OPERATION: INFORMATION FOR WOMEN

WHY THIS PAMPHLET IS IMPORTANT TO YOU

Sterilization is an operation which is intended to make it impossible for you to ever become pregnant. This pamphlet describes the different types of sterilization operations, their benefits, their discomforts, and their risks. You should read the pamphlet completely.

Both men and women can be sterilized. This pamphlet is about sterilization operations for a woman. (Ask your doctor or clinic for the pamphlet on sterilization for a man.)

If the Federal Government is to pay for your sterilization, certain conditions must be met. They are listed on page . The purpose of these conditions is to ensure that you understand sterilization and that you choose freely to have this operation.

MAKING UP YOUR MIND

Sterilization must be considered permanent. For nearly all women, once this operation has been done, it can never be undone. Some doctors try to undo a sterilization by rejoining the tubes. This is a difficult and expensive operation and it doesn't work very often. Some people call sterilization "tying the tubes." But don't think the tubes can be untied! They can't. So it's not a good idea to think your sterilization can be undone.

Make sure you do not want to bear children under any circumstances before you decide to be sterilized. Are you sure you would not want to bear children even if one of your present children died? Or your husband died? Or you got divorced and remarried? Be sure, before you decide to be sterilized.

No one can force you to be sterilized! Don't let anyone push you into it. If you do not want to be sterilized, no one can take away any of your Federal benefits such as welfare, Social Security, or health care—including sterilization at a later date. No one can force you to be sterilized as a condition for delivering your baby or performing an abortion.

To have this operation paid for with Federal funds, you must be at least 21 years old. If you are married, you should discuss the operation with your husband. However, his consent is not required if Medicaid or any other Federal Government program is going to pay for your operation. Your consent to sterilization cannot be obtained while you are in the hospital for childbirth or abor-

tion, or if you are under the influence of alcohol or other substances that affect your state of awareness.[1]

You must sign the consent form at least 30 days before you plan to have the operation. This is so you will have at least 30 days to think it over and discuss it with your family and others. You can change your mind any time before the operation and can cancel your appointment if you do.

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[1]This condition, the minimum age of 21, and the 30-day waiting period must be met if the Federal Government is to pay for your sterilization.

OTHER METHODS OF BIRTH CONTROL

There are many other ways to avoid pregnancy. Before you decide to be sterilized, think about these other methods of birth control.

TEMPORARY METHODS OF BIRTH CONTROL

The following methods of birth control are temporary. This means that when you or your partner stop using them you can become pregnant. Temporary methods of birth control are effective only if you use them according to instructions. If you think you might want to become pregnant later, you should use a temporary method of birth control instead of sterilization.

Ask your doctor or clinic for pamphlets and counseling on any of these temporary methods of birth control if you want them. If you decide you want a temporary method of birth control, ask for it today.

Birth control pill—A pill you take regularly which makes you 98 percent certain you will not get pregnant. It is usually safe, but has occasional side effects and rare serious complications. The pill has been linked in some women with minor side effects such as darkening of the skin of the face, nausea, and vaginal discharge. More serious complications which occur infrequently include depression, increased tendency for abnormal blood clotting, increased risk of heart attack and stroke (especially among women over age 35 who smoke), and a small increased risk of liver or gall bladder disease.

Loop, coil, intrauterine device (IUD)—A small piece of plastic a doctor or family planning specialist inserts into your uterus (womb) which makes you 96 percent certain you will not get pregnant. It is usually very safe, but has occasional side effects and rare serious complications. IUD use has been linked in some women with irregular periods, cramps, and increased risk of infection of the uterus.

Diaphragm with contraceptive jelly or cream—A cup of rubber or soft plastic you place in your vagina each time before intercourse. Contraceptive jelly or cream must be used with the diaphragm for it to be effective. Sometimes it fails if it is not used properly (85–90 percent effective) and you can get pregnant anyway, but it has no risk of serious complications.

Contraceptive foam, foaming tablet—A foam (which looks like shaving cream) or a tablet you place in your vagina each time before intercourse. Sometimes it fails (85 percent effective) and you can get pregnant anyway. It occasionally has minor side effects.

Condom, prophylactic—A thin sheath of rubber the man places over his penis each time before intercourse. Sometimes it fails (90 percent effective) and you can get pregnant anyway, but there is no risk of serious complications. A condom and contraceptive foam or diaphragm can be used at the same time for extra protection.

Natural methods—A type of birth control in which you do not have intercourse on the 8–15 days each month when you are likely to get pregnant. It is sometimes hard to tell when these days occur and effectiveness depends on proper instruction and motivation. The sympto-thermal method (90 percent effective) is an example of natural methods. It involves keeping a chart of your body temperature and checking your cervical mucus. Effectiveness depends upon the care with which you follow it. Some people think of natural methods as only rhythm (the calendar method), but this method is no longer recommended by experts in natural methods. There is no risk of complications with natural methods.

STERILIZATION FOR A MAN

A man can be sterilized by an operation called a vasectomy. This operation is intended to make it impossible for him to ever father children. It is simpler, quicker, and safer than the sterilization operation for a woman, so you and your partner may decide that it is better for him to have the sterilization operation. (Ask your doctor or clinic for the pamphlet on sterilization for a man.)

WHAT ABOUT ABORTION?

Abortion does not prevent pregnancy. It is an operation to stop a pregnancy which has already started. It should be done during the first 3 months of pregnancy. It can be done later, but it is more expensive, less safe, and usually requires that you stay in a hospital. Abortion works to stop a pregnancy almost 100 percent of the time. There are some discomforts and occasional complications (sometimes serious) with abortion. When this pamphlet was written, Medicaid and some other Federal Government programs would pay for abortions only in certain cases. Ask your doctor or clinic.

WHEN CAN A WOMAN HAVE A STERILIZATION OPERATION?

A sterilization operation can be done at different times. A talk with your doctor or clinic can help you to decide what might be most suitable for you.

A woman can have a sterilization operation at any time in her life. This means a woman can have a sterilization operation at any time she wants. It doesn't matter if she is not married or doesn't have children. It is up to her.

A woman can have a sterilization operation right after having a baby. This means that a woman may want to be sterilized while she is in the hospital for the delivery. A woman should think about this early in her pregnancy because in order for the sterilization to be paid for with Federal funds she must sign the consent form at least 30 days before the baby is due. If the woman delivers prematurely or has emergency abdominal surgery at least 72 hours after she has signed the consent form, she does not need to wait 30 days, and the sterilization may be performed at the same time as the other surgery. She should be sure that she would not want to have children again even if the baby did not live very long after birth.

A woman can have a sterilization operation at the same time she has a baby by cesarean section. Sometimes a baby has to be delivered by an operation through the abdomen. This is called a cesarean section. A sterilization operation can be done at the same time through the same incision, but the woman must make up her mind at least 30 days before the baby is due.

A woman can have a sterilization operation right after she has an abortion if she has signed the consent form at least 30 days previously. Remember that an abortion which is delayed may be more difficult and carry more risk. If a woman is not sure about the sterilization, she can still have an abortion, and then decide to be sterilized or not at a later time.

FACTS ABOUT THE OPERATION

The surgical method of birth control is called a tubal sterilization or tubal ligation.

In this operation the doctor blocks or separates each of your two tubes so that your eggs cannot travel through them from your ovaries to your uterus. Blocking the tubes makes pregnancy impossible. (See figures at left.) Menstruation (monthly bleeding period) continues as before. Tubal sterilization will not change your hormones (will not cause change of life).

IS THE OPERATION GUARANTEED TO WORK?

Tubal sterilization works almost all the time. This means that only from 2 to 5 out of every 1,000 women who have the operation will still get pregnant. This is usually because the two ends of the tubes have grown back together. It is more than 99 percent effective—higher than all other methods of birth control for women. You should use some temporary method of birth control until you have your operation. Your doctor will try to be certain you are not already pregnant at the time of the operation.

FOUR TYPES OF TUBAL STERILIZATION

1. Laparotomy, mini-laparotomy;
2. Laparoscopy;
3. Postpartum tubal ligation; and
4. Vaginal tubal ligation.

The operation you have depends on your health and your doctor. Talk to him or her about which operation you will have.

LAPAROTOMY, MINI-LAPAROTOMY

In both of these operations, the doctor makes an incision (cut) in the lower portion of your abdomen. The difference between the two is the length of the incision and the extensiveness of the surgery. In a mini-laparotomy the incision is very short (1 or 2 inches) and leaves only a small scar. In a laparotomy it is much longer (3 to 5 inches) and leaves a longer scar. Ask your doctor which method he or she uses.

Through the incision on the abdomen, the doctor can reach both tubes, one at a time. The doctor can either remove a section and then use surgical thread to tie the tubes shut or seal them with electric current, bands, or clips. After the tubes are sealed, the incision on your abdomen is stitched closed.

The operation, including the anesthesia, takes about 30 minutes. With a mini-laparotomy, you will probably stay in the hospital less than 24 hours, and be back to normal in 2 or 3 days. With a laparotomy, you will be in the hospital 4 days or more, and it may

be 2 weeks before you feel back to normal.

LAPAROSCOPY

Using a special needle, the doctor inflates your abdomen with a harmless gas which pushes your intestines away from your uterus and tubes. (See figure at left.)

The doctor then makes a small incision about one-half inch long near your navel. A "laparoscope," or special telescope, is inserted through this incision. It is a thin metal tube with a light on it which allows the doctor to see your tubes, and through which the doctor can insert the operating instrument. Your tubes are sealed by the use of electric current, bands, or clips. Some doctors make a second small incision at the pubic hairline to insert the operating instrument.

After the gas in your abdomen is released, the incision is closed.

The operation, including the anesthesia, takes about 30 minutes. You will probably stay in the hospital less than 24 hours and be back to normal in 2 or 3 days. Because of the gas, you may feel a pain in your neck or shoulders and you may seem bloated after the surgery. This goes away after a day or two.

POSTPARTUM TUBAL LIGATION

This operation is done in the hospital shortly after a woman has a baby. The doctor makes a small incision below your navel. The doctor then closes off a section of each tube using surgical threads. After the tubes are tied, a small section between the ties is removed. The incision below your navel is stitched closed.

The operation, including the anesthesia, usually takes about 30 minutes. Having the operation may make your hospital stay a day or two longer. How fast you get better will depend on how you feel after having the baby.

VAGINAL TUBAL LIGATION

In this operation, the doctor makes a small incision far back in the vagina. Through this, the doctor finds your tubes, then closes them off either with electric current, bands, or clips, or by removing a small section and closing the ends with surgical threads. After the tubes are sealed, the incision in your vagina is stitched closed.

Sometimes the doctor will use a metal tube with a light (called a culdoscope) to see your tubes and seal them.

The operation, including the anesthesia, usually takes about 30 minutes. Your stay in the hospital will probably be less than 24 hours. You should be back to normal in 2 or 3 days. After this type of operation, you should not have intercourse for 3 to 4 weeks so the vagina can heal.

THE ANESTHETIC

With any method of sterilization, you will first be given an anesthetic which is a drug to keep you from feeling pain during the operation. A medical person who specializes in anesthesia may do this part of the operation.

Sometimes the operation is done under "general" anesthesia. That means you will be asleep during the operation. The drugs used are a gas which you inhale and/or a liquid given to you by injection.

Sometimes the operation is done under "local" anesthesia or "spinal" anesthesia. That means you are awake, but do not feel any pain.

A local anesthetic is given by injection into the skin. It makes your skin numb.

A spinal anesthetic is given by injection low in the spine. This type of injection makes you feel numb from the waist down.

With local or spinal anesthesia, you may also be given pills or another injection to help you relax.

You should have a chance to discuss and participate in the decision regarding your type of anesthesia with someone before your operation.

BENEFITS OF TUBAL STERILIZATION

The benefits of tubal sterilization are:

You never have to use a temporary method of birth control again (such as the pill or the IUD).

You don't have to worry about getting pregnant.

DISCOMFORTS AND RISKS

No matter which type of operation you have, you can expect to feel pain and soreness in your abdomen for a few days. You can take medicine to help relieve the discomfort.

If you had general anesthesia, you may have a sore throat for a day or two from the tube used to keep your airway open while you were asleep. This goes away quickly and is not serious. Spinal anesthesia may give some persons a temporary headache.

Sterilization operations have some risks, including a very small risk of death. This is true of any type of operation. serious problems happen rarely. Most of the time serious problems can be treated and cured by the doctor without further surgery; however, an operation may be necessary to correct some of these problems.

Some of the medical problems you could have during or after a sterilization operation:

1. You may bleed from the incision on your skin or in your vagina.

2. You may bleed inside your abdomen. (Another operation may be necessary to stop the bleeding.)

3. You may get an infection on or near the stitches or inside your abdomen.

4. The operation may not make you sterile. The operation cannot be guaranteed 100 percent to make you sterile. From 2 to 5 out of 1,000 women get pregnant after the operation.

5. As in other operations, the anesthetic drugs used to put you to sleep or to make the operation painless may cause problems. You may vomit while under anesthesia, and pneumonia may result.

Go back to your doctor at once if you get fever and/or severe pain in your abdomen. Either of these could be signs that you have an infection.

WHAT ABOUT HYSTERECTOMY?

Hysterectomy is different from tubal sterilization. Instead of blocking off the tubes, the whole uterus is taken out. A hysterectomy should be done only when there is a disease of the woman's uterus or some other problem that can only be treated by removing the uterus.

A hysterectomy is a much more serious operation than a tubal sterilization. A hysterectomy takes much longer to do, and the woman is in the hospital longer than with a tubal sterilization. There are more discomforts, and there is a greater chance of serious health problems. For these reasons, neither medicaid nor any other Federal program will pay for a hysterectomy if the only reason you are having it is to avoid bearing children, and you have no disease of your uterus.

SUMMARY

If you are sure you do not want to bear children and you want to become permanently sterile, then tubal sterilization is a safe, effective operation. It requires a relatively brief stay in the hospital, and problems are rare.

IF YOU HAVE QUESTIONS

If there is anything that is not clear to you, or anything you are worried about, it is important that you bring up these questions. All of your questions should be answered to your satisfaction before the operation.

REMEMBER

You may change your mind at any time before the operation. Make sure you do not wish to bear children under any circumstances before you decide to be sterilized.

RULES FOR STERILIZATION OPERATIONS FUNDED BY THE FEDERAL GOVERNMENT

You must be at least 21 years old.

You must wait at least 30 days to have the operation after you sign the consent form except in instances of premature delivery or emergency abdominal surgery that take place at least 72 hours after consent is obtained.

Your consent to sterilization cannot be obtained while you are in the hospital for childbirth or abortion, or under the influence of alcohol or other substances that affect your state of awareness.

You may, if you choose, bring someone with you when you sign the consent form.

Your consent is effective for 180 days from the date you sign the consent form.

Be sure to take this pamphlet and your signed consent form with you.

YOUR STERILIZATION OPERATION: INFORMATION FOR MEN

WHY THIS PAMPHLET IS IMPORTANT TO YOU

Sterilization is an operation which is intended to make it impossibe for you to ever father children. This pamphlet describes the sterilization operation for a man—called vasectomy—its benefits, its discomforts, and its risks. You should read the pamphlet completely.

Both men and women can be sterilized. (Ask your doctor or clinic for the pamphlet on sterilization for a woman.) The man's operation is easier, safer, and less expensive than the woman's operation.

If the Federal Government is to pay for your sterilization, certain conditions must be met. They are listed on page ——. The purpose of these conditions is to ensure that you understand sterilization and that you choose freely to have this operation.

MAKING UP YOUR MIND

Sterilization must be considered permanent. For nearly all men, once this operation has been done, it can never be undone. Some doctors try to undo a vasectomy by re-

joining the tubes. This is a difficult and expensive operation and it doesn't work very often. So it's not a good idea to think your vasectomy can be undone.

Some men have heard about storing their sperm in sperm banks to use later. There is not enough known right now about keeping sperm to show that it works.

Make sure you do not want to father children under any circumstances before you decide to be sterilized. Are you sure you would not want to father children even if one of your present children died? Or your wife died? Or you got divorced and remarried? Be sure, before you decide to be sterilized.

No one can force you to be sterilized! Don't let anyone push you into it. If you do not want to be sterilized, no one can take away any of your Federal benefits such as welfare, Social Security, or health care—including sterilization at a later date.

To have this operation paid for with Federal funds, you must be at least 21 years old. If you are married, you should discuss the operation with your wife. However, her consent is not required if Medicaid or any other Federal program is going to pay for your operation.

You must sign the consent form at least 30 days before you have the operation.[1] This is so you will have at least 30 days to think it over and discuss it with your family and others. You can change your mind any time before the operation and can cancel your appointment if you do.

OTHER METHODS OF BIRTH CONTROL

There are other ways to avoid fathering children. Before you decide to be sterilized, think about these other methods of birth control.

TEMPORARY METHODS OF BIRTH CONTROL

The following methods of birth control are temporary. This means that when you or your partner stop using them you can father children. Temporary methods of birth control are effective only if you use them according to instructions. If you think you might want to father children later, you should use a temporary method of birth control instead of sterilization.

Ask your doctor or clinic for pamphlets and counseling on any of these temporary methods of birth control if you want them. If you decide you want a temporary method of birth control, ask for it today.

Condom, prophylactic—A thin sheath of rubber the man places over his penis each time before intercourse. Sometimes it fails (90 percent effective) and the woman can get pregnant anyway, but there is no risk of serious complications. A condom and contraceptive foam or diaphragm can be used at the same time for extra protection.

Birth control pill—A pill the woman takes regularly which makes her 98 percent certain she will not get pregnant. It is usually safe, but has occasional side effects and rare serious complications. The pill has been linked in some women with minor side effects such as darkening of the skin of the face, nausea, and vaginal discharge. More serious complications which occur infrequently include depression, increased tendency for abnormal blood clotting, increased risk of heart attack and stroke (especially among women over age 35 who smoke), and a small increased risk of liver of gall bladder disease.

Loop, coil, intrauterine devise (IUD)—A small piece of plastic a doctor or family planning specialist inserts into the woman's uterus (womb) which makes her 96 percent certain she will not get pregnant. It is usually very safe, but has occasional side effects and rare serious complications. IUD use has been linked in some women with irregular periods, cramps, and increased risk of infection of the uterus.

Diaphragm with contraceptive jelly or cream—A cup of rubber or soft plastic the woman places in her vagina each time before intercourse. Contraceptive jelly or cream must be used with the diaphragm for it to be effective. Sometimes it fails if it is not used properly (85-90 percent effective) and she can get pregnant anyway, but it has no risk of serious complications.

Contraceptive foam, foaming tablet—A foam (which looks like shaving cream) or a tablet the woman places in her vagina each time before intercourse. Sometimes it fails (85 percent effective) and she can get pregnant anyway. It occasionally has minor side effects.

Natural methods—A type of birth control in which the woman does not have intercourse on the 8-15 days each month when she is likely to get pregnant. It is sometimes hard to tell when these days occur, and effectiveness depends on proper instruction and motivation. Effectiveness can be as high as 90 percent for the sympto-thermal method if used properly. There is no risk of complications with natural methods.

STERILIZATION FOR A WOMAN

A woman can be sterilized by an operation called a tubal ligation. This operation is intended to make it impossible for her to ever bear children. Tubal ligation is more complex and not as safe as the sterilization operation for a man. (Ask your doctor or clinic for the pamphlet on sterilization for a woman.)

WHEN CAN A MAN HAVE A STERILIZATION OPERATION?

A man can have a sterilization operation at any time in his life. This means a man can have a sterilization operation at any time he wants. It doesn't matter if he is not married or doesn't have children. It is up to him.

FACTS ABOUT THE OPERATION

The surgical method of birth control is called a vasectomy. It is done in a doctor's office or clinic. Under local anesthesia, the doctor closes off the sperm duct (tubes) so that sperm cannot get through these ducts into the semen (the fluid ejected at climax). (See diagram at left.) When there are no sperm in the semen, you cannot cause a pregnancy. Only the sperm are blocked, not the liquid part of the semen. You will still ejaculate (eject fluid) as before. Vasectomy will not change your hormones. (NOTE: Vasectomy is not castration. The testicles are not removed.)

HOW A VASECTOMY IS DONE

First, a local anesthetic is given by injection into your skin on each side of the scrotum (sac) to make it temporarily numb. You will feel mild pain, like a pin prick, for a few seconds.

Once the area is numb, the doctor makes one or two very small (one-half inch) incisions (cuts). Through these, the doctor reaches the sperm ducts, cuts them, and closes them off. The incisions on the skin are then closed with stitches. The scars can hardly be seen after a couple of weeks.

The operation, including anesthesia, usually takes about 15-20 minutes. You can usually go home shortly after the operation.

IS THE OPERATION GUARANTEED TO WORK?

Vasectomy works almost all the time. This means that only about 1 out of 1,000 men who have the operation will still be able to get a woman pregnant. This is usually because the two ends of the ducts have grown back together. It is more than 99 percent effective—higher than all other methods of birth control for men. You should use some temporary method of birth control until you have your operation.

You are not immediately sterile after your vasectomy. There will still be some sperm in your ducts until you have ejaculated 10 or more times after your operation. During this time, you can still cause a pregnancy. So it is important that you and your partner use another good method of birth control until tests of your semen show it contains no more sperm. Your doctor will tell you when to return for a simple test of your semen under a microscope.

BENEFITS OF VASECTOMY

The benefits of vasectomy are:

You never have to use a temporary method of birth control again (such a rubber).

You never have to worry about making a woman pregnant.

DISCOMFORTS AND RISKS

Vasectomy is considered a safe and simple operation, but there is a small chance you will have some medical problems afterwards. You can expect some soreness after the operation. This is not serious and will go away after a few days.

Serious medical problems happen rarely. Most of the time they can be treated and cured by the doctor without further surgery; however, an operation may be necessary to correct some of them. Some of the medical problems you could have after a sterilization operation:

1. You may have swelling around the incision on your skin. This happens right after the operation and is only temporary.

2. You may have bleeding under the skin which causes a bruise. This usually clears up by itself. Ice bags are often recommended to reduce the chance of this bleeding.

3. You may get an infection either on the skin or inside the scrotum. It is important to follow the doctor's recommendations about the care and cleansing of the incision while it is healing.

4. The operation may not make your sterile. The operation cannot be guaranteed 100 percent to make you sterile. About 1 out of 1,000 men who have the operation will still be able to get a woman pregnant.

Go back to your doctor at once if swelling lasts for more than a few days, or you have a fever, or you have severe pain.

A very few men (4 out of 1,000 who have had the operation) said they had sexual problems after the operation. These were

[1] This condition must be met if the Federal Government is to pay for your sterilization.

either decreased sexual desire or inability to have an erection. There is no medical explanation for these rare symptoms, and they are believed to result from an emotional reaction to the operation.

Some doctors have reported long term medical problems, but so far research has not proven that such problems really exist.

SUMMARY

If you are sure you do not want to father children and you want to become permanently sterile, then vasectomy is a safe, effective operation. It requires only a short time in a doctor's office or clinic, and problems are rare.

IF YOU HAVE QUESTIONS

If there is anything that is not clear to you, or anything you are worried about, it is important that you bring up these questions. All of your questions should be answered to your satisfaction before the operation.

REMEMBER

You may change your mind any time before the operation. Make sure you do not wish to father children under any circumstances before you decide to be sterilized.

RULES FOR STERILIZATION OPERATIONS FUNDED BY THE FEDERAL GOVERNMENT

You must be at least 21 years old.

You must wait at least 30 days to have the operation after you sign the consent form.

You may, if you choose, bring someone with you when you sign the consent form.

Your consent is effective for 180 days from the date you sign the consent form.

BE SURE TO TAKE THIS PAMPHLET AND YOUR SIGNED CONSENT FORM WITH YOU.

[FR Doc. 78-31576 Filed 11-7-78; 8:45 am]

d. Abortions: DHHS has amended Public Health Service Regulations (42 CFR Part 50) with regard to Federal Financial Participation (FFP) in expenditures for abortions, effective August 21, 1978, as follows:

Title 42—Public Health

CHAPTER I—PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

SUBCHAPTER D—GRANTS

PART 50—POLICIES OF GENERAL APPLICABILITY

Abortions and Related Medical Services in Federally Assisted Programs of the Public Health Service

AGENCY: Public Health Service.

ACTION: Final rules.

SUMMARY: The Department is amending final regulations governing Federal financial participation in expenditures for abortions funded through various HEW programs. These regulations were published on February 2, 1978, and republished on February 3, 1978, in the FEDERAL REGISTER.

Two sets of amended regulations are being published. One set applies to programs administered under title XIX of the Social Security Act, and another to programs and projects supported with funds appropriated to the Department of Health, Education, and Welfare and administered by the Public Health Service. A third set of regulations governing programs administered under title XX of the Social Security Act, which incorporates the title XIX regulations by cross-reference, is also amended by this action.

In addition, the Department is responding to written public comments timely received in response to an invitation to comment which was published in the preamble to the final regulations. These amendments and responses fulfill the Department's commitment in that preamble to respond in the FEDERAL REGISTER to written comments received on or before March 20, 1978, and to amend the regulations where appropriate.

EFFECTIVE DATE: The amended regulations will be effective on August 21, 1978. Prior to this date, programs and projects will be held accountable to the regulations which are presently in effect.

Subpart C of Part 50 is amended to read as set forth below:

1. Section 50.304 is revised to read as follows:

§ 50.304 Life of the mother would be endangered.

Federal financial participation is available in expenditures for an abortion when a physician has found, and so certified in writing to the program or project, that on the basis of his/her professional judgment, the life of the mother would be endangered if the fetus were carried to term. The certification must contain the name and address of the patient.

2. Section 50.305 is revised to read as follows:

§ 50.305 Severe and long-lasting damage to physical health.

Federal financial participation is available in expenditures for an abortion when two physicans have found, and so certified in writing to the program or project, that on the basis of their professional judgment, severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term. The certification must contain the name and address of the patient. At least one of the two physicians must also certify that he/she is not an "interested physician" as defined in the next succeeding sentence. For purposes herein, an "interested physician" is one: (a) Whose income is directly or indirectly affected by the fee paid for the performance of the abortion; or (b) who is the spouse of, or another relative who lives with, a physician whose income is directly or indirectly affected by the fee paid for the performance of the abortion.

3. Section 50.306 is revised to read as follows:

§ 50.306 Rape and incest.

Federal financial participation is available in expenditures for medical procedures performed upon a victim of rape or incest if the program or project has received signed documentation from a law enforcement agency or public health service stating:

(a) That the person upon whom the medical procedure was performed was reported to have been the victim of an incident of rape or incest;

(b) The date on which the incident occurred;

(c) The date on which the report was made, which must have been within 60 days of the date on which the incident occurred;

(d) The name and address of the victim and the name and address of the person making the report (if different from the victim); and

(e) That the report included the signature of the person who reported the incident.

Federal financial participation is also available in expenditures for abortions for victims of rape or incest under the circumstances described in §§ 50.304 and 50.305 without regard to the requirements of the preceding sentence.

(Sec. 101, Pub. L. 95-205, 91 Stat. 1461, December 9, 1977.)

Dated: July 10, 1978.

JULIUS B. RICHMOND,
Assistant Secretary for Health.

Approved: July 14, 1978.

JOSEPH A. CALIFANO, Jr.,
Secretary.

[FR Doc. 78-20262 Filed 7-20-78; 8:45 am]

110.8 Exclusions

The following items are not covered for benefit payments when provided as either an inpatient hospital or inpatient professional service:

a. Physical examinations routine in nature and not relating to a condition requiring hospital admission
b. Routine foot care
c. Cosmetic surgery
d. Custodial care
e. Personal comfort items
f. Visitor's meals or cots
g. Transportation or ambulance service, except when ambulance service is required to transfer a patient from a participating hospital to a non-participating hospital for admission or return the patient to a participating hospital
h. Air ambulance or other non-surface emergency transportation
i. Dental services, except for those services outlined as covered professional services of dental surgery or dental medicine

   NOTE: When the condition of the patient is such that hospitalization is required for routine dental services, then hospital benefits can be paid upon adequate documentation as to the medical necessity of such an admission. In such a case, there would still be *no* allowance for professional fees for routine dental service
j. Chronic renal disease requiring dialysis

   NOTE: The nearest Social Security Office should be notified for application under the Medicare Program
k. Organ transplantations
l. Workmen's compensation claims, either in whole or in part
m. Durable medical equipment.

120 HOSPITAL REIMBURSEMENT

120.1 Negotiating the Rate of Payment for a Participating Hospital

Two rates of payment are available to pay for covered services provided by a participating hospital. One rate shall be for newborn nursery inpatients and the other shall be for all other inpatients. The two per diem rates will be prospective and all inclusive, and will be negotiated, using as a basis the lower of the hospitals average per diem cost or average per diem charge of providing each of such services.

In its role as fiscal intermediary, the Office of Direct Reimbursement will be responsible for developing data to be used in negotiating each of the rates based on the following guidelines:

a. Inpatient Per Diem:

1. Allowable costs will be determined in accordance with existing Medicare regulations and principles of reimbursement to the extent that they are applicable to the benefits and inpatient services covered under the migrant program. Such allowable costs include inpatient general routine, special care and ancillary department costs.

2. Allowable charges for services covered under the migrant program will be based on each hospital's established schedule of charges providing such charges are reasonable and are uniformly billed to all patients receiving identical services.

3. Inpatient days will include all inpatient and special care unit days.

4. Allowable costs (Item 1) will be divided by total inpatient days (Item 3) and total allowable charges (Item 2) will be divided by total inpatient days (Item 3) in order to determine the basis for negotiating the hospital's fixed rate of payment.

b. Nursery Per Diem:

1. Allowable costs for nursery care will be based upon the total allowable costs of providing nursery care to newborn inpatients.

2. Allowable charges will be based upon each hospital's established schedule of charges for inpatient nursery care providing such charges are reasonable and uniformly billed to all patients receiving identical services.

3. Nursery days will include total "newborn days—nursery."

4. Allowable costs (Item 1) will be divided by total nursery days (Item 3) and total allowable charges (Item 2) will be divided by total nursery days (Item 3) in order to determine the basis for negotiating the hospital's fixed rate of payment.

120.2 Determining the Rate of Payment for a Non-Participating Hospital

When covered services are provided by a non-participating hospital, reimbursement will be according to the non-participating hospital's established schedule of charges, provided such charges are reasonable and are uniformly billed to all patients receiving identical services. If the patient was admitted to the participating hospital, the non-participating hospital will prepare and submit a bill to the participating hospital in its customary manner, and the participating hospital will forward the bill (including the itemized billings of attending and/or consulting physicians) to the Office of Direct Reimbursement for payment. If the patient was referred directly to the non-participating hospital as provided in Section 270 then the non-participating hospital and physician bills should be submitted to the migrant project.

120.3 Admission Control

Each project receives an annual allocation of admissions and a budget amount for each fiscal year; i.e., from October 1 through September 30. The Office of Direct Reimbursement monitors the use of admissions allocations by assigning a sequential control number to each referral received and tracking the amount of Migrant Hospitalization Program funds expended for each admission. Periodically during the fiscal year, ODR reviews utilization of admissions and funds expended to determine if the number of admissions allocations should be changed and notifies each Project Director accordingly.

130 PROFESSIONAL SERVICES

Physicians participating in this program will provide attending physician services, arrange for any specialty care required, and report needed follow-up care to the project upon discharge of the patient.

130.1 Reimbursement

Full-time salaried project physicians will not be reimbursed by this program for inpatient hospital medical services provided. It is expected that the full-time project physician would serve as attending physician for a majority of patients admitted under the program. Physicians who are not employed full time by the project and may serve as attending physicians, as well as other physicians required by the patient's condition, will be reimbursed for inpatient hospital medical services provided to eligible recipients using the Relative Value Studies of the California Medical Association and the Relative Value Guide of the American Society of Anesthesiologists. A

conversion factor developed by the Bureau of Health Insurance is applied to the relative value units and the resulting allowable charge for each specific procedure and type of service closely approximates the Medicare carriers' area prevailing rates.

Physicians on call, but not affiliated with a project, who provide emergency services to eligible recipients who are admitted will also be reimbursed at a customary and usual fee as utilized by Medicare.

Reimbursements to physicians for services rendered to eligible migrants and their dependents will be made by the Office of Direct Reimbursement (ODR) through the participating hospital or project.

Depending on the option selected by the participating hospitals the physician will submit his or her bill to the hospital where services were provided, or to the local migrant project which will forward it to the ODR, or directly to ODR. The hospital or project will transmit the treasury check representing the physician's payment when it is received. The physician's bill must be itemized and describe services and procedures provided (see Section 370). ODR will usually reimburse physicians within four weeks of billing.

The basis for the payment of hospital-based physicians' services under the migrant hospitalization and Medicare programs is the same. Therefore, the combined billing method must be used to bill for services covered under the migrant program if it is used presently to bill for services covered under the Medicare program.

130.2 Certification and Recertification

An attending physician's order of admission to inpatient status satisfies the medical necessity requirement for the first 12 days of inpatient hospital care. After 12 days of continuous inpatient hospital care, the attending physician, or another physician familiar with the case, must certify as to the need of continuing inpatient hospital care. This certification will be recorded in the doctor's progress notes, or in the manner established as routine for Medicare patients, on the thirteenth day. This certification will include a written explanation (the diagnosis alone is not adequate although it may appear to be obvious) of the reason for continuation of hospitalization, and should include an estimated length of additional stay that will be required. A recertification will be required if the need for additional hospitalization exceeds the estimate in the first certification. Certification of routine maternity cases must be made on the third day after delivery, including an estimated length of additional stay. A refusal by the physician to certify the need for continued stay will be a determination that any continuation of the stay is not medically necessary.

Section 200: PATIENT REFERRAL PROCEDURES

210 GENERAL PROCEDURES

210.1 Eligibility

When a physician has determined that a migrant worker or family dependent is in need of hospitalization, the Project Director will verify the patient's eligibility and certify that he or she is an agricultural migrant worker or a family dependent of such a worker, as defined in Migrant Health Program regulations. The Project Director will then assign a migrant beneficiary account number and refer the patient to a nearby participating hospital by completing the Referral Form for the Migrant Hospitalization Program (see Section 280).

210.2 Emergency Admissions

In the event of an emergency admission, the participating hospital will contact the project by telephone to determine the migrant's eligibility. The project will verify the patient's eligibility, issue a beneficiary account number, and process the Referral Form as in Section 260. Where the emergency admission is for a patient who has received previous benefits, the project, if in doubt, will telephone ODR to determine the patient's remaining entitlement.

210.3 Remaining Entitlement

When the patient being referred has received previous benefits under the Migrant Hospitalization Program, the Project Director may verify the patient's remaining entitlement by telephone with ODR prior to referral. That telephone number is (301) 594-7502.

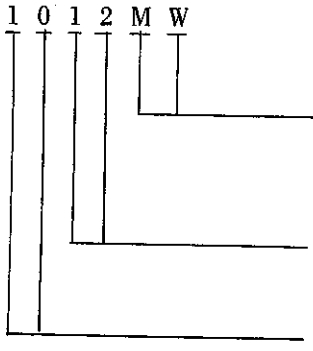
When ODR furnishes eligibility by telephone, written confirmation of remaining benefit days will be sent to the project with a copy to the hospital.

220 PROJECT NUMBER

Each project is assigned a three-position identification number by the Bureau of Community Health Services. The project number is also a component of the migrant beneficiary account number (see Section 240).

230 PROVIDER NUMBER

The provider number is a six position alpha/numeric designation assigned by the Bureau of Community Health Services to hospitals participating in the Migrant Hospitalization Program. The provider code is structured as shown below:



Two-position alpha code indicating the hospital is a participating provider of hospital services to migrant workers.

Two-position serial number identifying the participating hospital.

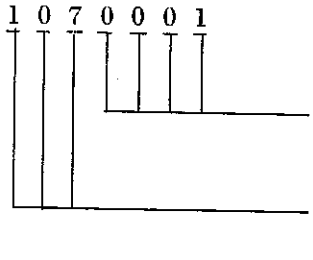
Two-position number identifying the State in which the provider is located. State codes are determined by the State's relative alphabetic position. Numbers for States presently in this program are:

Arizona	–03
Colorado	–06
Florida	–10
Idaho	–13
Texas	–45
Washington	–50

NOTE: The *non-participating hospital* will be identified by a change in the participating hospital's identification code suffix from "W" to "T" (see Section 110.6)

240 MIGRANT BENEFICIARY ACCOUNT NUMBER

240.1 The migrant beneficiary account number is a seven-position numeric identifier assigned by the project to each beneficiary of migrant hospital services. The account number is structured as shown below:



Four-position sequential number assigned by the project

Three-position number identifying the project

240.2 Each project is responsible for maintaining accurate and reliable records of migrant beneficiary account numbers assigned as necessary to prevent duplication of assigned numbers and to prevent assigning more than one number to any beneficiary. The record system must provide for a reference file by beneficiary name and a separate file in beneficiary account number sequence.

250 DETERMINING BENEFICIARY ELIGIBILITY

A migrant patient certified by the project is entitled to have payment made on his behalf for up to 30 days of covered inpatient hospital services in each benefit period. A benefit period begins on the date of admission to a participating provider of migrant hospital services and ends 60 days after the patient's discharge from any hospital.

The project is responsible for determining the migrant patient's entitlement prior to referral for admission, or in the case of an emergency, immediately upon notification of the admission.

If the project determines that the patient is a new beneficiary under the Migrant Hospitalization Program, a migrant beneficiary account number will be assigned and the patient referred for admission to a participating hospital.

If the patient has received prior benefits under the program the project may verify the patient's remaining entitlement by contacting the Office of Direct Reimbursement, telephone (301) 594-7502, and furnishing the following information:

a. Migrant beneficiary's account number
b. Migrant beneficiary's last name and first initial
c. Migrant beneficiary's date of birth
d. Migrant beneficiary's sex
e. Date of proposed admission
f. Hospital to which beneficiary will be admitted

The Office of Direct Reimbursement will provide entitlement data by telephone to the project within 1 working day after receiving the entitlement status request. Written confirmation will follow to the project with a copy to the participating hospital.

If the patient is eligible or potentially eligible for hospitalization through a Federal, State or local government agency or through another third party, the project must annotate the Referral Form and notify the participating hospital that the other insuring agency must be billed first.

If the patient has other insurance which covers the hospital stay in full, the patient is not eligible for coverage of any professional services by the Migrant Hospitalization Program. A referral should not be submitted.

260 PROCESSING REFERRAL FORM FOR MIGRANT HOSPITALIZATION

After the migrant patient's eligibility for hospital services under the program has been assured and a migrant beneficiary account number assigned, the Project Director will refer the patient for admission to a participating hospital by completing the form, Referral for Migrant Hospitalization (see Section 280).

Within 24 hours after referring a migrant patient for admission the project will distribute copies of the form to the following:

Part 1 – Provider hospital (to accompany or precede the beneficiary for non-emergency admissions)
Part 2 – This copy of the referral form and the patient encounter forms are no longer required by BCHS. (May be discarded or utilized by project.)
Part 3 – Office of Direct Reimbursement, HCFA
Health Studies Services Branch
P.O. Box 80
Baltimore, Maryland 21203
Part 4 – Retained by the project.

(See attached form HSA 50, Referral for Migrant Hospitalization)

ASSURANCE OF CONFIDENTIALITY - The Health Services Administration hereby gives its assurance that the identity of the individual and his relationship to any information reported on this form will be kept confidential in accordance with the PHS Regulations (42 CFR Part 1) and subject only to the disclosure conditions contained in Section 1.103 of the Regulations.

DEPARTMENT OF
HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE

REFERRAL FOR MIGRANT HOSPITALIZATION

(SEE INSTRUCTIONS IN PATIENT REFERRAL PROCEDURES)

TYPE OR PRINT ALL ITEMS

NAME OF PROJECT

PROJECT NUMBER (2-4) | PROVIDER NO. (5-10)

PATIENT DATA

NAME OF PATIENT *(Last, First, Middle or Initial)*

BENEFICIARY ACCOUNT NO. (11-17)

PATIENT IDENTIFICATION NO. (18-24)

LOCAL ADDRESS *(Include Camp Name/No., County, State, Zip Code)*

DATE OF BIRTH (25-30) *(Month, Day, Year)*

DATE OF ARRIVAL IN AREA *(Month, Day, Year)*

HOME ADDRESS *(Include County, State, Zip Code)*

SEX (31)
1 ☐ MALE
2 ☐ FEMALE

MARITAL STATUS (32)
1 ☐ MARRIED 3 ☐ WIDOWED 5 ☐ SEPARATED
2 ☐ SINGLE 4 ☐ DIVORCED 6 ☐ UNSPECIFIED

RELATION TO HEAD OF FAMILY (36)
1 ☐ HEAD 2 ☐ SPOUSE 3 ☐ CHILD 4 ☐ OTHER

PATIENT'S STATUS (35)
1 ☐ MIGRANT WORKER 2 ☐ NON-WORKING FAMILY MEMBER

DATES OF EMPLOYMENT *(Mo/Day/Yr)* FROM | TO

BENEFIT DAYS AVAILABLE

NAME OF HEAD OF FAMILY *(Last, First, Middle Initial)*

ADDRESS OF WORKER'S LAST AGRICULTURAL EMPLOYMENT OUTSIDE OF AREA *(Include County, State, Zip Code)*

PRIOR HOSPITALIZATION DURING PRECEDING 12 MONTHS (37)
1 ☐ YES
2 ☐ NONE
3 ☐ UNKNOWN
IF "YES", GIVE DATES AND LOCATION

CERTIFICATION OF ELIGIBILITY FOR HOSPITAL SERVICES

I certify that this patient is a domestic agricultural migrant worker, or a family member of such worker, and eligible for hospital services in the Migrant Hospitalization Demonstration Program. A domestic agriculture migrant, as defined in Migrant Health Program Regulations, means an individual residing in a state whose principal occupation is in agriculture on a seasonal basis who establishes for the purpose of such employment a temporary place of abode, and who has been employed within the last 24 months.

SIGNATURE

NAME *(Printed)*

DATE *(Month, Day, Year)*

IS THIS A POST-ADMISSION CERTIFICATION? (38)
1 ☐ YES 2 ☐ NO

IS THIS A WORK RELATED ADMISSION? (39)
1 ☐ YES 2 ☐ NO

INITIAL VERIFICATION OF MEDICAL NEED

NAME AND TITLE OF PERSON REQUESTING REFERRAL

NAME OF PHYSICIAN DETERMINING MEDICAL NEED

DATE OF ADMISSION (40-45) *(Month, Day, Year)*

REASON FOR ADMISSION (46)
1 ☐ EMERGENCY-ACCIDENT
2 ☐ EMERGENCY-NON ACCIDENT
3 ☐ DELIVERY
4 ☐ ELECTIVE
5 ☐ NEWBORN
6 ☐ OTHER

PART 1

HOSPITAL COPY

SEND TO HOSPITAL ADMITTING OFFICE

270 ADMISSIONS TO NON-PARTICIPATING PROVIDERS

270.1 Inpatient Services by Non-Participating Providers

On occasion, participating hospitals will be unable to provide those services required by the eligible migrant patient. When the patient has been admitted to the participating hospital, that hospital will arrange to move the patient to a hospital which has not entered into an agreement with the Migrant Hospitalization Program. The participating hospital will:

a. Notify the migrant health project of the transfer.
b. Prepare and forward with the patient such medical records as will be required by the non-participating hospital accepting the patient.
c. Advise the non-participating hospital as to the number of days remaining in the patient's benefit period.
d. Arrange for transfer by ambulance when the patient's condition makes this form of transportation medically necessary.

In addition, the participating hospital will advise the non-participating hospital of the program's limitation and exclusions; that the non-participating hospital charges, in accordance with its regular schedule of charges and billing procedures, are to be returned to the participating hospital for transmittal to ODR for payment; and that all physician bills describing services provided (see Section 370) are to be attached to the non-participating hospital's billing at the time of the patient's discharge, death, or exhaustion of available benefit days.

If it is known prior to admission that the patient requires a service which cannot be furnished by a participating hospital, the project will coordinate the direct admission to a non-participating hospital. The participating hospital will be notified of the admission by the project and will be asked to submit a written certification that the needed service is not furnished. Such certification must accompany the non-participating hospital's bill when it is submitted to ODR.

270.2 Outpatient Services by Non-Participating Providers

Occasionally, a participating hospital may find it necessary to transfer a migrant beneficiary to another area hospital on an outpatient basis for specialized services. If the patient does not need to be admitted to the second hospital, the Migrant Hospitalization Program will pay the cost of the special services obtained by the participating hospital if all the following conditions are met:

a. The specialty service is not available to any patient in the participating hospital; i.e., all patients requiring the service are referred to another facility.
b. The administrator of the hospital must certify in writing that the service is not available in the participating hospital.
c. The participating hospital must bill for the service and provide ODR with the non-participating hospital's bill for the specialty service.

This policy became effective October 1, 1978, and is intended to reduce unnecessary admissions to transfer hospitals. However, since the cost of such services is outside the reimbursement methodology established for payment of hospitals participating in the hospitalization program, each outpatient transfer will be carefully screened by ODR before payment is approved.

280 INSTRUCTIONS FOR COMPLETION OF REFERRAL FORM

280.1 General Instructions

A separate referral form is needed for each patient admitted or readmitted. If a patient is hospitalized without prior referral by the project, the hospital must notify the project as soon as possible, at which point the project will complete a referral form for the patient. The hospital must receive the completed referral form within 3 workdays of the admission. (Sample attached)

A separate referral form is needed for a newborn only if the infant stays longer than the mother or the infant is transferred to a different hospital.

After Completion—Follow the instructions at the bottom of the individual copies of the form.

280.2 Instructions for Completing Referral Form

Dates—All dates should be completed using two-digit numbers for the month, day and year. For example, August 4, 1978 should be recorded as 08/04/78. Enter "99" for any part of the date that is unknown.

Addresses—All addresses should include street address, county, State and zip code. The name of the labor camp may be used if no street address is available.

Project Number—Give the three-digit number assigned to each project by BCHS.

Provider Number—Give the four-digit number followed by a two-letter code assigned to each participating hospital by BCHS.

280.3 Patient Data

This part contains essential patient data which must be completed as accurately as possible. Most of the data requested are self-explanatory.

Beneficiary Account Number *NOTE:* ACCURACY HERE IS EXTREMELY IMPORTANT. Give the seven-digit code assigned to each patient referred for hospitalization by the project. The first three digits are the same as the project number; the last four digits are assigned sequentially to the patients. If a patient has been hospitalized previously, he must use the SAME beneficiary account number as before.

Patient Identification Number—Give the number used by the project to identify the medical record of the patient.

Patient's Status—Indicate the patient's status. (If the patient is not a migrant worker himself, he must be the family dependent of a migrant worker in order to qualify as a beneficiary of the hospitalization program.)

Head of Family—If the patient is the head of family, the "name of head of family" space may be left blank.

Address of Worker's Last Agricultural Employment Out of Area—"Worker" refers to the patient, unless he is a non working dependent, in which case "Worker" then refers to the head of the family.

Dates of Employment—Give the approximate dates of the worker's last agricultural employment if the exact dates are not available.

Hospitalization Dates and Locations During Preceding Twelve Months—Determine whether the patient has been hospitalized in the past year and if so, when, where, and for how long.

280.4 Certification of Eligibility for Hospital Services

The Project Director is responsible for certifying the eligibility of the patient. While he may delegate the responsibility of verifying the information given by the patient, he cannot delegate the certification responsibility.

NOTE: In the blank space immediately below the words "CERTIFICATION OF ELIGIBILITY FOR HOSPITAL SERVICES" add the following question: Does patient have hospitalization insurance? ☐ Yes ☐ No
If yes, name of insurer _____

Is This a Post Admission Certification? A post admission refers to admission made prior to the project determining the patient's eligibility. If the patient is referred by the project prior to admission to the hospital, then the "No" block should be checked.

280.5 Initial Verification of Medical Need

Name and Title of Person Requesting Referral—Give the name and title of the person making the referral if other than the physician admitting the patient (such as a family health worker or nurse referring a patient to the emergency room of a participating hospital in an emergency).

Date—Give the date that the patient is admitted to the hospital. Do *not* give a prospective admission date. This may be different from the certification date.

Section 300: PROCEDURES FOR HOSPITAL AND PHYSICIAN BILLING

310 Hospital Billing for Inpatient Services

Migrant patients certified and referred for admission by a participating migrant health project are entitled to care for up to 30 days of covered inpatient hospital services for each benefit period. A benefit period begins on the first day of admission to a participating hospital and ends 60 days after the patient's discharge from any hospital.

A signed copy of the Referral Form for Migrant Hospitalization should accompany or precede the migrant beneficiary at the time of admission. Hospitals admitting patients thought to be eligible under emergency conditions are responsible for notifying the project within 24 hours after admission. If the patient is an eligible migrant, the project must advise the hospital of the patient's eligibility and number of benefit days available within three calendar days after the emergency admission.

For a hospital to be eligible to receive payment for services provided, the project must file a copy of the Referral for Migrant Hospitalization form with the Office of Direct Reimbursement, and, with the exception of the guarantee of payment provision, the migrant beneficiary must have covered days remaining. Payment to participating hospitals will be computed by ODR in accordance with the executed Provider Reimbursement Contract for Inpatient Hospital Care based on the covered days of service provided.

Non-participating hospitals will be reimbursed through a participating provider on the basis of the non-participating hospital's established schedule of charges provided such charges are reasonable and are uniformly billed to all patients receiving identical services (see Section 270).

320 Billing for Services Billed First to Insurers Other Than the Migrant Hospitalization Program

When an eligible migrant receives services in a participating hospital and a Federal agency, a State or local government agency, or other insurer would be responsible for part of the cost of the service provided by the participating hospital, the responsible agency or third-party payor shall be billed first. The Migrant Hospitalization Program (MHP) will assume responsibility for the amount of reimbursement which would have been payable less the amount paid by the other agency or third-party insurer. EXAMPLE: Private insurance pays the first $200.00 of a 7-day inpatient stay. The MHP hospital's per diem rate is $79.80. Reimbursement by the MHP will be 7 x $79.80 or $558.60 less $200.00. Total reimbursement to the hospital by the MHP would be $358.60.

If an eligible migrant receives services in a participating hospital and a Federal, State, or local government agency or other third-party would be responsible for the total cost of the hospital service, the MHP will not assume responsibility for any part of the cost of providing the service and MHP shall not be billed.

It is the responsibility of the project and participating hospitals to obtain evidence of other insurance from the migrant beneficiary and to bill the other insurer first. If, however, the ODR has released reimbursement to a participating hospital for services which would have been covered totally or in part by another Federal, State, or local government agency or other third-party payor, an adjustment in reimbursement to the hospital will be made.

When another insurer has approved payment and the stay is covered in full, the hospital or project must notify ODR in writing of the migrant's name, identification number and the date of admission shown on the Referral Form. This notification will permit ODR to delete the admission notice from the bill control system.

When another insurer has approved payment and the stay is covered in part, the hospital will complete a uniform bill set according to instructions in Section 360, and forward evidence of the amount paid by the other insurer.

330 Guarantee of Payment

Under the guarantee of payment provisions, a hospital may be paid, under certain conditions, for inpatient hospital services furnished to a migrant worker or member of his family even when there may be no further benefit days available to the patient. The provision assures that payment will be made to a hospital for services it provides during the time it takes to ascertain from the project, but not more than 3 calendar days, the extent of the patient's remaining entitlement of benefits.

Conditions applicable to the guarantee of payment are:

a. The patient must be admitted under emergency conditions.
b. The patient must be a migrant beneficiary certified by the project whose entitlement to inpatient hospital days has been exhausted or will become exhausted within 3 calendar days following the admission.
c. The hospital must have acted in good faith in assuming that the individual was entitled to inpatient hospital benefits. There would be an absence of good faith if the hospital had, or should have had, a substantial doubt that a remaining entitlement existed.

340 Use of the Uniform Bill

The Uniform Bill UB-16 (sample attached) will be used to bill the program for inpatient hospital services provided by both participating and non-participating hospitals. For admissions July 1, 1975 and later, hospitals which have been consolidating physician bills with their Uniform Bill for submission to ODR, may exercise an option to bill only for hospital services. The local migrant project will then assume responsibility for the physician bills if the option is taken by the hospitals. The cooperation of the hospitals in identifying all physician services rendered to inpatients reimbursed under the Migrant Hospitalization Program will be needed by the projects which coordinate the physician billings.

If the hospital continues to bill for hospital and physician services, the Uniform Bill (UB-16) and Provider Bill for Patient Services by physicians (HSA-380) will be used to submit claims to ODR.

Bills submitted for mother and infant should be submitted together. If the infant will remain hospitalized for a substantially longer period of time than the mother, the mother's bill may be submitted separately. The two bills must be cross-referred to each other and the fact and date the infant began receiving special care must be clearly indicated on the billing form for the child. If special nursery care is not indicated on the UB-16, the bill for separate payment may be denied and payment made only for the mother according to existing policy.

Hospitals which currently use a computer prepared bill or have a ledger bill which summarizes charges by department may request authorization from ODR to use their internal billing forms for the charge information required in items 39 through 48 on the UB-16.

Bills should be submitted as soon as possible after the patient's discharge, death, or after benefits are exhausted. There is a 1-year time limit for filing bills for services rendered to migrant beneficiaries. Claims for covered services must be received by ODR within 1 year after the discharge date from the hospital. Bills received after the time limit will be returned. No interim bills are submitted unless the patient's stay overlaps the fiscal year end or other accounting period ending date when the per diem reimbursement rate changes.

Detailed instructions for preparation of these forms are contained in Section 360. Forms may be obtained through the local project.

For the Migrant Hospitalization Program, only two parts of the six-part Uniform Bill, UB-16 are used. The Primary Payor copy should be submitted to the ODR. The Hospital Copy should be retained by the provider.

Bills should be submitted to:

Office of Direct Reimbursement, HCFA
Health Services Studies Branch
P.O. Box 80
Baltimore, Maryland 21203

NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED ON THIS FORM MAY UPON CONVICTION BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND OR STATE LAW

(1) Doctor's Hospital | (2) HOSPITAL NO. | (3) PROVIDER NO. 1124MW | (4) FED. I.D. NO. | (5)

(6) PATIENT'S LAST NAME	FIRST NAME	INITIAL	(7) STREET ADDRESS	CITY	STATE	ZIP
Doe	John	T	123 Maple Dr	Anytown	Pa	19000

(8) PATIENT CONTROL NO.	(9) S R	(10) BIRTHDATE	(11) ATTENDING PHYSICIAN	(12) ADMISSION—START OF CARE DATE HR	(13) QUALIFYING STAY DATES FROM THRU	(14) NUM. PLAN EST.
66-03-82	M	06 02 36	W. E. Jones	02 01 79		

(15) PRIMARY PAYOR—NAME	(16) INSURED'S NAME & RELATIONSHIP TO PATIENT	(17) CLAIM CERTIFICATE—I.D. NO. (H.I.C.)	(18) GROUP NAME—NO.	(19) Y.N.
XYZ Insurance Co.		109-0001		
(20) SECONDARY PAYOR—NAME	(21) INSURED'S NAME & RELATIONSHIP TO PATIENT	(22) CLAIM CERTIFICATE—I.D. NO. (H.I.C.)	(23) GROUP NAME—NO.	(24) Y.N.
(25) TERTIARY PAYOR—NAME	(26) INSURED'S NAME & RELATIONSHIP TO PATIENT	(27) CLAIM CERTIFICATE—I.D. NO. (H.I.C.)	(28) GROUP NAME—NO.	(29) Y.N.

BASE INFG INTE SD

(30) BILL TO
- HCFA
- Office of Direct Reimbursement
- Health Services Studies Branch
- P. O. Box 80
- Baltimore, Maryland 21203

(31) Class of Care	Rate	Days	Total Charges
C	60.00	7	420.00

(32) TYPE OF BILL

PROFESSIONAL COMPONENTS: (33) RADIOLOGY | (34) PATHOLOGY | (35) OTHER

(36) MPIST COMM SEMI-PVT RATE: 60 00 | (37)

(38) CODE	(39) DESCRIPTION	(40)	(41) TOTAL CHARGES	(42) PRIMARY PAYOR	(43) SEC. PAYOR ITEM 20	(44) TERT. PAYOR ITEM 25	(45) PATIENT
	Seven (7) days routine room & board		420 00				
	Operating Room Charge		175 00				
	Anesthesia - RN		40 00				
	Supplies - Gastroscopy		10 00				
	Lab - CBC with Diff		8 00				
	Chest X-Ray 2 views		27 00				
	TOTALS →	(46)	(47) 680 00	(48) 300 00	(49)	(50)	(51)

BLOOD RECORD (PINTS)

(52) FURN.	(53) REPLACED	(54) NOT REPLACED	(55) DED	(56) CHG/PT.	(57) BLOOD DED	(58) PRIM PLANG	(59) TREATMENT AUTHORIZATION	(60) INPATIENT DEDUCTIBLE	(61) DEDUCTIBLES	(62) DEDUCTIBLES	(63) DEDUCTIBLES	(64) PAID BY PATIENT

(65) STATEMENT COVERS PERIOD FROM	THRU	(66) PS CODE	(67) DIS. HR	COINSURANCE (68) DAYS	(69) RATE	(70) L.R. DAYS USED	(71) PIP	(72) E.R.	(73)	(74) COINSURANCE	(75) COINSURANCE	(76) COINSURANCE	AMOUNT DUE
02 01 79	02 08 79												

(77) OCCURR. DATE	(78) CODE	(79) OCCURR. DATE	(80) CODE	(81) COV DAYS	(82) N. COV DAYS	(83)	(84) DUE FROM PRIMARY PAYOR	(85) DUE FROM SEC. PAYOR ITEM 20	(86) DUE FROM TERT. PAYOR ITEM 25	(87) DUE FROM PATIENT
				7	0		300 00			

(88) CODE | (89) PRINCIPAL DIAGNOSIS/NATURE OF ILLNESS: Appendicitis, Gastric ulcer

OTHER DIAGNOSES: (90) | (91) CODE | (92) CODE | (93) CODE | (94) CODE

(95) CODE | (96) DATE: 02 02 | (97) PRINCIPAL SURGICAL OR OBSTETRICAL PROCEDURE: Appendectomy, Gastroscopy

OTHER PROCEDURES: (98) | (99) CODE | (100) DATE | (101) CODE | (102) DATE

(103)

(104)

(105) REMARKS

(106) I CERTIFY THAT THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF. | (107) DATE

PROVIDER REPRESENTATIVE X

(108) VERIFIED NON COV STAY DATES FROM	THRU	(109) PAYMENT DISTRIBUTION PROVIDER	PATIENT

(110) VERIFIED PATIENT LIABILITY BLOOD	CASH DEDUCT	COINSURANCE	(111) NON PYMT CODE	(112) LIFE TIME USED

(113) AMOUNT REIMBURSED	(114) DATE RECEIVED	(115) APPROVED BY (INITIALS)	(116) DATE APPROVED

2 Copy No. Two 2

350 PATIENT CERTIFICATION

Before payment can be made for an inpatient hospital stay or for physicians' services billed through the hospital, a written authorization for release of information signed by the patient, or by another person qualified to do so on his behalf, must be filed. The patient's signature on the hospital admission records may serve as authorization for release of information provided the pertinent language of the following certification is incorporated:

> "I authorize release of any information relating to my care and treatment which may be required pursuant to the Migrant Hospitalization Program."

When the hospital uses the Uniform Bill, payment may be made based on the hospital execution of the Certification block certifying that the patient's statement is on file.

When the hospital uses internal billing forms in lieu of the Uniform Bill, the following certification must be printed on the bill or attached thereto:

> "Signature of patient or his authorized representative authorizing release of information is on file."

				(2) HOSPITAL NO.		(3) PROVIDER NO.	(4) FED. I.D. NO.	(5)					
Doctor's Hospital						1124MW							
(6) PATIENT'S LAST NAME	FIRST NAME		INITIAL	(7) STREET ADDRESS		CITY	STATE				ZIP		
Doe	John		T	123 Maple Dr		Anytown	Pa				19000		
(8) PATIENT CONTROL NO.	(9) S-R	(10) BIRTHDATE	(11) ATTENDING PHYSICIAN		(12) ADMISSION—START OF CARE DATE	HR	(13) QUALIFYING STAY DATES FROM	THRU	(14) H.H. PLAN EST.				
66-03-82	M	06 04 36	W. E. Jones		02 01 79								
(15) PRIMARY PAYOR—NAME			(16) INSURED'S NAME & RELATIONSHIP TO PATIENT		(17) CLAIM-CERTIFICATE—I.D. NO. (H.I.C.)			(18) GROUP NAME—NO.			(19) Y.N.	BASIS	
XYZ Insurance Co.					109-0001								
(20) SECONDARY PAYOR—NAME			(21) INSURED'S NAME & RELATIONSHIP TO PATIENT		(22) CLAIM-CERTIFICATE—I.D. NO. (H.I.C.)			(23) GROUP NAME—NO.			(24) Y.N.	FOR	
(25) TERTIARY PAYOR—NAME			(26) INSURED'S NAME & RELATIONSHIP TO PATIENT		(27) CLAIM-CERTIFICATE—I.D. NO. (H.I.C.)			(28) GROUP NAME—NO.			(29) Y.N.	INTESD	

Item 1—Provider Identification—Enter the name of the hospital providing the services.

Item 2—No entry necessary.

Item 3—Provider Number—Enter the six-position alpha/numeric designator assigned to the participating hospital providing services under the Migrant Hospitalization Program.

NOTE: When the bill being submitted is for services performed by a non-participating hospital or by an ambulance service, the participating hospital will have advised such providers to use its (the participating hospital's) Provider Number on their bills, except that the last letter of the alpha/numeric designator will be changed from "W" to "T". Non-participating hospitals or ambulance services should be certain to include their own name and address on the bill. It should be noted, too, that all bills for ambulance services should be submitted to the participating hospital for transmittal to the Office of Direct Reimbursement, HCFA.

Items 4 & 5—No entries necessary.

Item 6—Patient Name—Enter the patient's last name, first name, and middle initial as it appears on the referral for hospitalization.

Item 7—Street Address—Enter the patient's local address as it appears on the referral for hospitalization.

Item 8—Patient Control Number—This space may be used for entering numbers (Medical Record Number) assigned by the hospital for internal control and filing.

NOTE: This is not the patient identification number assigned by the Project (Migrant Beneficiary Account Number).

Item 9—Sex-Race—Enter "M" for Male, "F" for Female. No other entry is necessary.

Item 10—Birthdate—Enter the patient's date of birth by month, day and year. If birthdate is not known, enter an estimated year of birth.

Item 11—Attending Physician—Enter the initials and last name of the attending physician.

Item 12–Admission Date–Enter the date of the current admission. For example, if the patient was admitted to the hospital on February 1, 1979 enter the actual date of admission as:

Items 13 & 14–No entries necessary.

Item 15–Primary Payor Name–If another Federal, State, or local government agency or other third-party will assume responsibility for a part of the inpatient services, the name of that insurer should be entered here.

Item 16–No entry necessary.

Item 17–Claim Certificate I.D. No.–Enter the Migrant Beneficiary Account Number assigned by the project.

Items 18-29–No entries are necessary.

(30) BILL TO
- HCFA
- Office of Direct Reimbursement
- Health Services Studies Branch
- P.O. Box 80

Baltimore, Maryland 21203

(31)

Class of Care	Rate	Days	Total Charges
C	60.00	7	420.00

(32) TYPE OF BILL

PROFESSIONAL COMPONENTS: (33) RADIOLOGY | (34) PATHOLOGY | (35) OTHER | (36) MOST COMM SEMI-PVT RATE | (37)

(38) CODE	(39) DESCRIPTION	(40)	(41) TOTAL CHARGES	(42) PRIMARY PAYOR	(43) SEC. PAYOR ITEM 20	(44) TERT. PAYOR ITEM 25	(45) PATIENT
	Seven (7) days routine room & board		420 00				
	Operating Room Charges		175 00				
	Anesthesia - RN		40 00				
	Supplies - Gastroscopy		10 00				
	Lab - CBC with Diff		8 00				
	Chest X-Ray 2 views		27 00				
	TOTALS →	(46)	(47) 680 00	(48) 300 00	(49)	(50)	(51)

BLOOD RECORD (PINTS): (52) FURN. | (53) REPLACED | (54) NOT REPLACED | (55) DED | (56) CHG/PT. | (57) BLOOD DED | (58) FMLY PLNNG | (59) TREATMENT AUTHORIZATION | (60) INPATIENT DEDUCTIBLE | (61) DEDUCTIBLES | (62) DEDUCTIBLES | (63) DEDUCTIBLES | (64) PAID BY PATIENT

Item 30–Bill to: For billing under the Migrant Hospitalization Program enter:

Office of Direct Reimbursement, HCFA
Health Services Studies Branch
P.O. Box 80
Baltimore, Maryland 21203

Item 31–(Untitled)–Enter the accommodation information in the format shown below. Accommodations should be shown only for the period covered, shown in Item 65.

The accommodation days should not include the day of discharge, even where the discharge was late.

Ancillary charges for day of discharge, death, or the day on which a leave of absence begins, should be shown in the proper department. (Columns 39 & 41).

When the patient is discharged on his first day of entitlement, it is permissible to submit a billing form with no accommodation charge, but with ancillary charges shown in columns 39 & 41.

Use a separate line in the accommodations block for each accommodation.

Complete block 31 as follows:

Class of Care–Use codes to denote

B - 1 bed	E - Intensive Care	G - Nursery
C - 2, 3 or 4 beds	F - Other Accommodations	H - Special Nursery
D - 5 or more beds		

Rate–Enter the daily room and board rate for each type of accommodation occupied by the patient.

Days–Enter the total number of days occupied for each room the patient utilized.

Total Charges–Multiply the rate times the number of days in that class of room to determine the total charge. If a private room is provided and it is not considered medically necessary the rate used will be the most prevalent semi-private rate.

Items 32-35–No entries are necessary.

Item 36–Most Common Semi-Private Rate–Indicate the most prevalent semi-private room rate. The most prevalent semi-private room rate is determined from hospital data as follows:

1		2		3		4
Each Type of Accommodation	X	Total Rooms of Each Type	=	Total beds for Each Type	@	Rate Per Day for Each Type
2 beds		10		20		$60
2 beds		8		16		70
3 beds		2		6		40
4 beds		1		4		30

The most prevalent charge for semi-private accommodations is the single rate charged for the largest entry under column 3, total beds. Thus, the most prevalent rate would be $60.00.

Items 37 & 38–No entries necessary.

Item 39–Description–Enter a description of each service provided.

In lieu of completing Items 39 thru 48, you may attach an itemized and summary statement of charges to the UB-16.

Item 40--Entry necessary.

Item 41--Total Charges--Enter the charge for each service listed in item 39.

Item 42-46--No entries necessary.

Item 47--Enter the total of column 41 in this block.

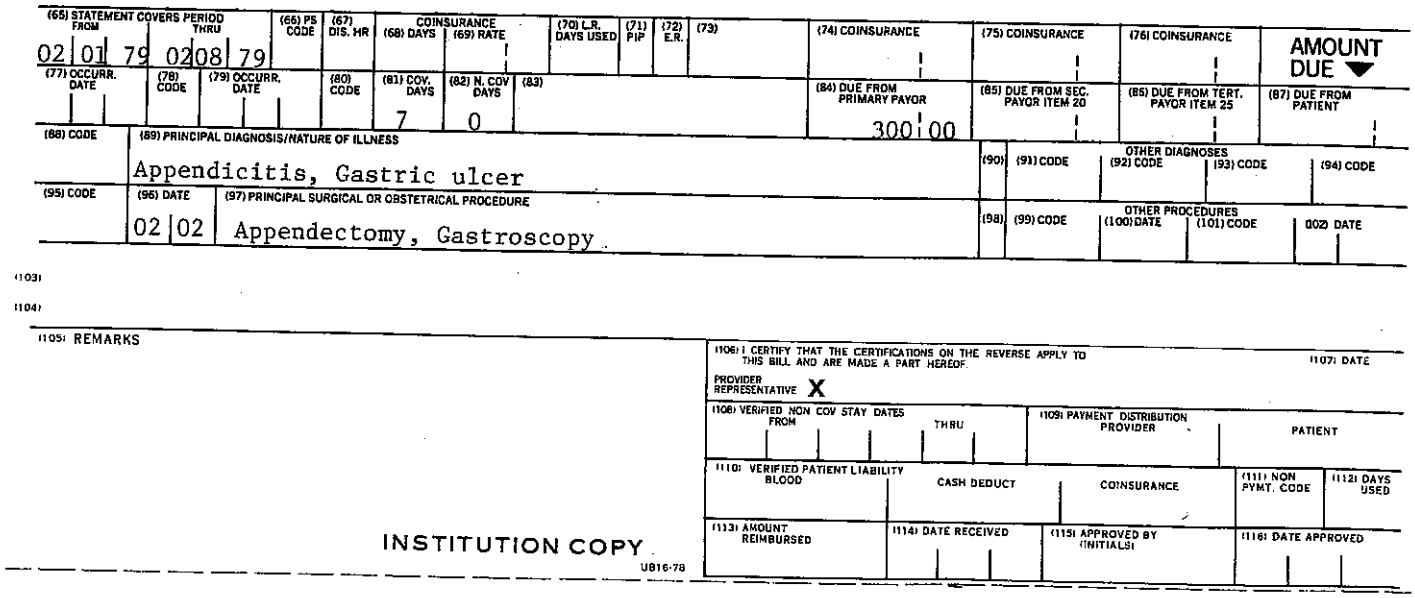
Item 48--Enter the total amount you expect to receive from any Federal, State or local government agency or other third-party who assumed responsibility for a part of the inpatient services.

Item 49-63--No entries are necessary.

NOTE: In lieu of completing Items 39 thru 48, you may attach an itemized and summary statement of charges to the UB-16.

Item 64--Paid by Patient--No entry necessary.

NOTE: The agreement with the hospital specifies that any monies incorrectly collected from the beneficiary for inpatient services covered by the benefit plan will be returned to the beneficiary.



Item 65--Statement Covers Period--Enter the inclusive days being reported on the bill. The "FROM" entry will reflect the date the patient became eligible for migrant hospitalization entitlement under the current admission. The "THRU" entry will show the date of discharge, death, or the date benefits were exhausted.

Example 1: A migrant patient was admitted to the hospital August 20, 1978. The patient's benefits began September 1, 1978. The patient was discharged September 15, 1978. Entries would be shown as follows:

Example 2: The patient was admitted October 10, 1978 and his benefits were exhausted October 15, 1978. Entries would be shown below regardless of the date the bill was prepared.

Items 66-80--No entries necessary.

Item 81–Covered Days–Enter total days covered by the Migrant Hospitalization Program. Days covered should equal the total days in the period entered in Item 65 less non-covered days entered in Item 82.

Example: If Item 65 is from 09/01/78 through 09/15/78 and Item 82 is 01 enter 13.

NOTE: When a patient is admitted as an inpatient with the expectation that he will remain over night, but he is discharged or dies before midnight, "01" will be entered in Item 81.

Item 82–Non-Covered Days–Enter the total number of days included in the period shown in Item 65. Non-covered days include:

a. Days under the guarantee of payment provision which are more than three (3) calendar days after the date of admission.
b. Days for which no payment can be made because covered days were exhausted.
c. Days for which no payments can be made because a Workmen's Compensation benefit payment is being made or can be expected to be made.
d. Days for which no payment can be made because the medical services rendered were furnished without cost or will be paid for by the Veterans Administration.
e. Days for which no payment can be made because payment will be made under a National Institutes of Health grant.
f. Days after the date covered services ended such as non-covered level of care.
g. Day of referral to the participating hospital when the patient is transferred at once to a non-participating hospital.

Example: The patient is admitted to the hospital under emergency conditions on October 23, 1978. On October 25, 1978 the hospital is notified the patient has one day of benefits remaining. The patient is discharged on October 27, 1978. Enter "01" in Item 82.

Item 83–No entry necessary.

Item 84–Due From Primary Payor–If another insurer has covered a portion of the hospital stay the total amount of payment received from the insuring agency is entered here. A copy of the payment notice from the other insurer must accompany any billing to the Migrant Health Program for the remaining benefits not covered by the other insurer.

Items 85-88–No entries necessary.

Item 89–Principal Diagnosis/Nature of Illness–Enter all of the diagnoses shown on the face sheet or discharge sheet of the patient's record which relate to the condition requiring the current hospitalization. The primary diagnosis is the diagnosis of the illness or condition which was the primary reason for the patient's hospitalization. Other diagnoses which are identified during the patient's hospitalization should also be shown. Diagnoses should be shown in accordance with recognized nomenclature, e.g., International Classification of Disease Adapted, Current Medical Terminology, or Standard Nomenclature of Diseases and Operations.

Items 90-95–No entries are necessary.

Item 96–Date–Enter the month and day that the principal procedure indicated in Item 97 was performed.

Item 97–Principal Surgical or Obstetrical Procedure–Obstetrical or surgical procedures should be specified in detail using recognized nomenclature such as that used in Current Medical Terminology, Standard Nonmenclature of Diseases and Operations, etc. For the purpose of this form, surgery includes incision, excision, amputation, introduction, endoscopy, repair, destruction, suture, and manipulations.

Enter the name of the procedures, if any, shown on the face sheet or discharge sheet of the patient's hospital record which performed during the period covered by the bill. Show the dates of each operation or endoscopic procedure listed. List first those procedures related to the primary diagnosis. List all other operation and endoscopic procedures in the same order as shown on the face sheet or discharge sheet.

Items 98-104—No entries are necessary.

Item 105—Remarks—This space may be used by the hospital to explain other entries on the billing form.

Item 106—Provider Certification Signature—Enter the signature of the provider representative certifying that the certifications on the reverse side of Form UB-16, if applicable to the bill, are made a part thereof.

Item 107—Date—Enter the date on which the bill was signed.

Items 108-116—For MHP use only.

370 PROCEDURES FOR REIMBURSEMENT OF PROFESSIONAL SERVICES

370.1 General Information

Bills for professional services must be submitted to ODR on the form designated for use by the Migrant Hospitalization Program. Form HSA-380, Bill for Patient Services by Physicians is the designated form. Physician billings may be submitted by one of three methods according to the option selected by the participating hospitals and physicians and approved by the local Migrant Health project.

Option 1—Hospital Submits Physician Bills—Under this option, the hospital where the patient received covered inpatient services requests the physicians who rendered services to complete the billing form, HSA-380, and submits the physician forms to ODR along with the hospital's bill for services.

Option 2—Project Submits Physician Bills—Under this option, the local Migrant Health project requests that physicians rendering services to inpatients covered under the Migrant Hospitalization Program complete the HSA 380. The project submits the bills to ODR. The project assures that all identifying information is present to permit ODR to associate the physician services with the corresponding hospital bill.

Option 3—Physicians Submit Bills Directly to ODR—Under this option, the physicians billing the program may prepare forms HSA-380 and submit them directly to:

Office of Direct Reimbursement, HCFA
Health Services Studies Branch
P.O. Box 80
Baltimore, Maryland 21203

NOTE: If Option 2 or 3 is selected, there is a greater chance for delay in payment to the physician because ODR must associate the bills for professional services with the hospital bill which has been submitted separately. Bills for physician services may not be reviewed and approved for payment without the corresponding hospital bill; consequently, if the hospital is delayed in submitting its bill, the physician bills will likewise be delayed. In addition, the physicians' office staffs may not be as aware of the correct claim number as are the hospitals and projects. If ODR cannot identify the migrant beneficiary for whom services are being billed, the billing form must be returned for development. This will also cause a delay in payment.

370.2 Instructions for Completing Form HSA-380, Bill for Patient Services by Physicians—Migrant Hospitalization Program

There are two ways in which a physician may bill the Migrant Hospitalization Program for services. The physician may bill *separately* or, if in a group practice, *under the group's name and tax identification number.* If a physician is a member of a group practice and wishes to have reimbursement reported separately, he or she must bill on a separate HSA 380, show his or her own tax identification number in Item 7 a., and name and address in Item 7. If a physician is in a group practice and reimbursement is made to the group, then the name and address of the group practice is shown in Item 7 and the group's tax identification number is shown in Item 7 a. However, each physician in the group who provided a service to the migrant patient must be identified in Item 10 c. In this case, individual tax numbers are not needed. The ODR will accumulate all reimbursement under the tax number shown in Item 7 a. and all checks will be sent in the name of the group.

370.3 Explanation of Each Item on Form HSA-380, Bill for Patient Services by Physicians (Sample attached)

Item 1	Name	Show patient's full name.
Item 2	Sex	Check Male or Female.
Item 3	Claim Number	Show the seven digit account number assigned by the local migrant health project.
Item 4	Patient Address	Enter the patient's local address.
Item 5	Date of Birth	Enter the patient's date of birth.
Item 6	Name of Hospital	Enter name and address of the hospital where services were provided.
Item 7	Name/Address of Physician or Physician Group	Show the name and the address of the physician or group providing the services to the migrant patient.
Item 7a	IRS Tax Number	Enter the IRS assigned tax identification number for the physician or group.
Item 8	Admission/Discharge	Enter the dates the patient was admitted to and discharged from the hospital. Date must agree with the hospital bill.
Item 9	Patient Signature	Obtain the signature of the patient or his authorized representative, or show an "X" in the box if signature is on record with the physician, hospital or local migrant health project.
Item 10	Statement of Services	a. Date of Each Service—Indicate the date of each service provided by the physician(s) identified in item 10c. Dates must be within the dates of admission and discharge. b. Description—Describe the surgical or medical procedures and any other services covered by the program. Separate each service description by date. Be sure to use standard terminology which can be converted to the California Relative Value Studies coding process. *NOTE:* Anesthesiology services must include time units. c. Physician Name and Specialty—This item must be completed only when more than one member of a group practice is billing the Migrant Hospitalization Program under the group's name and tax identification number. Enter the names of each physician and the appropriate specialty for each service.
Item 11	Provider Signature	The signature of the physician or authorized representative and the date the bill was prepared must be entered.

NOTE: Failure to complete the billing form in its entirety may cause a delay in payments. *Please review the form carefully* before mailing to the Office of Direct Reimbursement. To obtain a supply of forms HSA-380, call the Health Services Studies Branch, Office of Direct Reimbursement, HCFA, Baltimore, Maryland 21235. The telephone number is (301) 594-7502.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH SERVICES ADMINISTRATION

370.3 (a)

BILL FOR PATIENT SERVICES BY PHYSICIANS
MIGRANT HOSPITALIZATION PROGRAM

TYPE OR PRINT ALL ITEMS

INSTRUCTIONS IN PROCEDURES FOR HOSPITAL AND PHYSICIAN BILLING

NOTICE—Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law.

1. PATIENT'S LAST NAME	FIRST NAME	MI	2. SEX	3. CLAIM NUMBER (*Migrant Beneficiary account number*)
Jones	Jane		☐ M ☒ F	2199987

4. PATIENT'S ADDRESS (*Street number, City, State, Zip Code*)	5. DATE OF BIRTH	6. NAME OF HOSPITAL
123 Main Street Springfield, Florida 66666	10/03/43	Springfield General Hospital Springfield, Florida

7. NAME AND ADDRESS OF PHYSICIAN/PHYSICIAN GROUP	7a. IRS TAX NUMBER	8. ADMISSION/DISCHARGE DATES	
M. Justice 2542 W. 7th Street, Mason, Florida 23434	F1-234156	09/12/78	09/24/78

9. I authorize release of any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original.

SIGNATURE CONTAINED IN ☐ PROVIDER'S/ PROJECT'S RECORD	SIGNATURE (*Patient or authorized representative*) (*Signature by mark must be witnessed*)	DATE

10a. DATE OF EACH SERVICE	b. DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES FOR EACH DATE GIVEN	c. PHYSICIAN NAME AND SPECIALTY	d. CHARGE FOR PHYSICIAN SERVICES	LEAVE BLANK
09/12/78	Initial hosp. visit incl. routine history & physical exam.	M. Justice, M.D. OB/GYN	$40.00	
09/13/78 thru 09/15/78	Follow-up Care 3 days @ $15.00		$45.00	
09/16/78	Assisted Dr. Jackson, Abd. Hysterectomy, Cystectomy		$150.00	

11. SIGNATURE OF PROVIDER REPRESENTATIVE OR PROJECT DIRECTOR	DATE			
	09/30/78	TOTALS	$235.00	

HSA-380
6-78

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH SERVICES ADMINISTRATION

BILL FOR PATIENT SERVICES BY PHYSICIANS
MIGRANT HOSPITALIZATION PROGRAM

TYPE OR PRINT ALL ITEMS

INSTRUCTIONS IN PROCEDURES FOR HOSPITAL AND PHYSICIAN BILLING

NOTICE—Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law.

1. PATIENT'S LAST NAME	FIRST NAME	MI	2. SEX	3. CLAIM NUMBER *(Migrant Beneficiary account number)*
Jones	Jane	B.	☐ M ☒ F	2199987

4. PATIENT'S ADDRESS *(Street number, City, State, Zip Code)*	5. DATE OF BIRTH	6. NAME OF HOSPITAL
123 Main Street Springfield, Florida 66666	10/03/43	Springfield General Hospital Springfield, Florida

7. NAME AND ADDRESS OF PHYSICIAN/PHYSICIAN GROUP	7a. IRS TAX NUMBER	8. ADMISSION/DISCHARGE DATES	
D. Jackson & Associates 56 Jay Street, Mason, Florida 23445	F1-876543	09/12/78	09/24/78

9. I authorize release of any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original.

SIGNATURE CONTAINED IN ☐ PROVIDER'S/ PROJECT'S RECORD	SIGNATURE *(Patient or authorized representative) (Signature by mark must be witnessed)*	DATE

10a. DATE OF EACH SERVICE	b. DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES FOR EACH DATE GIVEN	c. PHYSICIAN NAME AND SPECIALTY	d. CHARGE FOR PHYSICIAN SERVICES	LEAVE BLANK
09/16/78	Appendectomy, Abd. Hysterectomy Cystectomy	D. Jackson, Surgeon	$750.00	
09/16/78	Anesthesia for Hysterectomy Time: 2:35 - 3:30	F. David, M.D. Anesthesiologist	$150.00	

11. SIGNATURE OF PROVIDER REPRESENTATIVE OR PROJECT DIRECTOR	DATE			
	09/30/78	TOTALS	$ 900.00	

HSA-380
6-78

380 PAYMENT PROCESS

The Office of Direct Reimbursement will usually authorize payment to hospitals and physicians within 4 weeks of billing. Payment will be made by U.S. Treasury check which will display a legend for hospitals which refers to a pay list date, and for physicians which shows the surname of the migrant beneficiary for whom payment is being made.

The paylist displays a line item for each hospital stay which is being reimbursed in the current payment run. The bills for physician services rendered during the inpatient stay will be shown following the explanation of hospital benefits. Late-filed physician claims will be shown as separate items on the pay list; i.e., the corresponding hospital stay will *not* be shown again on the pay list.

A sample pay list format is presented following this page.

MIGRANT HOSPITALIZATION PROGRAM PAYMENT LIST
FROM: HEALTH CARE FINANCING ADMINISTRATION
MEDICARE BUREAU
DIVISION OF DIRECT REIMBURSEMENT
P.O. BOX 80
BALTIMORE, MARYLAND 21203

HOSPITAL PAYMENT ADDRESS
BUSINESS MANAGER
GILA COUNTY HOSPITAL
123 E DRAGON ST
SUN VALLEY AZ 85350

PAYMENT DATE 12/11/78

PROVIDER NUMBER 7007MW

PAGE 1

PROJECT ADDRESS
MIGRANT HEALTH PROJECT, INC.
PO BOX 777
GILAMONSTER AZ 85350

PATIENT NAME	CLAIM NUMBER	MEDICAL RECORD NO.	FROM DATE	THRU DATE	COV DAYS	HOSP REIMB	PHYSICIAN/AMBULANCE OR TRANSFER NAME	PHYS REIMB
PERSON 1	9110477	895371	08-16-78	08-19-78	03	336.00	BR B H WELBY	5.50
							BR R KILEY	213.00
BABY PERSO	9110477	895371	08-17-78	08-19-78	02	58.00		
PERSON 2	9110567	895379	08-16-78	08-20-78	04	448.00	BR K G BLITZEN	500.00
							BR B H WELBY	40.50
							BR W L SHAKEY	81.00
BABY PERSO	9110567	895379	08-17-78	08-20-78	03	87.00		
PERSON 3	9111632	894909	07-27-78	08-01-78	05	560.00	BR F G ZONKERS	535.00
							OR E N STITCHER	105.80
							BR B H WELBY	128.00
							BR W L SHAKEY	109.00
PERSON 4	9112199	893920	06-12-78	06-18-78	06	672.00	OR R C BUZZARD	90.00
							BR B H WELBY	40.50
							OR G N MERCINARY	500.00
PERSON 5	9112366	896011	09-13-78	09-16-78	03	336.00	OR B H WELBY	8.50
							BR G B KILDARE	275.00
BABY PERSO	9112366	896011	09-13-78	09-16-78	03	87.00		

* SUPPLEMENTS PREVIOUS PAYMENT ** CORRECTION OF PREVIOUS PAYMENT *** PATIENT'S BENEFITS WITHIN THIS ILLNESS ARE EXHAUSTED
**** AMOUNT WAS DEDUCTED AS AN OVERPAYMENT ***** REMAINDER OF REIMBURSEMENT FOR THIS STAY WAS FURNISHED BY ANOTHER SOURCE

MIGRANT HOSPITALIZATION PROGRAM PAYMENT LIST
FROM: HEALTH CARE FINANCING ADMINISTRATION
MEDICARE BUREAU
DIVISION OF DIRECT REIMBURSEMENT
P.O. BOX 80
BALTIMORE, MARYLAND 21203

HOSPITAL PAYMENT ADDRESS
BUSINESS MANAGER
GILA COUNTY HOSPITAL
123 E DRAGON ST
SUN VALLEY AZ 85350

PAYMENT DATE 12/11/78

PROVIDER NUMBER 7007MW

PAGE 2

PROJECT ADDRESS
MIGRANT HEALTH PROJECT, INC.
PO BOX 777
GILAMONSTER AZ 85350

PATIENT NAME	CLAIM NUMBER	MEDICAL RECORD NO.	FROM DATE	THRU DATE	COV DAYS	HOSP REIMB	PHYSICIAN/AMBULANCE OR TRANSFER NAME	PHYS REIMB
PERSON 6	9112560	895795	09-05-78	09-13-78	08	896.00	DR W L KILEY	63.00
							DR R C CASEY	153.00
							DR ROBERT J FLASH	124.60
							DR FRANCIS P BARFF	773.00
PROVIDER TOTAL:		ADM: 6	CLAIMS: 27		37	3,480.00		3,753.40

* SUPPLEMENTS PREVIOUS PAYMENT ** CORRECTION OF PREVIOUS PAYMENT *** PATIENT'S BENEFITS WITHIN THIS ILLNESS ARE EXHAUSTED
**** AMOUNT WAS DEDUCTED AS AN OVERPAYMENT ***** REMAINDER OF REIMBURSEMENT FOR THIS STAY WAS FURNISHED BY ANOTHER SOURCE

Exhibit I Provider Reimbursement Contract for Inpatient Hospital Care

Exhibit II Inpatient Hospital Care of High Risk Maternity and Newborn Infant Care

Exhibit III Conditions of Participation for Migrant Health Projects

MIGRANT HOSPITALIZATION PROGRAM

PROVIDER REIMBURSEMENT CONTRACT FOR INPATIENT HOSPITAL CARE

This agreement is entered as of this _____ day of _____, 19__, by and between, _____ (hereinafter referred to as the "Provider"), the Bureau of Community Health Services, Health Services Administration, Department of Health and Human Services (hereinafter referred to as "BCHS"), the Office of Direct Reimbursement, Health Care Financing Administration, DHHS (hereinafter referred to as "ODR"), and the _____ (hereinafter referred to as the "Project").

(name of hospital)

(migrant health project)

Witnesseth that:

The Provider, BCHS, ODR, and Project mutually agree as follows:

Provider Responsibilities

1. That the purpose of this agreement is to provide the inpatient hospital care and related physician services for eligible migrant workers and their family dependents (hereinafter referred to as "beneficiaries"), under Section 329 of the Public Health Service Act, during the period of this agreement subject to the terms and conditions expressed herein.

2. That the Provider will provide inpatient hospital services described in Section 100, of the manual, *Migrant Hospitalization Program,* to all beneficiaries referred to them by the Project in accordance with this agreement.

3. The Provider may accept beneficiaries referred by other migrant health projects participating in the Migrant Hospitalization Program. If patients are accepted for inpatient care based on a referral from projects other than _____, the Provider agrees to accept the reimbursement procedures defined in this contract under Reimbursement Procedures, Section 1, 2, 3.

4. That the Provider will assign an attending physician for the beneficiary when requested by the Project.

5. That when services required by any beneficiary referred to it by the Project are not available at the Provider's facility, the Provider will refer such beneficiary to another hospital which provides such service.

6. That the Provider will submit a hospital medical record abstract and a discharge summary to the Project for each beneficiary.

7. That the Provider will submit billing forms to ODR, in such form and such manner as will be prescribed by ODR, to obtain reimbursement for the following services rendered to beneficiaries:

   a. Hospital services rendered by the Provider.
   b. Hospital services rendered by a nonparticipating hospital on a formal referral basis from the Provider, the proceeds of which shall be forwarded to the nonparticipating hospital.
   c. Any proper bills rendered by other Providers associated with the beneficiary's hospitalization.

Reimbursement Procedures

1. The Provider shall be reimbursed for covered services rendered to beneficiaries at a per diem rate determined on the basis of the Provider's average costs or charges, whichever is lower. The parties hereto agree to an inpatient per diem rate of $ _____ per patient and a routine nursery per diem rate of $ _____ per patient. The per diem rates of reimbursement shall represent the full charge for all such services, and patients will not be billed for deductibles, copayments, or other charges for covered services rendered.

2. Payments to the Provider for services covered under the Migrant Hospitalization Program are not subject to retroactive settlements. However, any over or under payments resulting from billing or claim processing errors will be adjusted when detected.

   The Provider will return to a patient any monies incorrectly collected for inpatient services covered by the benefit plan.

3. The Provider will receive reimbursement from ODR for covered services as defined in the instructions set forth in Section 110, of the manual, *Migrant Hospitalization Program,* which is hereby incorporated as a part of this agreement, rendered to each beneficiary for a maximum of thirty (30) inpatient hospital days during any benefit period, *provided,* that elective admissions must be certified by the Project prior to admission if reimbursement is to be made under this program. It is *further provided* that emergency admissions also must be certified by the Project, with written certification completed within three (3) calendar days after hospital admission. The Provider is guaranteed a maximum of three (3) days' reimbursement should an emergency admission and subsequent inpatient services be provided for a patient believed to be an eligible beneficiary and for whom a Referral Form has been completed but who, in fact, has exhausted benefits to which the patient had been entitled.

4. All admissions to a nonparticipating hospital for services not available through the Provider must be by referral or transfer from the Provider. Other applicable contingencies relating to the use of nonparticipating hospitals are described in Section 110.6 of the manual, *Migrant Hospitalization Program.*

Terms, Conditions and Limitations

1. Eligibility. All beneficiaries will be identified and certified for service by the Project by the use of appropriate forms.

2. Accommodations. The care provided to migrant beneficiaries must be in a semi-private room —2-, 3-, 4-bed rooms—or in a private room if medically necessary. Where the Provider's bed complement consists of only ward accommodations, such facilities will be acceptable.

3. Certification and Recertification. For elective or emergency admissions, a physician will determine the necessity for admission. The attending physician must certify to the need for continuing hospitalization when the length of stay exceeds 12 days. The recertification must be recorded in the physician's progress note, or in the manner established as routine for Medicare patients, on the 13th day and must indicate the reason for continued hospitalization and the estimated length of stay.

4. Utilization Review. Program patients must be reviewed in the same manner as Title XVIII (Medicare) patients as provided for in regulations pursuant to Section 1861(k) Utilization Review, of the Social Security Act. Where a Professional Standards Review Organization (PSRO) has been established and has assumed review in the facility, as provided for in regulations pursuant to Title XI of the Social Security Act, review should be performed in the manner established by the PSRO for Medicare patients.

5. Civil Rights. The requirements of Title VI of the Civil Rights Act of 1964 apply to this program. Particular attention is directed to Section 601 of the Act which provides that no person shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance. Regulations implementing such Title VI (45 CFR Part 80) also apply.

6. Limitations. Limitations in coverage for psychiatric care and rehabilitation services are described in Section 110.7 and exclusions in coverage are described in Section 110.8 of the manual.

BCHS Responsibilities

BCHS, on behalf of each beneficiary agrees to make, through ODR, those payments required for inpatient hospital services as described in Section 100 of the manual. In addition, BCHS will monitor overall program operation, evaluate program progress, and analyze program results.

ODR Responsibilities

ODR will receive and process properly authorized claims for reimbursement from participating hospitals, and will authorize the Treasury Department to issue payment therefor as expeditiously as possible. ODR will provide to BCHS financial and statistical data in formats as presently agreed upon or as may become necessary for appropriate program oversight.

Project Responsibilities

Project, through its Migrant Health Project Director, will discharge the responsibilities specified in "Conditions of Participation for Migrant Health Projects" (as set forth in Exhibit III which is hereby incorporated as a part of this agreement).

Special Provisions

1. Confidential Nature and Limitations of Use of Information and Records. The parties hereto agree that, in carrying out this program, information which identifies patients by name will not be disclosed to outside parties without the patient's written consent. (An example of an acceptable form of consent is found in Section 350 of the manual.)

2. Retention and Availability of Records. The prevailing Medicare requirements regarding retention of records, including medical records, and their availability for inspection and audit following the termination of the agreement will apply. In addition, until the termination of this program the parties hereto will have access to and the right to examine any directly pertinent books, documents, papers and records relating to the cost of hospital services.

3. Termination Clause. Any party may terminate this agreement upon 30 days written notice to the other parties; *provided,* that in the event this agreement is terminated for any reason, the Provider shall continue to furnish services and facilities in accordance with the terms hereof to all beneficiaries who were admitted to the Provider prior to the expiration of 30-day notice period.

EFFECTIVE PERIOD OF AGREEMENT. This agreement is effective as of _____

and will terminate on _____ .

Accepted for Provider of Services by:

_____
Name

_____
Title

_____
Date

Accepted for Bureau of Community Health Services, HSA, DHHS

_____
Name

_____
Title

_____
Date

Accepted for Office of Direct Reimbursement, HCFA, DHHS

_____
Name

_____
Title

_____
Date

Accepted for Migrant Health Program Project

_____
Name

_____
Title

_____
Date

EXHIBIT II

MIGRANT HOSPITALIZATION PROGRAM

PROVIDER REIMBURSEMENT CONTRACT FOR INPATIENT HOSPITAL CARE OF HIGH RISK MATERNITY AND NEWBORN INFANT CARE PROGRAM FOR MIGRANTS

This agreement is entered as of this _____ day of _____ ,19____, by and between _____ (hereinafter referred to as the
(name of hospital)
"Provider"), the Bureau of Community Health Services, Health Services Administration, Department of Health and Human Services (hereinafter referred to as "BCHS"), the Office of Direct Reimbursement, Health Care Financing Administration, DHHS (hereinafter referred to as "ODR"), and the_____ (hereinafter referred to as the "Project").
(migrant health project)

Witnesseth that:

The Provider, BCHS, ODR, and Project mutually agree as follows:

Provider Responsibilities

1. That the purpose of this agreement is to provide the inpatient hospital care and related physician services for eligible migrant mothers and their infants (hereinafter referred to as "beneficiaries"), under Section 329 of the Public Health Service Act, during the period of this agreement subject to the terms and conditions expressed herein.

2. That the Provider will provide inpatient hospital services described in Section 100, of the manual, *Migrant Hospitalization Program,* to all beneficiaries of the high risk program referred to them by the Project in accordance with this agreement. All other types of hospital admissions are specifically excluded from this program.

3. The Provider may accept beneficiaries referred by other Migrant Health Projects participating in the Migrant Hospitalization Program. If patients are accepted for inpatient care based on a referral from Projects other than _____ , the Provider agrees to accept the reimbursement procedures defined in this contract under Reimbursement Procedures, Section 1, 2, and 3.

4. That the Provider will assign an attending physician for the beneficiary when requested by the Project.

5. That when services required by any beneficiary referred to it by the Project are not available at the Provider's facility, the Provider will refer such beneficiary to another hospital which provides such services.

6. That the Provider will submit a hospital medical record abstract and a discharge summary to the Project for each beneficiary.

7. That the Provider will submit billing forms to ODR, in such form and such manner as will be prescribed by ODR, to obtain reimbursement for the following services rendered to beneficiaries:

   a. Hospital services rendered by the Provider.
   b. Hospital services rendered by a nonparticipating hospital on a formal referral basis from the Provider, the proceeds of which shall be forwarded to the nonparticipating hospital.
   c. Any proper bills rendered by other Providers associated with the beneficiary's hospitalization.

Reimbursement Procedures

1. The Provider shall be reimbursed for covered services rendered to beneficiaries at a per diem rate determined on the basis of the Provider's average costs or charges, whichever is lower. The parties hereto agree to an inpatient per diem rate of $ _____ per patient and a routine nursery per diem rate of $ _____ per patient. The per diem rates of reimbursement shall represent the full charge for all such services, and patients will not be billed for deductibles, copayments, or other charges for covered services rendered.

2. Payments to the Provider for services covered under the Migrant Hospitalization Program are not subject to retroactive settlements. However, any over or under payments resulting from billing or claim processing errors will be adjusted when detected.

   The Provider will return to a patient any monies incorrectly collected for inpatient services covered by the benefit plan.

3. The Provider will receive reimbursement from ODR for covered services (as defined in the instructions set forth in Section 110, of the manual, *Migrant Hospitalization Program,* which is hereby incorporated as a part of this agreement, rendered to each beneficiary for a maximum of thirty (30) inpatient hospital days during any benefit period, *provided,* that elective admissions must be certified by the Project prior to admission if reimbursement is to be made under this program. It is *further provided* that emergency admissions also must be certified by the Project, with written certification completed within three (3) calendar days after hospital admission. The Provider is guaranteed a maximum of three (3) days' reimbursement should an emergency admission and subsequent inpatient services be provided for a patient believed to be an eligible beneficiary and for whom a Referral Form has been completed but who, in fact, has exhausted benefits to which the patient had been entitled.

4. When it becomes necessary to admit the newborn infant to the status of regular hospital patient following discharge of the mother, the infant will be subject to the established inpatient per diem rate as stated above. Inpatient care may then be continued for a maximum of thirty (30) days on the same basis as other program beneficiaries. In addition, newborn beneficiaries of this program will remain eligible for hospital care under this agreement until the age of one (1) year is reached.

5. All admissions to a nonparticipating hospital for services not available through the Provider must be by referral or transfer from the Provider. Other applicable contingencies relating to the use of nonparticipating hospitals are described in Section 110.6 of the *Migrant Hospitalization Program* manual.

Terms, Conditions, and Limitations

1. Eligibility. All beneficiaries will be identified and certified for services by the Project by the use of appropriate forms.

2. Accommodations. The care provided to migrant beneficiaries must be in a semi-private room –2-, 3-, 4-bed rooms– or in a private room if medically necessary. Where the Provider's bed complement consists of only ward accommodations, such facilities will be acceptable.

3. Certification and Recertification. For elective or emergency admissions, a physician will determine the necessity for admission. The attending physician must certify to the need for continuing hospitalization when the length of stay exceeds twelve (12) days. The recertification must be recorded in the physician's progress note, or in the manner established as routine for Medicare patients, on the 13th day and must indicate the reason for continued hospitalization and the estimated length of stay.

4. Utilization Review. Program patients must be reviewed in the same manner as Title XVIII (Medicare) patients as provided for in regulations pursuant to Section 1861(k) Utilization Review, of the Social Security Act. Where a Professional Standards Review Organization (PSRO) has been established and has assumed review in the facility, as provided for in regulations pursuant to Title XI of the Social Security Act, review should be performed in the manner established by the PSRO for Medicare patients.

5. Civil Rights. The requirements of Title VI of the Civil Rights Act of 1964 apply to this program. Particular attention is directed to Section 601 of the Act which provides that no person shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance. Regulations implementing such Title VI (45 CFR Part 80) also apply.

6. Limitation. Limitations in coverage for psychiatric care and rehabilitation services are described in Section 110.7 and exclusions in coverage are described in Section 110.8 of the manual.

BCHS Responsibilities

BCHS, on behalf of each beneficiary agrees to make, through ODR, those payments required for inpatient hospital services as described in Section 100 of the manual. In addition, BCHS will monitor overall program operation, evaluate program progress, and analyze program results.

ODR Responsibilities

ODR will receive and process properly authorized claims for reimbursement from participating hospitals, and will authorize the Treasury Department to issue payment therefor as expeditiously as possible. ODR will provide to BCHS financial and statistical data in formats as presently agreed upon or as may become necessary for appropriate program oversight.

Project Responsibilities

Project, through its Migrant Health Project Director, will discharge the responsibilities specified in "Conditions of Participation for Migrant Health Projects" which are set forth in Exhibit III which is hereby incorporated as a part of this agreement.

Special Provisions

1. It is expressly understood that physician and hospital-based services to beneficiaries are restricted to prenatal care, delivery service, post partum care and necessary care of the infant up to age 1 year. Medical needs of these particular beneficiaries other than those itemized above will not be provided under terms of this agreement.

2. Confidential Nature and Limitations of Use of Information and Records. The parties hereto agree that, in carrying out this program, information which identifies patients by name will not be disclosed to outside parties without the patient's written consent. An example of an acceptable form of consent is found in Section 350 of the manual.

3. Retention and Availability of Records. The prevailing Medicare requirements regarding retention of records, including medical records, and their availability for inspection and audit following the termination of the agreement will apply. In addition, until the termination of this program the parties hereto will have access to and the right to examine any directly pertinent books, documents, papers and records relating to the cost of hospital services.

4. Termination Clause. Any party may terminate this agreement upon thirty (30) days written notice to the other parties; *provided*, that in the event this agreement is terminated for any reason, the Provider shall continue to furnish services and facilities in accordance with the terms hereof to all beneficiaries who were admitted to the Provider prior to the expiration of 30-day notice period.

EFFECTIVE PERIOD OF AGREEMENT. This agreement is effective as of _____

and will terminate on _____ .

Accepted for Provider of Services by:

_____
Name

_____
Title

_____
Date

Accepted for Bureau of Community Health Services, HSA, DHHS

_____
Name

_____
Title

_____
Date

Accepted for Office of Director Reimbursement, HCFA, DHHS

_____
Name

_____
Title

_____
Date

Accepted for Migrant Health Project by:

_____
Name

_____
Title

_____
Date

MIGRANT HOSPITALIZATION PROGRAM

CONDITIONS OF PARTICIPATION FOR MIGRANT HEALTH PROJECTS

PROJECT NAME: _____

PROJECT ADDRESS: _____

Purpose of Program

The purpose of the Migrant Hospitalization Program is to provide inpatient hospital care effectively and economically for a selected migrant population through the use of a fiscal intermediary that has established quality, cost, and utilization controls. The program is a joint effort of the Bureau of Community Health Services (BCHS), Office of Direct Reimbursement (ODR), participating Migrant Health Projects, and hospitals in the selected areas.

Conditions of Participation

The undersigned accept the following responsibilities on behalf of the above-named Project as conditions of participation in the Migrant Hospitalization Program:

1. The Project Director will complete the Referral Form for hospitalization provided by BCHS and certify that a patient is a domestic agricultural migrant worker or a family dependent of such worker as defined in the Migrant Health Program regulations. The Project Director shall not certify for benefits under this program those patients who have hospital care coverage from another source. After medical necessity has been determined by a physician, the Project Director will certify the individual's eligibility and make the referral to a participating hospital. In cases of emergency admission, upon notification by the participating hospital, the Project Director will initiate the eligibility determination and certification process in writing within three (3) calendar days.

2. The Project Director will verify by telephone with ODR remaining entitlement for patients who have previously received hospital services under this program. ODR will provide written confirmation of entitlement to the participating hospital.

3. If the hospital admits a beneficiary certified by the Project Director and it is later discovered that the beneficiary has exhausted his entitlement for that benefit period, payment for the hospital stay will be arranged by the Project.

4. The Project Director will submit completed copies of the Referral Form to the hospital, ODR, and BCHS, and will retain a copy in the Project records. ODR will consult its files on receipt of the form to ascertain the number of benefit days to which the patient is entitled. Should the patient have less than thirty (30) days entitlement available, ODR will notify the Project by telephone within two (2) working days. Written confirmation will follow, with a copy to the hospital, if such written confirmation has not been provided previously as provided in Item 2, above.

5. The Project will arrange for services of an attending physician.

6. The Project will receive and submit physician billings to ODR for payment and disburse the payment checks to the physicians if the participating hospitals agree not to bill the program for physician services.

7. The Project will receive from the hospital, and include in the patient's record, a copy of the hospital medical record abstract, a discharge summary, and a notice from ODR of payment for hospital services rendered. The Project will maintain strict confidentiality of the medical abstract and hospital discharge summary.

8. The Project will develop and implement a system to provide predischarge planning and post-hospital follow-up services for hospitalized patients in order to assure maximum continuity of care for hospitalized patients.

9. Upon request by any Project Policy Board member, the Project Director shall provide the names of all persons referred for hospitalization by the Project Director and a summary of claims paid by ODR.

10. The Migrant Health Program Project with the approval of the Project Policy Board will become a party to the Provider Reimbursement Contract for Inpatient Hospital Care.

11. In that these conditions of participation are applicable for projects participating in the basic Migrant Hospitalization Program, the "high risk" mothers and infants program, or both, it is understood that hospital and physician referrals will be made in strict conformance with applicable guidance procedures.

12. Should BCHS find it necessary to terminate the Migrant Hospitalization Program, or a portion of the Program, it will give thirty (30) days' notice to the Project, the participating hospital, and ODR. The Project will refer no additional migrant patients for hospitalization during that thirty-day period.

It is understood that failure on the part of the _____
(Name of Project)
to comply with the conditions listed above will result in a review for possible termination of the Project's participation in the Program.

Approved for Board of Directors
(Project Policy Board)

Name _____

Title _____

Signature _____

Date _____

Approved by Project Director

Name _____

Title _____

Signature _____

Date _____

Section 500: ADDENDUM

Directory, Information Resources
Notes and Update Memoranda

FOR FURTHER INFORMATION—

Any general questions concerning the operation of the Migrant Hospitalization Program should be directed to:

Program Manager
Migrant Hospitalization Program
Division of Health Services Financing
Bureau of Community Health Services
Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20857

(301) 443-6580

Questions relating specifically to billing or reimbursement matters should be directed to:

Director
Office of Direct Reimbursement
Health Care Financing Administration
P.O. Box 80
Baltimore, Maryland 21203

(301) 594-7502

Questions pertaining to program operations within a specific Region of the Department of Health and Human Services should be directed to the appropriate Regional Health Administrator at one of the following addresses:

Region IV:
101 Marietta Tower
Atlanta, Georgia 30323

(404) 221-2316

Region VI:
1200 Main Tower Building
Dallas, Texas 75202

(214) 767-3879

Region VIII:
1961 Stout Street
Denver, Colorado 80294

(303) 837-4461

Region IX:
Federal Office Building
50 United Nations Plaza
San Francisco, California 94102

(415) 556-5810

Region X:
Arcade Plaza
1321 Second Avenue
Seattle, Washington 98101

(206) 442-0430