CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 41 **Date: DECEMBER 8, 2003**

CHANGE REQUEST 2990

I. SUMMARY OF CHANGES: This transmittal replaces CR 2817, Transmittal 1898, clarifies the HPSA bonus payment and establishes instructions for physicians rendering anesthesia.

In some instances only the section number, the section title, or both, were revised.

NEW/REVISED MATERIAL - EFFECTIVE DATE: January 5, 2004
***IMPLEMENTATION DATE: January 5, 2004**

Disclaimer for manual changes only: The revision date and transmittal number apply only to italicized material. Any other material was previously published and remains unchanged.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	4/Table of Content/Part B Hospital
R	4/250/Special Rules for Critical Access Hospital Outpatient Billing
R	4/250.1/Standard Method- Cost-Based Facility Services, with Billing of Carrier for Professional Services
R	4/250.2/ Optional Method for Outpatient Services: Cost-Based Facility Services Plus 115 percent Fee Schedule Payment for Professional Services
N	4/250.3/Payment for Anesthesia in a Critical Access Hospital
R	4/250.3.1/Anesthesia File
N	4/250.3.2/Physician rendering Anesthesia in a Hospital Outpatient Setting
R	4/250.3.3/CRNA Services (CRNA Pass-Through Exemption of 115 percent Fee Schedule Payments for CRNA Services
R	4/250.4/CAH Outpatient Services Part B Deductible and Coinsurance
R	4/250.5/Medicare Payment for Ambulance Services Furnished by Certain CAHS
R	4/250.6/Clinical Diagnostic Laboratory Tests Furnished by CAHs

***III. FUNDING:**

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

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

***Medicare contractors only**

Business Requirements

Pub. 100-04	Transmittal: 41	Date: December 8, 2003	Change Request 2990

I. GENERAL INFORMATION

A. Background: To insure that physicians utilizing (or servicing) small rural hospitals receive the maximum payment to which they are entitled, physicians rendering services in a Critical Access Hospital (CAH) that has elected the optional method for payment, and is located in a Health Professional Shortage Area (HPSA), will receive the incentive payment.

B. Policy: In accordance with §1833(m) of the Social Security Act, physicians who provide covered professional services in any rural or urban HPSA are entitled to an incentive payment. This incentive is equal to an additional 10 percent of the payment amount. It is not enough for the physician merely to have his/her office or primary service location in a HPSA, nor must the beneficiary reside in a HPSA, although frequently this will be the case. The key to eligibility is where the service is actually provided (place of service). For example, a physician providing a service in his/her office, the patient's home, or in a hospital, qualifies for the incentive payment as long as the specific location of the service provision is within an area designed as a HPSA. On the other hand, a physician may have an office in a HPSA but go outside the office (and the designated HPSA area) to provide the service. In this case, the physician would not be eligible for the incentive payment.

C. Provider Education: Intermediaries shall inform affected provider communities by either posting this instruction on their Websites within two weeks of the issuance date of this instruction, or by posting a notice on their Web sites that this information is available in the Internet Only Manual (IOM) and include a link to this section of the IOM. In addition, a notice about this information shall be published in your next regularly scheduled bulletin. If you have a listserv that targets the affected communities, you must use it to notify subscribers that information about Health Professional Shortage Area (HPSA) for CAHs is available on your Web site.

Intermediaries shall remind their Method II CAHs to keep adequate records to pay physicians the appropriate amounts for those HCPCS procedures the physicians have performed. In addition to keeping records of which physicians perform what procedures, CAHs will have to track procedures subject to the HPSA bonus, to assure the quarterly HPSA bonus is also properly distributed.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
2990.1	This instruction replaces CR2817, Transmittal 1898, dated August 22, 2003.	FI, SSM
Ch 4, Sec 250.2 2990.2	The FI shall place an indicator on the provider file showing the effective date for the CAH's, that elected Method II payment, HPSA status,	FI, SSM

	after receiving the information from the CAH in writing.	
Ch 4, Sec 250.2 2990.3	The FI shall pay the HPSA payment on Revenue Code 96x, 97x, or 98x, if one of the following modifiers is on the claim: QB – physician providing a service in a rural HPSA; or QU – physician providing a service in an urban HPSA; along with one of the following Professional Component/Technical Component (PC/TC): (Field 20 on the full Medicare Physician Fee Schedule (MPFS) file layout) statuses: 0 – Physician services. The concept PC/TC does not apply since physician services cannot be split into professional and technical components. 2 – Professional Component only 6 – Laboratory physician interpretation codes. 8 – Physician interpretation codes.	FI, SSM
Ch 4, Sec 250.2 2990.4	The FI shall not pay the bonus for Revenue Code 96x, 97x, or 98x, if the following PC/TC indicators are present on the MPFS file. 1 – Globally billed. Only the professional component of this service qualifies for the HPSA bonus payment. The HPSA bonus cannot be paid on the technical component of globally billed services. ACTION: Return the service as unprocessable. Instruct the provider to re-bill the service as separate professional and technical component revenue codes. The HPSA modifier should only be used with the professional component code. Do not pay the incentive unless the professional component can be separately identified. 3 – Technical component only.	FI, SSM

	4 – Global test only. Only the professional component of this service qualifies for the HPSA bonus payment. (See ACTION under #1 above) 5 – Incident to codes. 7 – Physical therapy service. 9 (Status of "X") Concept of PC/TC does not apply. These are not considered HPSA services.	
Ch 4, Sec 250.2 2990.5	The FI shall pay 10 percent of the payable amount to the CAH for outpatient professional services with Revenue Code 96x, 97x or 98x.	FI, SSM
Ch 4 Sec 250.2 2990.6	The FI shall not include the HPSA payment on each claim.	FI, SSM
Ch 4 Sec 250.2 2990.6.1	The FI shall create a utility file to run paid claims for a quarterly report.	FI, SSM
Ch 4 Sec 250.2 2990.7	The FI shall create a quarterly HPSA Report for each CAH, using the format listed in Section 250.1.2.	FI, SSM
Ch 4 Sec 250.2 2990.7.1	The FI shall send the CAH the HPSA quarterly payment along with the HPSA report for the corresponding quarter one month following the end of the quarter.	FI, SSM
Ch 4 Sec 250.2 2990.8	The FI shall include any adjustments/cancels processed during a quarter on the report.	FI, SSM

Ch 4 Sec 250.2 2990.8.1	The FI shall include adjustments/cancels processed after the end of the quarter on the next quarter's report.	FI, SSM
Ch 4 Sec 250.3.2 2990.9	The FI shall pay the HPSA bonus to a CAH for a physician that rendered an anesthesia service within a HPSA area.	FI, SSM
Ch 4 Sec 250.3.2 2990.9.1	The FI shall pay the HPSA bonus when CPT codes 00100 through 01999 are billed with one of the following modifiers: QY – medical direction of one CRNA by an anesthesiologist; QK – medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals; AA – anesthesia services performed personally by anesthesiologist; GC – service performed, in part, by a resident under the direction of a teaching physician; and modifiers "QB" or "QU" in revenue code 963.	FI, SSM
Ch 4 Sec 250.3.2 2990.9.2	The FI shall pay an additional 10 percent per line item, of the payment amount to a Method II CAH for physician anesthesia service with Revenue Code 963, for the HPSA bonus payment.	FI, SSM
Ch 4 Sec 250.3.2 2990.10	The FI shall pay 80% of the allowed amount for modifiers AA and GC after any applicable deductible and coinsurance have been applied.	FI, SSM
Ch 4 Sec 250.3.2 2990.10.1	The FI shall pay 50% of the allowed amount times 80 percent for modifiers QK and QY after any applicable deductible and coinsurance have been applied.	FI, SSM

Ch 4 Sec 250.3.2 2990.11	The FI shall use the following data elements to calculate payment for physician anesthesia service plus the HPSA bonus effective January 1, 2004: - HCPCS plus Modifier - Base Units - Time in 15 minute increments - Locality specific conversion factor, and Allowed amount adjusted for applicable deductibles and coinsurance amounts.	FI, SSM
Ch 4 Sec 250.3.2 2990.11.1	The FI shall use the following formula for calculating payment for physicians providing anesthesia service(s) plus the HPSA bonus. Multiply the allowed amount by 80%. - HCPCS - xxxx - Modifier - AA - Base units - 4 - Anesthesia Time is 60 minutes. Anesthesia time units - 4 (60/15) - Sum of Base units plus time units - 4 + 4 = 8 - Locality specific Anesthesia conversion factor - $17.00 (varies by locality) - Coinsurance - 20% (See Example 1 under section 250.1.3)	FI, SSM
Ch 4 Sec 250.3.2 2990.11.2	The FI shall use the following formula for calculating payment for a physician directing two concurrent cases involving CRNAs. Multiply the allowed amount by 50%. - HCPCS - xxxx - Modifier - QK - Based Units - 4 - Anesthesia Time is 60 minutes. Anesthesia time units - 4 (60/15) - Sum of Base units plus time units - 4 + 4 =8 - Locality specific Anesthesia conversion factor - $17.00 (varies by locality) - Coinsurance - 20% (See Example 2 under Section 250.1.3)	FI, SSM

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: Yes.

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. OTHER CHANGES

Citation	Change
250	Revised to move Section Title 250.1.
250.1	Section title changed.
250.2	Section number changed from 250.1.2 and expanded to include the HPSA incentive payment for professional services rendered in urban or rural HPSAs.
250.3	New section – Files used for payment of anesthesia services.
250.3.1	New section – Record Layout for the Anesthesia Conversion Factor File.
250.3.2	New section – How to make payment for Physicians rendering anesthesia in addition to the HPSA incentive payment.
250.3.3	Section number changed from 250.1.3.
250.4	Section number changed from 250.2.
250.5	Section number changed from 250.3.
250.6	Section number changed from 250.4.

SCHEDULE, CONTACTS, AND FUNDING

Effective Date: January 5, 2004 **Implementation Date: January 5, 2004** **Pre-Implementation Contact(s):** **Doris Barham, 410-786-6146 (FI)** **Pat Barrett, 410-786-0508 (FI)** **George Morey, 410-786-4653 (Policy)** **Post-Implementation Contact(s):** **Regional Office**	**These instructions should be implemented within your current operating budget.**

Medicare Claims Processing Manual

Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

Table of Contents

(Rev. 41, 12-08-03)

250 – Special Rules for Critical Access Hospital Outpatient Billing

(Rev. 41, 12-08-03)

A3-3610.19
A3-3610.22.B

For cost reporting periods beginning before October 1, 2000, a CAH will be paid for outpatient services under the method in *§250.1*. The BIPA legislation on payment for professional services at 115 percent of what would otherwise be paid under the fee schedule is effective for services furnished on or after July 1, 2001. This provision was implemented with respect to cost reporting periods starting on or after October 1, 2001.

For cost reporting periods beginning on or after October 1, 2001, the CAH will be paid under the method in item 1 below unless it elects to be paid under the method in §250.1.

If a CAH elects payment under the elective method (cost-based facility payment plus fee schedule for professional services) for a cost reporting period, that election is effective for the entire cost reporting period to which it applies. If the CAH wishes to change an election, that election should be made in writing by the CAH, to the appropriate FI, 60 days in advance of the beginning of the affected cost reporting period.

All outpatient CAH services, other than pneumococcal pneumonia vaccines, influenza vaccines, administration of the vaccines, screening mammograms, and clinical diagnostic laboratory tests are subject to Part B deductible and coinsurance. Regardless of the payment method applicable for a period, payment for outpatient CAH services is not subject to the following payment principles:

- Lesser of cost or charges,
- Reasonable compensation equivalent (RCE) limits,
- Any type of reduction to operating or capital costs under 42 CFR 413.124 or 413.30(j)(7), or
- Blended payment rates for ASC-type, radiology, and other diagnostic services.

The mammography services are not exempt from the "lower than" rules. However, see §250.4 below regarding payment for screening mammography services.

250.1 - Standard Method - Cost-Based Facility Services, With Billing of Carrier for Professional Services

(Rev. 41, 12-08-03)

Payment for outpatient CAH services under this method will be made for 80 percent of the reasonable cost of the CAH in furnishing those services, after application of the Part B deductible. Payment for professional medical services furnished in a CAH to CAH

outpatients is made by the carrier on a fee schedule, charge, or other fee basis, as would apply if the services had been furnished in a hospital outpatient department. For purposes of CAH payment, professional medical services are defined as services provided by a physician or other practitioner, e.g., a physician assistant that could be billed directly to a carrier under Part B of Medicare or a nurse practitioner that could be billed directly to a carrier under Part B of Medicare.

In general, payment for professional medical services, under the cost-based CAH payment plus professional services billed to the carrier method should be made on the same basis as would apply if the services had been furnished in the outpatient department of a hospital.

Bill type 85X is used for all outpatient services including services approved as ASC services. Referenced diagnostic services will continue to be billed on a 14X type of bill.

250.2 - Optional Method for Outpatient Services: Cost-Based Facility Services Plus 115 percent Fee Schedule Payment for Professional Services

(Rev. 41, 12-08-03)

R1870.A.3, A3-3610.22

The BIPA legislation on payment for professional services at 115 percent of what would otherwise be paid under the fee schedule is effective for services furnished on or after July 1, 2001. A CAH may elect to be paid for outpatient services in any cost reporting period under this method. An election of this payment method, once made for a cost reporting period, remains in effect for all of that period and applies to all CAH services furnished in the CAH outpatient department during that period. Under this election a CAH will receive payment for all professional services received in that CAH's outpatient department (all licensed professionals who otherwise would be entitled to bill the carrier under Part B).

Payment to the CAH for each outpatient visit will be the sum of the following:

- For facility services, not including physician or other practitioner, payment will be the reasonable costs of the services. On the Form CMS-1450, (or electronic equivalent) list the facility service(s) rendered to outpatients along with the appropriate revenue code. Pay the amount equal to the sum of 80 percent of its reasonable costs of its outpatient services after application of the Part B deductible and coinsurance, plus

- On a separate line, list the professional services, along with the appropriate HCPCS code (physician or other practitioner) and in one of the following revenue codes - 096X, 097X, or 098X.

    - Use the Medicare Physician Fee Schedule (MPFS) supplementary file, established for use by the CORF, and the CORF Abstract File, to pay for

all the physician/professional services rendered in a CAH that elected the all-inclusive method. The FI will pay 115 percent of whatever Medicare would pay of the physician fee schedule. (The fee schedule amount, after applicable deductions, will be multiplied by 1.15 percent.) Payment for nonphysician practitioners will be 115 percent of 85 percent of the allowable amount under the physician fee schedule; and

- Outpatient services, including ASC, rendered in an all-inclusive rate provider method should be billed using the 85X type of bill. Referenced diagnostic services (non-patients) are billed on bill type 14X.

The Medicare Physician Fee Schedule (MPFS) supplementary file and the CORF Abstract File are used for payment of all physician/professional services rendered in a CAH that has elected the optional method. The data in the supplemental file will be in the same format as the abstract file.

If a nonphysician (e.g., Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist) renders a service, the "GF" modifier must be on the applicable line. **The "GF" modifier is not to be used for CRNA services. If a claim is received and it has the "GF" modifier for CRNA services, the claim is returned the claim to the provider.**

Health Professional Shortage Area (HPSA) Incentive Payments for Physicians.- In accordance with §1833(m) of the Social Security Act, physicians who provide covered professional services in any rural or urban HPSA are entitled to an incentive payment. Physicians providing services in either rural or urban HPSAs are eligible for a 10-percent incentive payment. It is not enough for the physician merely to have his/her office or primary service location in a HPSA, nor must the beneficiary reside in a HPSA, although frequently this will be the case. The key to eligibility is where the service is actually provided (place of service). For example, a physician providing a service in his/her office, the patient's home, or in a hospital, qualifies for the incentive payment as long as the specific location of the service provision is within an area designed as a HPSA. On the other hand, a physician may have an office in a HPSA but go outside the office (and the designated HPSA area) to provide the service. In this case, the physician would not be eligible for the incentive payment.

*If the CAH electing the Optional Method (Method II) is located within a HPSA, the physicians providing (outpatient) professional services in the CAH are eligible for HPSA physician incentive payments. Therefore, payments to such a CAH for professional services of physicians in the outpatient department will be 115 percent **times** the amount payable under fee schedule times 110 percent. An approved Optional Method CAH that is located in a HPSA County should notify you of its HPSA designation **in writing**. Once you receive the information, place an indicator on the provider file showing the effective date of the CAH's HPSA status. One of the following modifiers must be on the claim along with the physician service:*

- *QB - physician providing a service in a rural HPSA; or*
- *QU - physician providing a service in an urban HPSA.*

The HPSA incentive payment is 10 percent of the amount actually paid, not the approved amount. Do not include the incentive payment in each claim. Create a utility file so that you can run your paid claims file for a quarterly log. From this log you will send a quarterly report with the following information to the CAHs for each physician payment, one month following the end of each quarter. The sum of the "10% of line Reimbursement" column should equal the payment sent along with the report to the CAH. If any of the claims included on report are adjusted, be sure the adjustment also goes to the report. If an adjustment request is received after the end of the quarter, any related adjustment by the FI will be included on next quarter's report. CAHs must be sure to keep adequate records to permit distribution of the HPSA bonus payment when received. The required format for the quarterly report:

Quarterly HPSA Report for CAHs

Provider Number	*Beneficiary HICN*	*DCN*	*Rev. Code*	*HCPCS*	*LIDOS*	*Line Item Payment Amount*	*10% of Line Payment Amount*
123456	*Abcdefghijk*	*xxxxxxxxx*	*xxx*	*12345*	*3/2/03*	*$1000.00*	*$100.00*
789012	*Lmnopqrstu*		*xxx*	*67890*	*10/30/02*	*$5378.22*	*$537.82*

Use the information in the Professional Component/Technical Component (PC/TC) indicator field of the CORF extract of the Medicare Physician Fee Schedule Supplementary File to identify professional services eligible for HPSA bonus payments. The following are the rules to apply in determining whether to pay the bonus on services furnished within a geographic HPSA and billed with a QB or QU modifier, as appropriate.

(Field 20 on the full MPFS file layout)

PC/TC Indicator	*HPSA Payment Policy*
0	Physician services. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. ACTION: *Pay the HPSA bonus.*
1	*Globally billed. Only the professional component of this service qualifies for the HPSA bonus payment. The HPSA bonus cannot be paid on the technical component of globally billed services.* *ACTION: Return the service as unprocessable. Instruct the provider to re-bill the service as separate professional and technical component revenue codes. The HPSA modifier should only be used with the professional*

component code. Do not pay the incentive payment unless the professional component can be separately identified.

2 *Professional Component only.*
ACTION: Pay the bonus.

3 *Technical Component only.*
ACTION: Do not pay the bonus

4 *Global test only. (See 1 above)*

5 *Incident to codes.*
ACTION: Do not pay the bonus.

6 *Laboratory physician interpretation codes.*
ACTION: Pay the bonus.

7 *Physical therapy service.*
ACTION: Do not pay the bonus.

8 *Physician interpretation codes.*
ACTION: Pay the bonus.

9 (Status of "X" *Concept of PC/TC does not apply.*
ACTION: Do not pay the bonus.

NOTE: *Codes that have a status of "X" on the CORF extract Medicare Physician Fee Schedule Database (MFSDB) have been assigned PC/TC indicator 9 and are not considered physician services for MFSDB payment purposes. Therefore, the HPSA bonus payment will not be paid for these codes.*

250.3 – Payment for Anesthesia in a Critical Access Hospital (CAH)

Payment for anesthesia services is based on the HCPCS FILE, the Anesthesia Conversion Factor File, and the CORF extract of the MPFS Summary File.

(Rev 41, 12-08-03)

250.3.1 – Anesthesia File

(Rev. 41, 12-08-03)

Conversion Factor File = MU00.@BF12390.MPFS.CY04.ANES.V1023

Record Layout for the Anesthesia Conversion Factor File

Data Element Name	Picture	Location	Length

Data Element Name	Picture	Location	Length
Carrier Number	X (5)	1-5	5
Locality Number	X (2)	13-14	2
Locality Name	X (30)	19-48	30
Anesthesia CF 2002	99V99	74-77	4

250.3.2 – Physician Rendering Anesthesia in a Hospital Outpatient Setting

(Rev. 41, 12-08-03)

When a medically necessary anesthesia service is furnished within a HPSA area by a physician, a HPSA bonus is payable. In addition to using the PC/TC indicator on the CORF extract of the MPFS Summary File to identify HPSA services, pay physicians the HPSA bonus when CPT codes 00100 through 01999 are billed with the following modifiers: QY, QK, AA, or GC and "QB" or "QU" in revenue code 963. The modifiers signify that a physician performed an anesthesia service. Using the Anesthesia File (See Section above) the physician service will be 115 percent times the payment amount to be paid to a CAH on Method payment plus 10 percent HPSA bonus payment.

Anesthesiology modifiers:

AA = anesthesia services performed personally by anesthesiologist.
GC = service performed, in part, by a resident under the direction of a teaching physician.
QK = medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.
QY = medical direction of one CRNA by an anesthesiologist.

Modifiers AA and GC result in physician payment at 80% of the allowed amount.
Modifiers QK and QY result in physician payment at 50% of the allowed amount.

Data elements needed to calculate payment:

- *HCPCS plus Modifier,*
- *Base Units,*
- *Time units, based on standard 15 minute intervals,*
- *Locality specific anesthesia Conversion factor, and*
- *Allowed amount minus applicable deductions and coinsurance amount.*

***Formula 1**: Calculate payment for a physician performing anesthesia alone*

HCPCS = xxxxx

Modifier = AA
Base Units = 4
Anesthesia Time is 60 minutes. Anesthesia time units = 4 (60/15)
Sum of Base Units plus Time Units = 4 + 4 = 8
Locality specific Anesthesia conversion factor = $17.00 (varies by localities)
Coinsurance = 20%

Example 1: *Physician personally performs the anesthesia case*

Base Units plus time units - 4+4=8
Total units multiplied by the anesthesia conversion factor times .80
8 x $17= ($136.00 – (deductible) x .80 = $108.80*
Payment amount times 115 percent for the CAH method II payment.
$108.80 x 1.15 = $125.12 (Payment amount)
$125.12 x .10 = $12.51 (HPSA bonus payment)

**Assume the Part B deductible has already been met for the calendar year*

Formula 2*: Calculate the payment for the physician's medical direction service when the physician directs two concurrent cases involving CRNAs. The medical direction allowance is 50% of the allowance for the anesthesia service personally performed by the physician.*

HCPCS = xxxxx
Modifier = QK
Base Units = 4
Time Units 60/15=4
Sum of base units plus time units = 8
Locality specific anesthesia conversion factor = $17(varies by localities)
Coinsurance = 20 %

(Allowed amount adjusted for applicable deductions and coinsurance and to reflect payment percentage for medical direction).

Example 2: *Physician medically directs two concurrent cases involving CRNAs*

Base units plus time - 4+4=8
Total units multiplied by the anesthesia conversion factor times .50 equal allowed amount minus any remaining deductible

8 x $17 = $136 x .50 = $68.00 –(deductible) = $68.00*

Allowed amount Times 80 percent times 1.15
$68.00 x .80 = $54.40 x 1.15 = 62.56 (Payment amount)
$62.56 x .10 = $6.26 (HPSA bonus payment)

**Assume the deductible has already been met for the calendar year.*

250.3.3 - CRNA Services (CRNA Pass-Through Exemption of 115 percent Fee Schedule Payments for CRNA Services)

(Rev. 41, 12-08-03)

If a CAH that meets the criteria for a pass-through exemption is interested in selecting the Method II option, it can choose this option for all outpatient professionals except the CRNA's and still retain the approved CRNAs exemption for both inpatient and outpatient professional services of CRNAs. The CAH, with an approved exemption, can choose to give up its exemption for both inpatient and outpatient professional services of CRNAs in order to include its CRNA outpatient professional services along with those of all other professional services under the Method II option. By choosing to include the CRNAs under the Method II for outpatient services, it loses its CRNA pass-through exemption for not only the outpatient CRNA services, but also the inpatient CRNA services. In this case the CAH would have to bill the Part B carrier for the CRNA inpatient professional services.

Provider Billing Requirements for Method I - CRNA Services

Billing requirement

TOB = 85X

Revenue Code = 37X for CRNA technical services

Value code = Blank

Reimbursement

Revenue Code 37X = CRNA technical service - Cost Reimbursement

Deductible and coinsurance apply.

Provider Billing Requirements for Method II CRNA Services

TOB = 85X

Revenue Code = 37X for CRNA Technical service

Revenue Code = 964 for CRNA Professional service

HCPCS Code = Anesthesia HCPCS code (00100 through 01999 HCPCS range)

Units = Anesthesia

Reimbursement

Revenue Code 37X for CRNA Technical = cost reimbursement

Revenue Code 964 for CRNA Professional = 50% of Allowed Amount times 115%; or

Revenue Code 964 and the "QZ" modifier for non-medically directed CRNA Professional = 80% of Allowed Amount times 115%

How to calculate payment for anesthesia claims based on the formula

Identify anesthesia claims by HCPCS code range from 00100 through 01999

Add the anesthesia code base unit and time units. The time units are calculated by dividing actual anesthesia time (Units field on the UB92) by 15. Multiply the sum of base and time units by the locality specific anesthesia conversion factor (file name below).

The Medicare program pays the CRNA 80% of this allowable charge (non-medically directed). Deductible and coinsurance apply.

If the CRNA is medically directed, pay 50% of the allowable charge. Deductible and coinsurance apply.

Base Formula

Number of minutes divided by 15, plus the base units = Sum
Sum times the conversion factor = allowed amount

Source

Number of minutes = Number of units on the claim (Units field of the UB92)
Base Units = Anesthesia HCPCS

Conversion Factor = File – MU00.@BF12390.MPFS.CY04.ANES.V1023

250.4 - CAH Outpatient Services Part B Deductible and Coinsurance

(Rev. 41, 12-08-03)

3610.22.C

Payment for outpatient services of a CAH is subject to applicable Part B deductible and coinsurance amounts, except as follows:

A - Part B of Medicare pays 100 percent for pneumococcal pneumonia vaccines (PPV) and influenza virus vaccines and their administration. Payment is on a reasonable cost basis. Deductible and coinsurance does not apply. Part B of

Medicare also covers the reasonable cost of hepatitis B vaccine and its administration. Deductible and coinsurance apply.

B - For claims with dates of service on or after January 1, 2002, §104 of the Benefit Improvement and Protection Act (BIPA) 2000, provides for payment of screening mammography under the Medicare Physician Fee Schedule (MPFS) for such services furnished in hospitals, skilled nursing facilities (SNFs), and in CAHs not electing the optional method of payment for outpatient services.

Method I (Standard)

CAHs paid under the standard method bill the **technical** component (CPT codes 76092 or G0202 and 76085) using revenue code 403 and Type of Bill (TOB) 85X. The contractor pays for these services at 80 percent of the lesser of the fee schedule amount or the actual charges.

Professional component services (CPT codes G0202 or 76092 and 76085 (Use 76085 in conjunction with code 76092)) in standard-method CAHs are billed by the physician to the carrier and are paid at 80 percent of the lesser of the fee schedule amount or the actual charges. The payment for code 76092 is equal to the lower of the actual charge or the locality specific technical component payment amount under the MPFS. Program payment for the service is 80 percent of the lower amount and coinsurance is 20 percent. This is a final payment.

Method II (Optional Method)

For CAHs that elected the optional method of payment for outpatient services, the payment for **technical** services would be the same as the CAHs that did not elect the optional method. TOB 85X and revenue code 403 are used for the technical service.

However, the **professional** component is paid at 115 percent of the lesser of fee schedule amount or actual charge. There is no deductible but coinsurance is applicable.

CAHs electing the optional method of outpatient payment will bill the professional amount for CPT codes G0202, or 76092 and 76085 (Use 76085 in conjunction with 76092) using revenue code 97X. These services are paid at 115 percent of 80 percent (that is, 92 percent) of the lesser of the fee schedule amount or the actual charge.

Regardless of the payment method that applies under paragraph B, payments for clinical diagnostic laboratory tests furnished to CAH outpatients on or after November 29, 1999, are made on a reasonable cost basis with no beneficiary cost-sharing – no coinsurance, deductible, copayment, or any other cost-sharing.

250.5 - Medicare Payment for Ambulance Services Furnished by Certain CAHs

(Rev. 41, 12-08-03)

A-01-52

Ambulance services furnished on or after December 21, 2000, by eligible CAHs will be paid on a reasonable cost basis. Eligible CAHs will continue to be paid based on reasonable cost after implementation of the ambulance fee schedule.

Section 205 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 exempts certain CAHs from the current Medicare ambulance cost per trip payment limit as well as from the ambulance fee schedule. Section 205(a) of BIPA states:

> The Secretary shall pay the reasonable costs incurred in furnishing ambulance services if such services are furnished (A) by a CAH (as defined in §1861(mm)(1)), or (B) by an entity that is owned and operated by a CAH, but only if the CAH or entity is the only provider or supplier of ambulance services that is located within a 35-mile drive of such CAH.

This provision is effective for ambulance services furnished on or after December 21, 2000.

250.6 - Clinical Diagnostic Laboratory Tests Furnished by CAHs

(Rev. 41, 12-08-03)

A-01-31, A-01-68

Medicare beneficiaries are not liable for any coinsurance, deductible, copayment, or other cost sharing amount for clinical diagnostic laboratory services furnished as a CAH outpatient service.

Effective for services furnished on or after November 29, 1999, CAHs are excluded from the lab fee schedule for outpatient clinical diagnostic lab services. Payment is made under reasonable cost. Lab services provided by CAHs before November 29, 1999, were paid under the clinical diagnostic fee schedule.

CAH clinical diagnostic lab services provided for nonpatients of the CAH **are** paid under the lab fee schedule.