# Medicare
## Intermediary Manual
## Part 3 - Claims Process

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

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**CHANGE REQUEST 2817**


| HEADER SECTION NUMBERS | PAGES TO INSERT | PAGES TO DELETE |
|---|---|---|
| 3610.22 (Cont.) – 3610.24 | 6-120.1 - 6-120.7 (7 pp.) | 6-120.1 – 6-120.5 (5 pp.) |

**NEW PROCEDURES--EFFECTIVE DATE: January 1, 2004**
**IMPLEMENTATION DATE: January 1, 2004**

3610.22, Payment for Services Furnished by a CAH, has been expanded to include a section on incentive payments for professional services rendered in urban or rural Health Professional Shortage Areas (HPSAs).

**On a quarterly basis, post on your web sites the CAHs in your service area where health professionals would qualify for these incentive payments.**

**Provider Education**: All fiscal intermediaries need to remind their Method II CAHs to keep adequate records to pay physicians the appropriate amounts for those HCPCS procedures the physicians have performed.

This is even more crucial for CAHs located in HPSAs. In addition to keeping records of which physicians perform what procedures, CAHs will also have to track procedures subject to the HPSA bonus, to assure the quarterly HPSA bonus is also properly distributed.

**These instructions should be implemented within your current operating budget.**

**DISCLAIMER: The revision date and transmittal number only applies to the redlined material. All other material was previous published in the manual and is only being reprinted.**

(b) On a separate line, the professional services will be listed, along with appropriate HCPC code (physician or other practitioner) and one of the following Revenue Codes - 96x, 97x, or 98x.

Use the Medicare Physician Fee Schedule (MPFS) supplementary file and the CORF Abstract File, 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. Pay 115 percent of whatever Medicare would pay of the physician fee schedule for physicians. (Multiply the fee schedule amount, after applicable deductions, by 1.15 percent.) If there is a code listed on the bill that is not in either of these files, please contact your carrier. The file names are:

MU10.@BF12390.MFS2001.QTR4.C00000.V0807.FI
MU10.@BF12390.MFS2001.SUPL.Q4.V0807.FI

Beginning January 2002 the file names are:

MU00.@BF12390.MPFS.CY02.ABSTR.V1114.FI
MU00.@BF12390.MPFS.CY02.SUPL.V1114.FI

These files are available for retrieval through CMS's Mainframe Telecommunications System formerly known as the Network Data Mover system. The record layout is the same layout used for the physician fee schedule abstract file disregarding the field defining the fee indicator, found in the Intermediary Manual §3653, page 6-304.9.

If a non-physician renders a service, the "GF" modifier must be on the claim. Pay 115 percent of 85 percent of the Physician Fee Schedule for this service.

- Certified Registered Nurse Anesthetist (CRNA) Services Pass-Through Exemption of 115 percent Fee Schedule Payments for CRNA Services. 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 CRNA 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.

Your system must be able to accommodate the national fee schedule.

**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 = Number of Minutes of Anesthesia

**Reimbursement:**

Revenue Code 37X for CRNA Technical = cost reimbursement

Revenue Code 964 for CRNA Professional = 50% of Allowed Amount times 115% if under physician supervision or 80% of Allowed Amount times 115% if CRNA services are provided without the medical direction of an Anesthesiologist – in this case the "QZ" modifier must be on the claim.

**How to calculate payment for anesthesia claims based on the formula.**

Identify anesthesia claims by HCPCS code range from 00100 through 01999.

Using the number in the Units field on the UB92 divide by 15, add the national fee to get the Sum, take 50% of the sum and multiply by 115%.

**Record Layout for the Anesthesia Conversion Factor File**

| 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 |

- 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 1.15 **times** the amount that equals 1.10 percent of the amount payable under fee schedule. An approved Optional Method CAH that is located in a HPSA County should notify you of the 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:

- o 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 with 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 UPIN, one month following the end of each quarter. The sum of the "10% of line Reimbursement" column should equal the payment to be 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 is received after the end of the quarter include it on next quarter's report.

**The following is 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 file layout)

| PC/TC Indicator | HPSA Payment Policy |
|---|---|
| 0 | 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.<br><br>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. Pay the bonus. |
| 3 | Technical Component only. Do not pay the bonus. |
| 4 | Global test only. Only the professional component of this service qualifies for the HPSA bonus payment. |

ACTION: Return the service as unprocessable. Instruct the provider to re-bill the service as separate professional and technical component procedure 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.

5 Incident to codes. Do not pay the bonus.

6 Laboratory physician interpretation codes. Pay the bonus.

7 Physical therapy service. Do not pay the bonus.

8 Physician interpretation codes. Pay the bonus.

9 (Status of "X") Concept of PC/TC does not apply. 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.

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 CRNA Section above), pay 1.15 percent of the rate listed for physician service times 1.10 percent for the HPSA bonus.

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,
- Units,
- Time in 15 minute increments,
- Conversion factor for the HCPCS code, and
- Allowed amount minus applicable deductions and coinsurance amount.

**Formula**: Calculate payment for a physician-rendering anesthesia

HCPCS = xxxxx
Modifier = AA
Base Units = 4
Anesthesia Time is 60 minutes divided by 15 = 4
Sum of Units plus Time = 4 + 4 = 8
Conversion factor for HCPCS xxxxx = $17.00
Coinsurance = 20%

**Example 1:** Base Units plus time units = 4+4=8
Total units multiplied by the conversion factor for the HCPCS
8 x $17= $136.00 = Allowed amount
Allowed amount minus coinsurance = allowed amount multiplied by .80
$136 x .80=$108.80
Allowed amount multiplied by .80 multiplied by 1.15 for the CAH method II = payment to a method II CAH for a physician personally rendering anesthesia = $136 x .80 = $108.80 x 1.15 = $125.12.

To calculate the HPSA bonus amount, calculate 10% of the method II CAH payment.
$100.10 x .10 = $10.01 –this is the amount you put in the quarterly report.

**Formula**: Calculate payment for a physician directing two concurrent cases involving CRNAs. Multiply the allowed amount by .50

HCPCS = xxxxx
Modifier = QK
Based Units = 4
Total Time 60/15=4
Sum of units plus time = 8
Conversion factor for HCPCS xxxxx = $17
(Allowed amount decreased for applicable deductions, coinsurance and assisting CRNA = allowed amount times .50)

**Example 2:** Base Units plus time = 4+4=8
Total units multiplied by the conversion factor for the HCPCS = (4+4=8x$17) x .50 = $68.00
Allowed amount multiplied by .50 multiplied by 1.15 for the CAH method II = payment to a method II CAH for a physician directing one CRNA = $136 x .50 = $68.00 x 1.15 = $78.20.

To calculate the HPSA bonus amount, calculate 10% of the method II CAH payment.
$78.20 x .10 = $7.82

C. Outpatient services, including ASC services, rendered in an optional method payment provider will be billed using the 85X type of bill. Referenced diagnostic services (nonpatients) will continue to be billed on a 14X type of bill.

D. Payment for outpatient services of a CAH is subject to applicable Part B deductible and coinsurance amounts, as described in §3626.3, except as described in paragraphs D. and E.

E. 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.

F. For claims with dates of service on or after January 1, 2002, §104 of the Benefits 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) to you using revenue code 403 and Type of Bill (TOB) 85X. Pay for these services at 80 percent of the lesser of the fee schedule amount or the actual charges, in accordance with the instructions as described in §3660.10.

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. Use TOB 85x and revenue code 403 for the technical service.

However, you would pay the professional component at 115 percent of the lesser of fee schedule amount or actual charge. There is no deductible but coinsurance is applicable. (See §§3660.10B, 3660.19, and 3660.20)

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

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

H. Costs of emergency room on-call physicians.--For cost reporting periods beginning on or after October 1, 2001, the reasonable costs of outpatient CAH services may include the reasonable compensation and related costs for an emergency room physician who is on call but not present at the premises of the CAH, if the physician is not otherwise furnishing physicians' services and is not on call at any other provider or facility. The costs are allowable only if they are incurred under a written contract which requires the physician to come to the CAH when the physician's presence is medically required. An emergency room physician must be a doctor of medicine or osteopathy who is immediately available by telephone or radio contact, and available on site, on a 24-hour a day basis, within 30 minutes, or within 60 minutes in areas described in 42 CFR 485.618 (d)(2).

I. Costs of ambulance services.--Effective for services furnished on or after December 21, 2000, payment for ambulance services furnished by a CAH or by an entity that is owned and operated by a CAH is, under certain circumstances, the reasonable cost of the CAH or the entity in furnishing those services. Payment is made on this basis only if the CAH or the entity is the only provider or supplier of ambulance services located within a 35-mile drive of the CAH or the entity. Reasonable cost will be determined without regard to any per-trip limits or fee schedule that would otherwise apply.

The distance between the CAH or entity and the other provider or supplier of ambulance services will be determined as the shortest distance in miles measured over improved roads between the CAH or the entity and the site at which the vehicles of the nearest provider or supplier of ambulance services are garaged. An improved road is any road that is maintained by a local, State, or Federal government entity and is available for use by the general public. An improved road includes the paved surface up to the front entrance of the CAH and the front entrance of the garage.

3610.23 Payment for Post-Hospital Extended (Swing bed) Care Furnished by a CAH.--Under §203 of the Benefits Improvement and Protection Act (BIPA) of 2000, swing beds in CAHs are exempt from §1888(e)(7) of the Act (as enacted by §4432(a) of the Balanced Budget Act of 1997), which applies the SNF Prospective Payment System (PPS) to SNF services furnished by swing-bed hospitals generally. In addition, this provision establishes a new reimbursement system for CAHs that provides full reasonable cost payment for CAH swing-bed services. This provision is effective with cost reporting periods beginning on or after the date of the enactment of the BIPA 2000, December 21, 2000.

Medicare substitutes the pre-determined regional rate as a proxy for total swing bed routine costs and then applies that same pre-determined rate to total swing bed days. Under the BIPA 200 provision, adjust the CAH swing bed rate effective with the first day of the provider's fiscal year beginning on/after December 21, 2000. Instead of using the pre-determined rate for SNF-like swing bed days, calculate an interim payment reflecting an estimate of each facility's routine cost in the current year. This interim payment rate will be calculated from the latest available cost reporting data. To reimburse a CAH for its swing bed services based on cost, it will be necessary to refer to the CAH's most recent cost report to track the number of SNF-like swing bed days, NF-like swing beds, total patient days, and total routine costs. Presently, the cost report calculates total routine costs through worksheet D-1 of the Form CMS-2552-96.

NF-like swing bed routine costs should be calculated using existing procedures; i.e., multiplying the average statewide rate per patient day paid under the state Medicaid plan by the number of NF-like swing bed days. The NF-like swing bed costs should then be deducted from the hospital's total routine costs. Then, to calculate the SNF-like swing bed cost per day, the adjusted routine costs are divided by the sum of the total number of inpatient routine care days and total SNF-like swing bed days. This cost per day is then applied against the SNF-like swing bed days to arrive at the carve out for SNF swing bed costs. That same per diem is then applied against the Medicare swing bed days resulting in Medicare share of routine swing bed costs.

The cost report instructions will be modified on Worksheet D-1 to accommodate this change in payment procedures for CAHs.

The ancillary costs are apportioned to Medicare based on billed charges. The cost report currently calculates Medicare's share of ancillary costs through worksheet D-4 of the same cost reporting Form CMS-2552-96. No change would be required to the cost report for calculating swing bed ancillary costs.

Settlement for CAHs for swing bed services will continue to be calculated on Worksheet E-1.

All CAH SNF-like swing bed bills should have a "z" in the third position of the provider number.

**NOTE:** Certified SNFs (i.e., 5000 provider number series) owned and operated by CAHs are reimbursed under SNF PPS.

3610.24 Review of Form CMS-1450 for the Inpatient.--All items on Form CMS-1450 are completed in accordance with §3604.