# Medicare Hospital Manual

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 |
|---|---|---|
| 415.22 (Cont.) – 415.24 | 4- 181 – 4-184 (4 pp.) | 4-181– 4-183 (3 pp.) |

**NEW/REVISED MATERIAL--*EFFECTIVE DATE: January 1, 2004***
***IMPLEMENTATION DATE: January* 1, 2004**

415.22 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).

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

(b) On a separate line, list the professional services, along with the appropriate HCPC code (physician or other practitioner) and one of the following revenue codes - 96x, 97x, or 98x. Payment will be 115 percent of the physician fee schedule, after applicable Part B deductible and coinsurance

The Medicare Physician Fee Schedule (MPFS) supplementary file, established for use by the CORF, and the CORF Abstract File, will be used to pay for all the physician/professional services rendered in a CAH that elected the all-inclusive method. Your fiscal intermediary 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 non-physician practitioners will be 115 percent of 85 percent of the physician fee schedule.

If a professional service is performed by a non-physician, (eg., Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), place the "GF" modifier on the applicable line. You will receive 115 percent of 85 percent of the Physician Fee Schedule for these services. **The "GF" modifier is not to be used for CRNA services.**

Outpatient services, including ASC, rendered in an all-inclusive rate provider method should be billed using the 85X type of bill. Continue to bill referenced diagnostic services on bill type 14x.

- 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.

**Method I**

**Billing requirement**

TOB = 85X
Revenue Code = 37X for CRNA technical services
Value code = Blank

**Reimbursement**

37X = CRNA technical service - Cost Reimbursement

Deductible and coinsurance apply.

**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)
For CRNA services provided without the medical direction of an anesthesiologist – "QZ" modifier must be on claim.
Units – Place number of minutes in the Units Field on the UB92

**Reimbursement**

Revenue Code 37X for CRNA Technical = cost reimbursement

Revenue Code 964 for CRNA Professional = 50% of Allowed Amount times 115% or 80% of allowed amount times 115% if CRNA is not under medical direction.

Deductible and coinsurance apply.

- 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 outpatient services of physicians would be 1.15 **times** the amount which equals 1.10 percent of the amount payable under fee schedule. An approved Optional Method CAH, which is located in a HPSA County, should notify the intermediary, **in writing,** of the HPSA **designation date**. Once this information is received by the intermediary, an indicator will be placed on your 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 incentive payment is 10 percent of the amount actually paid, not the approved amount. The incentive payment will not be included in each claim. A utility file will be created so that the intermediary can run the claims for a quarterly log. From this log you will receive a quarterly report, along with the HPSA quarterly 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. If any of the claims included on report are adjusted, the adjustment will also go to the report. If an adjustment is received after the end of the quarter, it will be included on next quarter's report. Be sure to keep adequate records to permit distribution of the HPSA bonus payment when you receive it. 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 | xxxxxxx | xxx | 12345 | 3/2/03 | $1000.00 | $100.00 |
| 789012 | lmnopqrstu | xxxxxxx | xxx | 67890 | 10/30/02 | $5378.22 | $537.82 |

When a medically necessary anesthesia service is furnished within a HPSA area by a physician, a HPSA bonus is payable. To receive payment you must bill an anesthesia CPT code (00100 through 01999) with one of the following modifiers: QY, QK, AA, or GC and "QB" or "QU" in revenue code 963. This will signify that a physician performed the anesthesia service. You will receive 1.15 percent times the 1.10 percent for an anesthesia service performed by a physician.

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.

C. Payment for outpatient services of a CAH is subject to applicable Part B deductible and coinsurance amounts.

D. 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 do not apply. Part B of Medicare also covers the reasonable cost for hepatitis B vaccine and its administration. Deductible and coinsurance apply. Payment for screening mammography is not subject to applicable Part B deductible, but coinsurance does apply.

E. 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) using revenue code 403 and Type of Bill (TOB) 85X. These services will be paid 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. Use TOB 85x and revenue code 403 for the technical service.

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

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

G. 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).

H. 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 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.

415.23 Payment for Post-Hospital SNF Care Furnished by a CAH.--Under §203 of the Benefits Improvement and Protection Act (BIPA) of 2000, swing beds in CAH's 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.

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.

415.24 Review of Form CMS-1450 for the Inpatient.--Complete all items on Form CMS-1450 in accordance with §460.