CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 63 **Date: JANUARY 16, 2004**

CHANGE REQUEST 3051

I. SUMMARY OF CHANGES: This transmittal 1) expands the payment for CAH outpatients services to 101 percent of reasonable cost; and 2) a CAH must inform the intermediary in writing for their election of payment methodology at least 30 days in advance of the beginning of a cost reporting period.

NEW/REVISED MATERIAL - EFFECTIVE DATE: January 1, 2004
***IMPLEMENTATION DATE: April 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	4/250/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
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**

Attachment - Business Requirements

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SUBJECT: Special Rules for Critical Access Hospital (CAH) Outpatient Billing

I. GENERAL INFORMATION

A. Background: Under the present law, CAHs are being paid reasonable cost for outpatient services. The Drug Improvement and Modernization Act (DIMA) of 2003, section 405(e) amends the present law to specify that payment to CAHs for outpatient services be made at 101 percent of the reasonable costs of those services.

B. Policy: The Drug Improvement and Modernization Act of 2003 was signed into law on December 8, 2003, allowing payment for outpatient CAH services to be made at 101 percent of reasonable costs of those services, after application of deductible and coinsurance provisions. This policy is effective beginning on or after January 1, 2004.

A CAH must notify their FI of an election, or change of a previous election, at least 30 days prior to the affected cost reporting period instead of 60 days.

C. Provider Education: Do not post to the Internet until you receive further instructions.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
3051.1	The FI shall pay CAH outpatient services at 101 percent of reasonable cost.	FI, SS

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: **N/A**

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: January 1, 2004 **Implementation Date: April 5, 2004** **Pre-Implementation Contact(s):** **Doris Barham, 410-786-6146** **Pat Barrett, 410-786-0508** **Post-Implementation Contact(s):** **regional offices**	**These instructions shall be implemented within your current operating budget.**

250 – Special Rules for Critical Access Hospital Outpatient Billing

(Rev. 63, 01-16-04)

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 period 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 make a new election or change a previous* election, that election should be made in writing by the CAH, to the appropriate FI, *at least 30* 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.

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. 63, 01-16-04)

Effective for cost reporting periods beginning on or after January 1, 2004, payment for outpatient CAH services under this method will be made for the lesser of 1) 80% of the 101% reasonable cost of the CAH in furnishing those services, or 2) 101% of the reasonable cost of the CAH in furnishing those services less applicable Part B deductible and coinsurance amounts. 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. *(See Section 260.6 – Clinical Diagnostic Laboratory Tests Furnished by CAHs).*

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

(Rev. 63, 01-16-04)

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 *by filing a written election with the intermediary at least 30 days before start of the Cost Reporting period to which the election applies*. 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 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 based on 101 percent of* 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 *lesser of 80 percent of 101 percent of the reasonable costs of its outpatient services, or the 101 percent of the outpatient services less applicable* Part B deductible and coinsurance amounts, 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 type services, 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.. *(See Section 250.6 – Clinical Diagnostic Laboratory Tests Furnished by CAHs.)*

        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.

250.6 - Clinical Diagnostic Laboratory Tests Furnished by CAHs

(Rev. 63, 01-16-04)

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.

Payment for clinical diagnostic laboratory tests furnished by a CAH is made on a reasonable cost basis only if the *patient is an outpatient of the CAH and is physically present in the CAH at the time the specimen is collected* - (Bill type 85x). A CAH cannot seek reasonable cost reimbursement for tests provided to individuals in locations such as rural health clinic, the individual's home or a skilled-nursing facility. *Individuals in these locations are non-patients of a CAH and their lab test would be categorized as "referenced lab tests" for the non-patients (Bill type 14x), and* ***are*** *paid under the lab fee schedule*.