Medicare Hospital Manual

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

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REFER TO CHANGE REQUEST 2110

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
415.21 - 415.23	4-179 - 4-183 (5 pp.)	4-179 - 4-182 (4 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE:* October 1, 2001
***IMPLEMENTATION DATE:* January 1,2003**

Section 415.22, Payment for Services Furnished by a CAH, is expanded to include the following changes and clarifications:

- CAHs are exempt from the window provisions.
- Payment methodology for screening mammography.
- Costs of emergency room on-call physicians.
- Costs of ambulance services.
- CRNA Services (CRNA Pass-Through Exemption or 115 percent Fee Schedule Payments for CRNA Services)
- Health Professional Shortage Areas (HPSAs) Incentive payments for Physicians.

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.

415.21 Requirements for CAH Services and CAH Long-term Care Services.--

A. Effective November 29,1999, CAHs are no longer required to maintain documentation showing that individual stays longer than 96 hours were needed because of inclement weather or other emergency conditions, or submit a case-specific waiver of the 96-hour limit from a peer review organization (PRO) or equivalent equity. Thus, intermediaries are not required to obtain documentation showing that a PRO or equivalent entity has, on request, approved stays beyond 96 hours in specific cases. A CAH may provide acute inpatient care for a period that does not exceed, as determined on an annual average basis, 96 hours per patient. A patient is considered discharged when the admission's office records the discharge and (1) the patient has been discharged by the appropriate practitioner on the medical chart and (2) the patient is no longer receiving services. The patient would have to be out of the room for it to be available for occupancy.

The CAH's length of stay will be calculated by their fiscal intermediary based on patient census data. If a CAH exceeds the length of stay limit, this information will be sent to the CMS Regional Office and a copy sent to the State agency. The CAH will be required to develop and implement a corrective action plan acceptable to the CMS regional office, or face termination of its Medicare provider agreement.

Items and services that a CAH provides to its inpatients are covered if they are items and services of a type that would be covered if furnished by a hospital to hospital inpatients.

B. A CAH may use its inpatient facilities to provide post-hospital SNF care and be paid for SNF-level services if it meets the following requirements.

1. The facility has been certified as a CAH by CMS;

2. The facility provides not more than 25 inpatient beds, and the number of beds used at any time for acute care inpatient services does not exceed 15 beds (any bed of a unit of the facility that is licensed as a distinct-part SNF is not counted under paragraph (1) of this section); and

3. The facility has been granted swing-bed approval by CMS.

C. A CAH that participated in Medicare as a rural primary care hospital (RPCH) on September 30, 1997, and on that date had in effect an approval from CMS to use its inpatient facilities to provide post-hospital SNF care, may continue in that status under the same terms, conditions, and limitations that were applicable at the time those approvals were granted.

415.22 Payment for Services Furnished by a CAH.--

A. Payment for Inpatient Services Furnished by a CAH.--Effective for cost reporting periods beginning after October 1, 1997, payment for inpatient services of a CAH is the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except that following principles do not apply: the lesser of costs or charges (LCC) rule, ceilings on hospital operating costs, and the reasonable compensation equivalent (RCE) limits for physician services to providers, and the payment window provisions for pre-admission services treated inpatient services under §3510.3. Payment for inpatient CAH services is subject to Part A deductible and coinsurance requirement. Inpatient services should be billed as an 11X type of bill.

CAHs are exempt from the 1- and 3-day window provision. Services rendered to a beneficiary while in the outpatient department who then becomes an inpatient are not bundled on the inpatient bill. Outpatient services must be billed as such and on a separate bill from inpatient services. Outpatient services rendered on the date of admission to an inpatient setting are still billed and paid separately as outpatient services.

B. Payment for Outpatient Services Furnished by a CAH.--For cost reporting periods beginning before October 1, 2000, a CAH will be paid for outpatient services under the method in item 1 below. 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 item 2. If a CAH elects payment under item 2 (cost-based facility payment plus fee schedule for professional services) for a cost reporting period, that election is effective for all of the 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 intermediary, 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 paragraph E below regarding payment for screening mammography services.

1. Standard method: Cost-based Facility Services, with Billing of Carrier for Professional Services.--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 or nurse practitioner, that could be billed directly to a carrier under Part B of Medicare.

In general, payment for professional medical service, under the cost-based CAH payment plus professional services 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 should be used for all outpatient services including ASC. Referenced diagnostic services will continue to be billed on a 14X type of bill.

2. Optional Method for Outpatient Services: Cost-Based Facility Services Plus 115% Fee Schedule Payment for Professional Services.--Section 202 of the Benefits Improvement and Protection Act of 2000 (BIPA 2000) permits the CAH to elect this method of reimbursement for cost reporting beginning 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 services furnished to outpatients during that period. Payment will be the sum of the following amounts:

(a) For facility services, not including physician or other practitioner, payment will be the reasonable costs of the services. On the HCFA-1450, (or electronic equivalent) list the facility service(s) rendered to outpatients along with the appropriate revenue code. Payment will be 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.

(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.

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 (non-patients) on bill type 14x.

- Health Professional Shortage Areas (HPSAs) Incentive Payments for Physician Services. 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 is within an area designated 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.

The CAH must present some proof to the FI that it is located in a HPSA. When billing, one of the following modifiers for physician services must be on the claim:

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

- CRNA Services (CRNA Pass-Through Exemption of 115 percent Fee Schedule Payments for CRNA Services. If a CAH 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.

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 HCFA-1450 for the Inpatient.--Complete all items on Form HCFA-1450 in accordance with §460.