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Part A Fall 2024 Virtual Conference:

Keeping Compliant with Medicare Starts With You

November 12th, 14th, and 19th

Mastering Critical Access Hospital Billing and Compliance

11/19/2024

NGSMU
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Objective

Provide basic billing instructions for outpatient services in a Critical Access Hospital (CAH) including Method 1 and Method II payment methods.

Today's Presenters

- Provider Outreach and Education Consultants
  - Mimi Vier
  - Jean Roberts, RN BSN, CPC

Agenda

Critical Access Hospital Overview

CAH

- Designation given to eligible rural hospitals
- Established in 1997 as part of the Balanced Budget Act
- Purpose
  - Small hospitals in rural areas to provide services to patients that would otherwise be a long distance from emergency care

CAH Eligibility

- Located more than 35 miles from any other hospital or CAH
  - Mountainous terrain or areas with only secondary roads – 15 miles
- 24-hour emergency care, seven days a week
- Not more than 25 inpatient beds (acute and swing bed)
- May operate rehabilitation and psychiatric distant part units (DPU) up to 10 beds each
  - Inpatient rehabilitation services paid under IRF PPS
  - Inpatient psychiatric services paid under IPF PPS
- Length of stay (inpatient) no longer than 96 hours per patient
  - Excludes: Swing bed and DPU beds

CAH Method I and Method II: Outpatient

CAH Method I: Outpatient (Standard)

- Bill facility services
  - Part A MAC on UB-04 form/electronic equivalent
  - Reimbursed at 101% of reasonable cost minus Part B deductible and coinsurance
    - Exception: CRNA pass-through
- Bill professional services
  - Part B MAC on CMS-1500 form/electronic equivalent
    - Reimbursed under MPFS minus Part B deductible and coinsurance

CAH Method II: Outpatient (Optional)

- Bill MAC for **both** facility services and professional services
  - Include professional fees on UB-04 form/electronic equivalent
  - Professional services reimbursed at 115% of MPFS
  - NPP services reimbursed at 115 percent of allowed percentage
  - Only applies to outpatient services

Method II Elections

- New elections
  - Must be made in writing
  - At least 30 days in advance of beginning cost report period
  - Include list of practitioners by specialty

Method II Practitioner Election

- Practitioners at Method II CAH may elect to reassign rights to CAH
- Will receive payment from Part A MAC for professional services in outpatient department
- Not all practitioners have to reassign benefits for hospital to become CAH
- Must attest will not bill Part B for any outpatient hospital services
- PECOS Individual Physicians/Non-Physicians or CMS 855I, section 4F should be submitted to reassign benefits to CAH

Practitioner Types Eligible to Reassign Benefits

- Doctor of Medicine or Osteopathy
- Clinical Psychologist
- Dental Surgery
- Certified Nurse Midwife
- Podiatric Medicine
- Licensed Clinical Social Worker
- Optometry
- Certified Registered Nurse Anesthetist
- Chiropractic Medicine
- Registered Dietician/Nutrition Professional
- Certified Clinical Nurse Specialist
- Physician Assistant

CAH Outpatient Billing

CAH Type of Bills

- Outpatient
  - 851 – Admit to discharge
  - 141 – Non-patient diagnostic reference laboratory services
  - 857/147 – Adjustment
  - 858/148 – Cancel
  - 850 – No payment
- Inpatient
  - 111 – Admit to discharge
  - 117 – Adjustment
  - 118 – Cancel
  - 110 – No payment
  - 12X – Part B only/ancillary
  - 18X – Swing bed

CAH – Method I and II

- Method I (Standard)
  - Professional services billed on CMS-1500 form/electronic equivalent
- Method II (Optional)
  - Bills both facility and professional services on UB04/electronic equivalent
  - Each practitioner furnishing professional services in outpatient setting can choose to receive payment under this option

Billing Method II

- 85X TOB – Outpatient
- Revenue code: 96X, 967, or 98X (professional charges)
  - Only applicable for physicians/practitioners who reassigned benefits to CAH
- Appropriate HCPCS and charges
  - Professional services used when HCPCS specifies global, technical and professional services
- Attending/rendering provider
  - Must be enrolled as valid Part B physician/practitioner

CRNA Pass-Through Services

- Eligible for both inpatient and outpatient services
  - If criteria met
- CAH that elects Method II for all outpatient professionals, except CRNA, can still retain pass-through exemption for both inpatient and outpatient CRNA professional services
- CAH can choose to give up pass-through exemption in order to include CRNA professional outpatient services under Method II
  - CAH loses CRNA pass-through exemption for both inpatient and outpatient
  - CAH bills Part B MAC for inpatient professional services

CRNA Pass-Through Services – Retains Exemption

- Applies to inpatient (including swing bed) and outpatient services
  - TOB 11X and 18X – inpatient
  - TOB 85X – outpatient
- Revenue code
  - 37X – CRNA technical service (cost reimbursement – 101% reasonable cost)
  - 964 – Professional services (100% reasonable cost)
- HCPCS – Anesthesia HCPCS CRNA legally authorized to perform
- Deductible and coinsurance apply

Method II CRNA Pass-Through - Declines Exemption

- TOB: 85X
- Revenue Code
  - 037X – CRNA technical service (paid cost reimbursement at 101 percent reasonable cost)
  - 0964 – CRNA professional service
    - 115% – not medically directed
    - 50% – medically directed
- HCPCS: Appropriate anesthesia code(s)
- QZ modifier – non-medically directed CRNA services
- Deductible and coinsurance apply

Method II: Marriage and Family Therapists and Mental Health Counselors

- Physicians and/or NPP have reassigned benefits to Method II CAH
  - Revenue code 96X, 97X or 98X
  - Reimbursement is 80 percent of the lesser of actual charge or 75 percent of MPFS

Change Request 13502 - *Payment for Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs) in a Method II Critical Access Hospital (CAH*

Method II Modifiers

- AK – Non-participating physician
  - 115% lesser of charge or 95% of MPFS
- GF – NP, PA, CNS
  - Do not use for CRNA
  - 115% lesser of charge or 85% of MPFS
- SB – Certified Nurse Midwife
  - 115% of charge or 85% of MPFS
- AH – Clinical Psychologist
  - 115% lesser charge or 100% of MPFS
- AE – Nutritional professional or registered dietician
  - 115% lesser of charge or 85% MPFS

Method II Modifiers cont.

- AJ – LCSW, MFT, MHC
  - 80% lesser of charge or 75% of amount determined for payment of LCSW, MFT and/or MHC
    - Facility specified MPFS amount times LCSW, MFT or MHC reduction (75 percent) minus (deductible and coinsurance) times 115%
- 54 – Global surgical split care for surgical care only
  - 85X TOB
  - Revenue codes: 96X, 97X, 98X
- 55 – Global surgical split care for postoperative management only
  - 85X TOB
  - Revenue codes: 96X, 97X, 98X

Method II Anesthesia

- Revenue code 963
- HCPC 00100–01999
- Units: base units in 15-minute increments excluding HCPCS 01995 and 01996
- Modifiers
  - AA – Anesthesia performed by anesthesiologist
  - GC – Performed by resident under direction of teaching physician
  - QK – Medical direction of two, three, or four concurrent anesthesia procedures
  - QY – Medical direction of one CRNA by anesthesiologist

Note: Medical direction modifiers should be listed first when reporting multiple modifiers

Method II Assistant at Surgery Modifiers

- Physician, PA, NP or CNS
  - 80 – Assistant surgeon
  - 81 – Minimum assistant surgeon
  - 85 – Assistant surgeon (qualified resident surgeon not available)
- PA, NP, CNS
  - AS – PA, NP, CNS
  - Must also have 80, 81 or 82
- Co-Surgeon
  - 62 – Two surgeons
  - Used with surgical procedure code
    - Can have two lines with same code and modifier if both physicians reassign benefits under Method II

LIDOS Requirement

- LIDOS required on every revenue code line
  - Identify DOS for each CPT/HCPCS code
    - Report in FL 45 “Service Date” (or electronic equivalent) Format: MMDDYY
    - Repeat each service (revenue code) on a separate line item with date service was provided for every occurrence
  - Example

Revenue Code	CPT/HCPCS	DOS	Units
0510	G0463	010324	1
0450	99282	010524	1
0305	85025	010524	1
0762	G0378	010524	10

Intensive Outpatient Program Services

IOP Services

- IOP provides treatment at level more intense than outpatient or psychosocial rehabilitation
- Less intense than partial hospitalization programs
- Patient requirements must:
  - Be under care of physician who certifies need for IOP
  - Need minimum nine hours per week and in their plan of care
  - Require a comprehensive, structured, multimodal treatment
  - Able to cognitively and emotionally participate in active treatment and tolerate IOP program

IOP Billing

- Bill
  - 85X TOB
  - Paid 101 percent of reasonable cost
  - Condition code 92 – identifying IOP services
- Intensive Outpatient Program

CAH Inpatient

CAH Inpatient

- Payment made at 101 percent of reasonable costs
- Subject to Part A deductible and coinsurance
- Benefit periods apply to Part A services
- Billed on UB-04 claim form/electronic equivalent
- Professional services billed to Part B on CMS-1500 claim form/electronic equivalent
- Split billing required for provider fiscal year and calendar year end

CAH Inpatient Admission

- Inpatient admission order required
  - Written order/verbal order
    - Include specific language for admission
    - Identify ordering physician/practitioner
    - Countersigned and dated by physician/practitioner
  - Written at or before the time of inpatient admission
  - Authenticated prior to discharge
- Expected to be discharged or transferred within 96 hours

CAH Swing Beds

- Not subject to SNF PPS
  - Payment is based on 101 percent of reasonable costs
- CAHs may bill for
  - Bed and board, nursing, and other related services
  - CAH facilities
  - Medical social services
  - Drugs
  - Biologicals
  - Supplies, appliances, and equipment for inpatient hospital care and treatment

CAH Special Services

Diagnostic Laboratory Services

- Outpatient services
  - On same day as specimen collection
  - Specimen collected by CAH employee
    - 85X TOB – in person patient
    - 14X TOB – Nonpatient (reference) test
- SNF labs
  - Billed by SNF if patient in Part A SNF stay
  - CAH may bill for Part B SNF patients
    - 85X TOB – if hospital employee draws lab or if SNF is hospital-based
    - 14X TOB – if nonhospital based or if SNF employee draws specimen
- Paid 101 percent of reasonable cost
  - No coinsurance or deductible applied

CAH Ambulance Services

- Paid under Ambulance Fee Schedule
  - If another ambulance is within 35 miles of CAH
  - Non-CAH based ambulance closer to CAH
- Exempt from Ambulance Fee Schedule
  - Paid at 101 percent of reasonable cost if
    - CAH-based ambulance closer to CAH
    - Services provided by entity owned/operated by CAH
    - Ambulance service only service available within 35 miles of CAH
- Bill
  - TOB 85X
  - Condition code B2 – CAH ambulance attestation

Rural Emergency Hospital (REH)

Eligible Facilities

- Facilities eligible to convert to REH must have been enrolled and certified to participate in Medicare as of 12/27/2020 as either
  - CAH or small rural hospital with no more than 50 beds as of 12/27/2020 (date of CAA enactment)
  - Facility enrolled as CAH or rural hospital with no more than 50 beds that closed after 12/27/2020 is eligible to seek REH designation
    - Must re-enroll in Medicare and meet all REH CoP and requirements
  - Subsection (d) hospital (rural hospital) with no more than 50 beds located in a county (or equivalent unit of local government) in a rural area or treated as being in a rural area
    - Subsection(d) hospital and rural hospital are defined in SSA sections 1886(d)(1)(B), 1886(d)(2)(D) and SSA section 1886(d)(8)(E)

REH

- Must
  - Not exceed 24 hours of service ALOS annually per-patient
  - Meet Medicare enrollment and CoPs applicable to CAHs regarding emergency services and hospital emergency departments
  - Meet certain licensure requirements
  - Provide emergency services and observation care
  - Maintain staffed emergency department 24 hours a day, seven days a week, with staffing requirements similar to CAHs
  - Have transfer agreement in effect with a level I or level II trauma center
  - Have not provided any acute care inpatient hospital services
    - Other than post-hospital extended care services furnished in DPU licensed as a SNF
- May elect to furnish other medical and health services on an outpatient basis, as specified by the Secretary

REH Technical Assistance and Revised Guidance

- Rural Emergency Hospital Technical Assistance Center
  - Offers technical assistance for REHs
  - Purpose of the technical assistance center is to:
    - Ensure rural hospitals and communities they serve have information and resources necessary to make informed decisions about whether an REH is best care model for their communities
    - Facilitate successful implementation of REH requirements for facilities converting to this new provider type
- 9/6/2024: CMS issued revised guidance regarding the Rural Emergency Hospital (REHs) enrollment and conversion process
  - Revised memo incorporates additional information to help clarify the process and respond to stakeholder feedback

REH Services

- All covered OPD services, including rural emergency services defined in section 1833(t)(1)(B) of the SSA
  - Furnished consistent with the conditions of participation at 42 C.F.R. Section 485.510–485.544
- REH emergency department compliance with EMTALA
  - Requires REH to offer medical screening exam to anyone in the REH ED requesting this exam
  - REH is prohibited from refusing to examine or offer stabilizing treatment to anyone with an emergency medical condition (EMC)

Non-REH Services

- Inpatient services cannot be provided
  - Exception: Services furnished in DPU licensed as SNF facility to furnish post-hospital extended care services
- REH services that do not meet the definition of an REH service are paid the same rate as service at OPPS hospital
  - Paid under applicable fee schedule but do not receive the additional five %
  - FYI: Non-REH outpatient services are described in section 1833(t)(1)(B)(ii) of the SSA
- Non-REH services examples
  - Services paid under the Clinical Lab Fee Schedule
  - Ambulance services furnished by an entity owned and operated by REH are paid under the ambulance fee schedule

REH Billing and Reimbursement

REH Billing

- Must be enrolled with Medicare as REH to submit outpatient claims to Part A MAC using institutional claim format (CMS-1450 or electronic equivalent)
  - PTAN range = XX0001 through XX0879 (XX = state number)
- Outpatient REH services are covered under Part B (of A)
  - Require patient to have active Medicare Part B coverage
- Bill for REH outpatient services rendered using TOB 013X or 014X
  - HCPCS and CPT codes
  - Modifiers, when applicable
  - LIDOS

REH Reimbursement: REH Services

- OPPS services: HCPCS/CPT code rates and status indicators (updated quarterly based on DOS)
  - Addendum A and Addendum B Updates
    - Use Addendum B for codes, rates, status indicators
  - CY2024 OPPS Status Indicators

    Refer to CMS-1786-FC > 2024 NFRM OPPS Addenda > open downloadable files > open excel file “2024 NFRM Addendum D2.110123”

REH Reimbursement

- REH services are reimbursed at OPPS rate plus five % increase over OPPS payment rate
  - Example: OPPS rate = $100.00
  - Service fee/rate + increase amount for REH services (five %) = allowed amount
  - $100.00 X 0.05 = $5.00 REH increase
  - $100.00 + $5.00 = $105.00 allowed amount
- Copayment calculated based on the standard OPPS rate (20%) for the service excluding the five % payment increase
  - Using example above
  - $100.00 X 0.20 = $20.00 copayment

REH Reimbursement: Non-REH Services

- Does not meet definition of an REH service
- Non-REH services are reimbursed at same rate as same service by an OPPS hospital
  - Based on the applicable fee schedule, such as the Clinical Laboratory Fee Schedule
- Non-REH services do not receive additional five % payment that REH services receive

REH Reimbursement: Non-REH Services cont.

- REH that owns/operates entity providing ambulance services are paid via ambulance fee schedule
- Post-hospital extended care services provided in REH licensed SNF DPU are reimbursed under SNF PPS
- Reminder: REH not allowed to provide inpatient services, except those furnished in a unit that is a distinct part licensed as SNF to furnish post-hospital extended care services

REH Monthly Facility Payment

- Monthly REH additional facility payment
  - 12 monthly installments included on remit for last day of each month
  - Same dollar amount for each REH facility; No adjustments
  - Must keep detailed documentation on how this money was used
- CY2024 monthly REH additional facility payment is $281,871
  - $276,233.58 after two % sequestration
- REH monthly facility payment for CY 2024 and each subsequent year is determined by
  - Hospital market basket percentage increase

References and Resources

CMS References and Resources

- Critical Access Hospital Center
  - CAH certification
- MLN Matters® Booklet: *MLN006400: Information for Critical Access Hospitals*
- CMS IOM Publications:
  - 100-04, *Medicare Claims Processing Manual*, Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPPS) Section 250 – Special Rules for Critical Access Hospital Outpatient Billing
  - 100-04, *Medicare Claims Processing Manual*, Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPPS) Section 250.3.3 – Anesthesia and CRNA Services in a Critical Access Hospital (CAH)
  - 100-07, *State Operations Manual*, Chapter 2 – The Certification Process

CMS Change Requests

- Change Request 13502 – *Payment for Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs) in a Method II Critical Access Hospital (CAH*
- Change Request 7896 – *Pass-through Payments for Certified Registered Nurse Anesthetist Anesthesia Services and Related Care*
- Change Request 13222 – *Enforcing Billing Requirements for Intensive Outpatient Program (IOP) Services with New Condition Code 92*

REH Resources

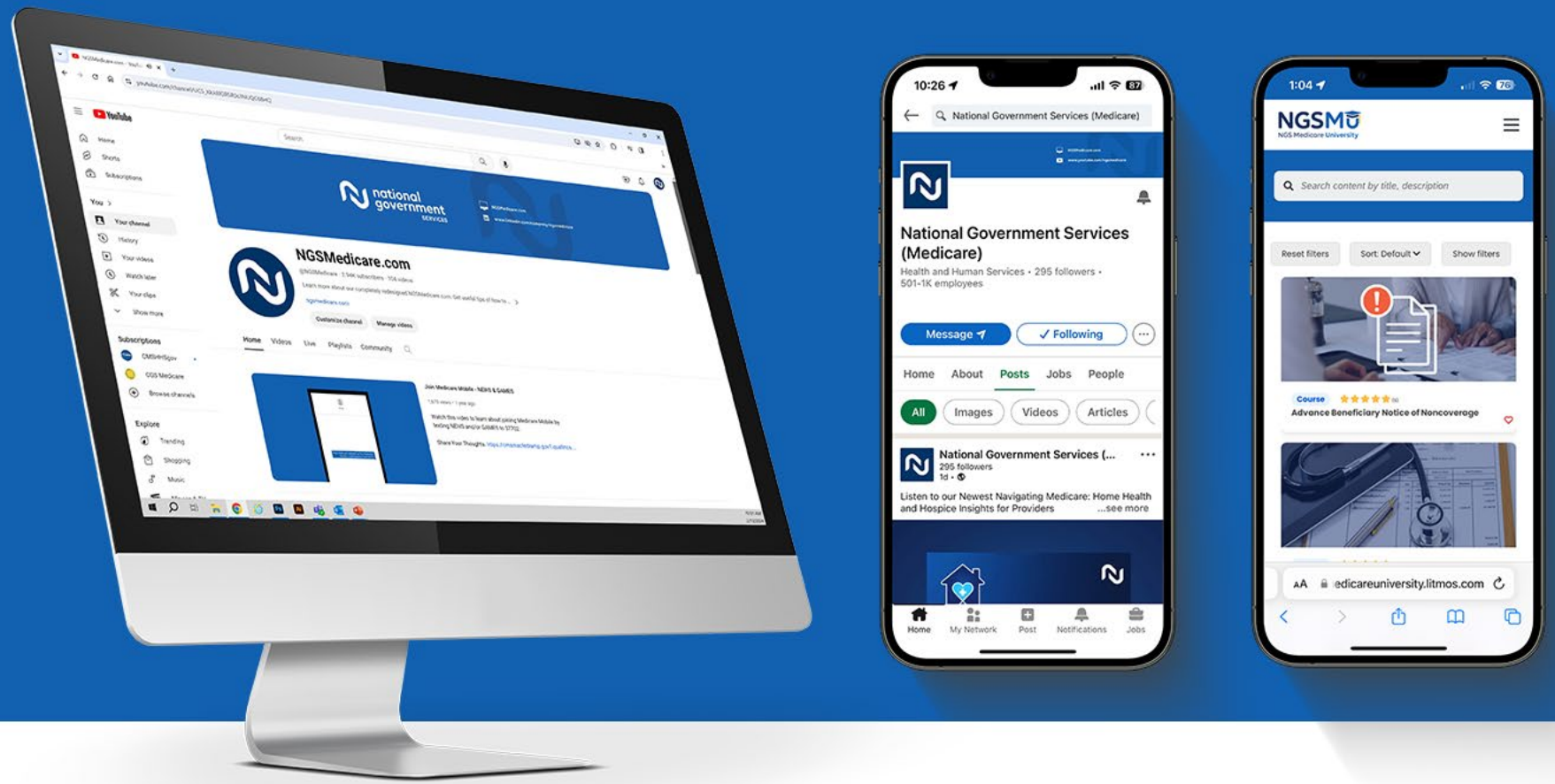
- MLN Matters® Fact Sheet: *MLN2259384: Rural Emergency Hospitals*
- CMS Rural Emergency Hospitals
- Rural Emergency Hospital Provisions, Conversion Process, & Conditions of Participation: Revised Guidance (released 9/6/2024)

NGS Resources

- Eligible Method II Providers
- How to Determine if the Provider is Active and Get the Provider Enrolled in Medicare Part B
- Critical Access Hospitals: Bill Correctly
- Intensive Outpatient Program

Questions?

Thank you!



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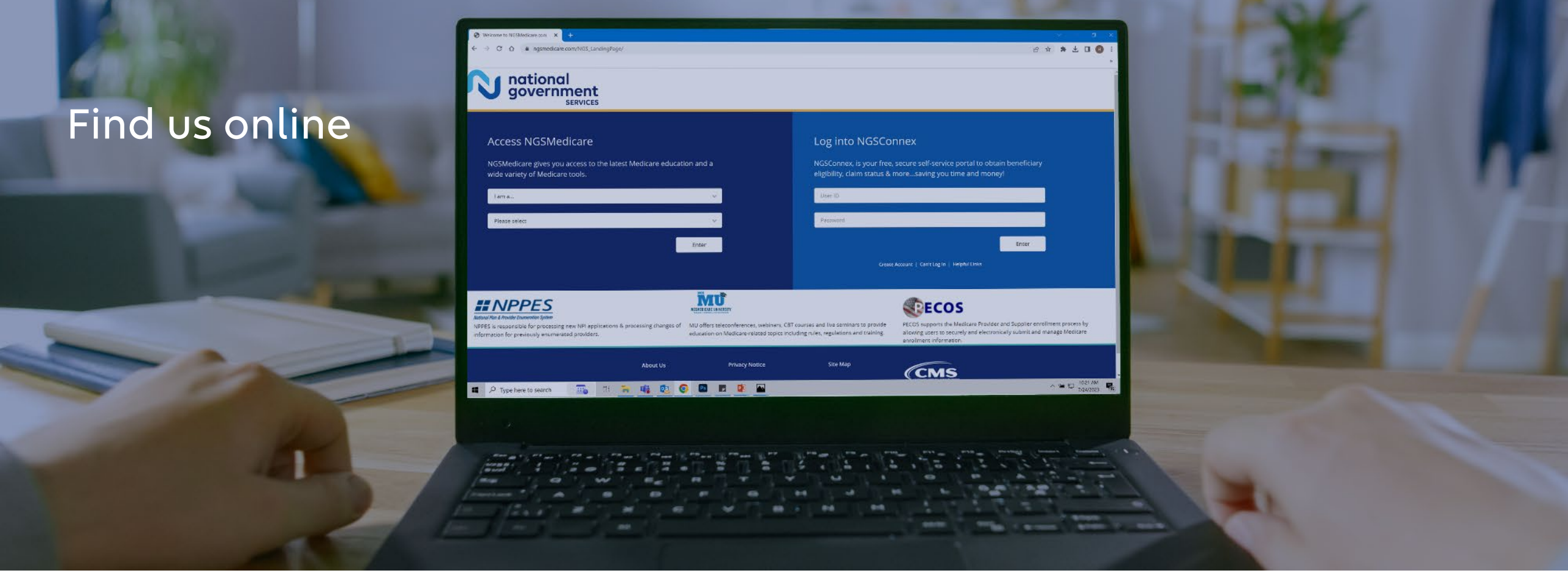

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