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 2370

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3610.22 (Cont.) – 3610.24	6-120.1 – 6-120.5 (5 pp.)	6-120.1 – 6-120.3 (4 pp.)

NEW PROCEDURES--EFFECTIVE DATE: April 1, 2003
IMPLEMENTATION DATE: April 1, 2003

Section 3610.22, Payment for Services Furnished by a CAH, has been expanded to include:

- The 2003 Physician Fee Schedule file name. (You will receive notification when this file is available.)
- The "GF" Modifier that must be on a claim if services are rendered by non-physicians (e.g., Nurse Practitioners, Physician Assistants, or Clinical Nurse Specialist. **This code is not to be used for CRNA services**). These types of services will be reimbursed at 115 percent of 85 percent of the Physician Fee Schedule.
- CRNA Reimbursement Requirements.

(Instruct your Option II providers to hold CRNA and non-physician claims with dates of service January 1, 2003 through March 31, 2003.)

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) 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:

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

Beginning January 2003 the file names are:

MU00.@BF12390.MPFS.CY03.ABSTR.V1114.FI
MU00.@BF12390.MPFS.CY03.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 (e.g., Nurse Practitioner; Physician Assistant; or Clinical Nurse Specialist), renders a service, the "GF" modifier must be on the applicable line. Pay 115 percent of 85 percent of the Physician Fee Schedule for this service. **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, return the claim to the provider.**

- CRNA Services (CRNA 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 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.

Method I

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

Reimbursement

Revenue Code 37X = CRNA technical service - Cost Reimbursement

Deductible and coinsurance apply.

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 = Anesthesia

Reimbursement

Revenue Code 37X for CRNA Technical = cost reimbursement
Revenue Code 964 for CRNA Professional = 50% of Allowed Amount times 115%; or
Revenue Code 964 and the "QZ" modifier for non-medically directed CRNA Professional = 80% of Allowed Amount times 115%

How to calculate payment for anesthesia claims based on the formula

Identify anesthesia claims by HCPCS code range from 00100 through 01999

Add the anesthesia code base unit and time units. The time units are calculated by dividing actual anesthesia time (Units field on the UB92) by 15. Multiply the sum of base and time units by the locality specific anesthesia conversion factor (file name below).

The Medicare program pays the CRNA 80% of this allowable charge (non-medically directed). Deductible and coinsurance apply.

If the CRNA is medically directed, pay 50% of the allowable charge. Deductible and coinsurance apply.

Base Formula

Number of minutes divided by 15, plus the base units = Sum
Sum times the conversion factor = allowed amount

Source

Number of minutes = Number of units on the claim (Units field of the UB92)
Base Units = Anesthesia HCPCS
Conversion Factor = File – MU00.@BF12390.MPFS.CY03.ANES.V1016

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

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.

C. 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.

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 does not apply. Part B of Medicare also covers the reasonable cost of hepatitis B vaccine and its administration. Deductible and coinsurance apply.

E. For claims with dates of service on or after January 1, 2002, §104 of the Benefit 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.

F. 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.

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 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.

Currently, to calculate the swing bed cost carve out from routine services, 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 CMS-1450 are completed in accordance with §3604.