



Medicare Critical Access Hospital Version

KEY CONCEPTS OUTLINE

Module 10: Overview of the Cost-Based Reimbursement System

I. Components of the Cost-Based Reimbursement System

A. Interim Payment Rates

1. For cost reporting periods beginning on and after January 1, 2004, a CAH is paid 101% of its "reasonable costs" of providing inpatient and outpatient services. <See 42 C.F.R. 413.70(a)(1), (b)(2)>
 - a. Under the principles of reimbursement, providers must report their costs on an annual cost report for their fiscal year. <See 42 C.F.R. 413.70; 42 C.F.R. 413.20>
 - i. The costs of services vary between providers and reflect the differences in the scope of each provider's services and the intensity of care provided. <42 C.F.R. 413.9(b)(2)>
 - ii. Cost includes both direct and indirect costs as determined under the applicable Medicare principles of reimbursement. <42 C.F.R. 413.9(a)>
 - iii. The determination of reasonable cost of services must be based on all costs related to the care of the patient, including expenses such as administrative costs, maintenance costs, and employee health premium and pension plans. <42 C.F.R. 413.9(c)(3)>
2. The cost report is used to determine an interim rate of reimbursement based on the previous year's costs of covered services. <42 C.F.R. 413.64(a)>
 - a. The interim rate is used for the current cost reporting period and is either an amount per inpatient day (i.e., per diem) or a percent of the CAH's outpatient charges.

If applicable, a per diem amount will also apply to a CAH's swing bed reimbursement. Swing beds will be discussed in a later module.

- b. If a CAH submits evidence that during its fiscal year, the actual costs are or will be significantly higher than the computed rate, the MAC may adjust the interim payment rate for inpatient or outpatient services. <42 C.F.R. 413.64(a)>

c. The MAC may also adjust the interim payment rate if it has evidence that the CAH's actual costs will be significantly lower than the computed rate.

3. A retroactive adjustment based on a CAH's actual costs for inpatient and outpatient services is made at the end of the reporting period based on the settlement of the cost report. <42 C.F.R. 413.64(a)>

B. Periodic Interim Payment for Inpatient Services

1. For Part A inpatient services, a CAH may elect to receive a periodic interim payment (PIP). <See 42 C.F.R. 413.70(d)>

a. A payment is made biweekly unless the provider requests a longer fixed interval (not to exceed one month). The payment is based on the total estimated Medicare payment for the CAH's cost reporting period, excluding inpatient deductible and coinsurance amounts.

b. The PIP amount may be adjusted at any time during the cost reporting period upon the request of the CAH or if the MAC obtains evidence regarding a change in the CAH's costs or utilization. <42 C.F.R. 413.64>

2. A retroactive adjustment based on a CAH's actual costs for inpatient services is made at the end of the reporting period based on the settlement of the cost report. <42 C.F.R. 413.64(a)>

C. Meaningful Use Electronic Health Record (EHR) Incentive Payment

1. A qualifying CAH may receive an incentive payment for the reasonable costs of purchasing certified EHR technology (CEHRT) in a cost reporting period. <See 42 C.F.R. 413.70(a)(6); 42 C.F.R. 495.106>

a. The incentive payment only applies to inpatient services.

b. In order to be considered a meaningful user and avoid a downward payment adjustment, eligible hospitals and CAHs may use (1) existing 2015 Edition certification criteria, (2) the 2015 Edition Cures Update criteria, or (3) a combination of the two in order to meet the CEHRT definition.

i. In CY 2023, the EHR reporting period is a minimum of any continuous 90-day period for participants in the Medicare Promoting Interoperability Program.

ii. For CY 2023, the CEHRT functionality must be in place by the first day of the EHR reporting period and the product must be certified by the last day of the EHR reporting period. The eligible hospital or CAH must be using their selected version's functionality for the full EHR reporting period.

Link: Promoting Interoperability – 2023 Program Requirements Medicare under Medicare Related Sites - General

Use links on left navigation

If a CAH is not a meaningful user for its EHR reporting period, the reasonable cost payments for inpatient services are reduced to 100% rather than the usual 101%.

II. Difference Between Method I and Method II Outpatient Billing

A. Election of Billing Methodology

1. For each cost reporting period, a CAH has the option to “elect” either Method I billing (standard method) or Method II billing (optional method) when submitting claims for outpatient services. <See 42 C.F.R. 413.70(b)>

Election of the optional method or Method II only applies to outpatient services and the related professional services billed on type of bill 085X.

B. Method I (standard method)

1. Under Method I billing, the payment for the hospital outpatient services billed on the UB04 claim will be 101% of the reasonable cost of furnishing the outpatient services, less applicable Part B deductible and coinsurance amounts. <See 42 C.F.R. 413.70(b)(2)>
 - a. Payment for the related professional services furnished in a CAH’s outpatient department and billed on the 1500 claim form, is made by the Part B MAC on a fee schedule amount, charge, or other fee basis.

The place of service (POS) reported on the 1500 claim form will be a hospital outpatient department.

C. Method II (optional method)

1. Under Method II billing, the payment to a CAH includes both the hospital outpatient services and the related professional services. Both services are billed on the UB04 claim form only. <See 42 C.F.R. 413.70(a)(2), (b)(3)>
 - a. Inpatient services and swing bed services are excluded from Method II payment as Part A does not include the costs of physician or other professional services.

2. Election of Method II

- a. For any given annual cost reporting period, a CAH may elect to be paid under Method II for outpatient services. <See 42 C.F.R. 413.70(b)(3)(i)(A)(1)(2)>
 - i. A written election (letter) must be filed with the MAC at least 30 days before the start of the CAH's cost reporting period to which the election applies.
 - ii. The election remains in effect for the entire cost reporting period and for all subsequent cost reporting periods, unless terminated.

If a CAH wants to terminate its Method II election for all or part of its previously elected outpatient services, the request must be submitted to the MAC at least 30 days prior to the start of the CAH's next cost reporting period.

- b. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 changed the requirement that practitioners providing outpatient services in a CAH that had elected Method II must reassign their billing rights to that CAH. <See *Medicare Claims Processing Manual*, Chapter 4 § 250.2>
 - i. Each practitioner can choose to either reassign billing rights to the CAH or file claims for professional services through his or her Part B MAC.
 - a) Once reassignment is selected by the practitioner, it will remain in effect for the entire cost reporting period and for all subsequent cost reporting periods, unless terminated.
 - ii. If reassignment has been given to the CAH, the individual practitioner must certify on the CMS 855R form that he or she wishes to reassign their billing rights. <See *Medicare Claims Processing Manual*, Chapter 4 § 250.2>

CMS has revised the 855R Reassignment of Benefits form. Beginning May 1, 2020, MACs will only accept the updated version of the form with an expiration date of 01/31/2023.

Link: Provider Enrollment, Chain and Ownership System (PECOS) under Revenue Integrity and Chargemaster Boot Camp Links
Use Enrollment Applications link on left navigation

- a) A copy of the CMS 855R form must be forwarded to the Part A MAC. The election will apply to all outpatient services performed by the individual practitioner at the CAH. It is not necessary to submit a copy of the form each cost reporting year.

- b) The Part B MAC must have the practitioner sign an attestation that he or she will not bill the Part A or Part B MAC for any *outpatient* services performed at the CAH.

Caution: Although the Medicare Claims Processing Manual states that the Part B MAC must have the practitioner sign an attestation, many MACs have verbally stated and posted on their websites that obtaining the attestation is the responsibility of the CAH. There is no specific form published by CMS and CAHs may consider creating a statement and maintaining the original statement with the 855R.

As new practitioners are added to the medical staff of a CAH and if the new practitioner wants to reassign his or her billing rights to the CAH, a CMS 855R must be submitted to the MAC to bill under Method II for that practitioner.

III. Billing and Payment for Outpatient Services Under Method II

A. UB04 Claim for Billing

1. Under Method II, the CAH bills for its outpatient services and the related professional fee on the UB04 claim form. <See 42 *C.F.R.* 413.70(b)(3)(ii)(A)>
 - a. The professional services must be reported using revenue codes 096X, 097X, or 098X. <See *Medicare Claims Processing Manual*, Chapter 4 § 250.2>
 - i. Special billing instructions found in the *Medicare Claims Processing Manual*, Chapter 12 apply when billing the related professional services on the UB04.
 - a) Unlisted HCPCS codes billed with revenue code 096X, 097X, or 098X will be returned to provider (RTP). A CAH must determine a more specific HCPCS code before submitting the claim. Per CMS, providers that are unable to determine a more specific code may contact the American Medical Association to request that a HCPCS code be assigned for that procedure. <CMS Joint Signature Memorandum 10161, March 2, 2010>

B. Payment for Outpatient Services Under Method II

1. In general, the CAH will receive payment from its MAC for both the facility outpatient services and the related professional services. <See *Medicare Claims Processing Manual*, Chapter 4 § 250.2>
 - a. The CAH will be paid 101% of the reasonable cost of the outpatient services, less applicable Part B deductible and coinsurance amounts. <See 42 *C.F.R.* 413.70(b)(2)>

- b. The CAH will also be paid 115% of the amount the Part B MAC would pay for the professional services under the Medicare Physician Fee Schedule (MPFS), less applicable Part B deductible and coinsurance amounts. <See 42 C.F.R. 413.70(b)(3)(ii)(B)>
- i. The payment for the services of the physician or non-physician practitioner will be the lesser of the actual charge or the MPFS amount. <See *Medicare Claims Processing Manual*, Chapter 4 § 250.2>
 - a) The payment for the professional service is based on the HCPCS code and the applicable modifier reported on the UB04 claim form.
 - b) For example, when reporting modifier -GF (services rendered by a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA)), the professional fee will be paid at the lesser of the actual charge or the MPFS non-physician services reduced amount (0.85) minus deductible and coinsurance multiplied by 115%.

For a complete list of related modifiers and the associated payment formulas, refer to the Medicare Claims Processing Manual, Chapter 4 § 250.2 behind the outline and in the Medicare Claims Processing Manual, Chapter 12.

C. Professional Fee Incentive Payments or Adjustments Under Method II

1. When a practitioner has reassigned his or her billing rights to the CAH for the purposes of Method II billing, incentive payments or negative adjustments will apply to the CAH's payment for the outpatient professional services.
2. Health Professional Shortage Area (HPSA) Incentive Payment
 - a. If a physician or non-physician practitioner is entitled to receive HPSA incentive payments and the practitioner has reassigned his or her billing rights to the CAH under Method II, the CAH will receive the incentive payments from the MAC. <See *Medicare Claims Processing Manual*, Chapter 4 § 250.2>
 - i. Eligibility for incentive payments is determined on an annual basis.
 - b. If the CAH is located within a primary medical care HPSA or mental health HPSA, the practitioners who have elected Method II may be eligible for HPSA incentive payments based on providing the outpatient service in the CAH. <See *Medicare Claims Processing Manual*, Chapter 4 § 250.2; see *MLN Fact Sheet: Health Professional Shortage Area Physician Program*, February 2021>
 - i. Payment to the CAH for the professional services will be 115% of the amount the Part B MAC would pay under the MPFS, less the patient

deductible and coinsurance. The Method II payment is then multiplied by 110% for the HPSA incentive payment.

- ii. Every quarter, a report with the incentive payment is provided to the CAH for each qualifying practitioner.

Link: Physician Bonuses under Medicare Related Sites – Physician/Practitioner

3. Medicare Quality Payment Program (QPP)

- a. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the Medicare sustainable growth rate (SGR) methodology for updates to the MPFS and replaced it with a new Merit-based Incentive Payment System (MIPS) for eligible practitioners or groups. <81 Fed. Reg. 77008>
 - i. MIPS applies to eligible practitioners who have elected Method II billing with a CAH.
 - ii. QPP replaced the Physician Quality Reporting System (PQRS), the Physician Value-based Payment Modifier (VM), and EHR incentive payments.

Link: Quality Payment Program for Physicians under Medicare Related Sites – Physician/Practitioner

- b. Performance year (PY) 2022 and related payment adjustments for CY2023 <2023 MIPS Payment Year Payment Adjustment User Guide>
 - i. PY2022 covers services provided from January 1, 2022 through December 31, 2022.
 - ii. In October 2022, CMS announced the release of 2023 performance feedback for the QPP MIPS. MIPS-eligible clinicians can now obtain their performance feedback, final score and accompanying MIPS payment adjustment information for CY2023 from the [QPP website](#).
 - a) To access the information, physicians will need to [log in to their QPP account](#) using their HCQIS Access Roles and Profile system credentials (the same credentials used to submit 2020 MIPS data).
 - b) MIPS-eligible clinicians will be able to access feedback on measure-level performance data and scores, activity-level scores, performance category-level scores and final score for PY2023.
 - c) According to CMS' [2023 MIPS Payment Year Payment Adjustment User Guide](#), each physician's final score is used to determine whether that physician will receive a positive, negative or neutral adjustment to

payments for covered professional services provided in the 2023 MIPS payment year.

- 1) For example, the basic performance threshold for CY2022 is set at 75 points, meaning MIPS-eligible clinicians with a PY2022 MIPS final score of 75 points or higher will avoid a negative payment adjustment in the 2023 MIPS payment year.
- 2) The performance threshold for exceptional performance for the CY2022 is 75 points. A MIPS-eligible clinician with a final score of 75 points or higher will receive an additional payment adjustment factor for exceptional performance.

For more information about the performance feedback process, physicians can review the following resources:

- *2020 Performance Period Quality Benchmarks Fact Sheet*
- *2020 MIPS Performance Feedback and 2020 Payment Adjustment FAQs*

CMS has provided flexible options for practitioners in small practices, including those in rural locations, health professional shortage areas, and medically underserved areas to assist them with participation in the QPP.

IV. CRNA Pass-Through Exemption

A. Qualifying for Pass-Through Exemption

1. A CAH must qualify for the MPFS payment exemption by meeting both of the following criteria:
 - a. The CAH is located in a rural area and employs one full-time CRNA. <42 C.F.R. 412.113(c)(2)(ii)>
 - 1) The CAH may employ or contract services with more than one CRNA; however, the total number of hours of service furnished by all CRNAs combined may not exceed 2,080 hours per year (full-time employment).
 - b. The CAH's total volume of surgical procedures that require anesthesia, including inpatients and outpatients, does not exceed 800 procedures during the calendar year. <42 C.F.R. 412.113(c)(2)(ii)>

- 1) To maintain its eligibility for CRNA pass-through exemption, a CAH must demonstrate to its MAC that prior to January 1 of each respective year, its total volume of surgical procedures requiring anesthesia did not exceed 800 procedures.

B. Billing for CRNA Pass-Through Services

1. When a CAH meets the criteria for the CRNA pass-through exemption, it can choose not to elect Method II for outpatient services provided by a CRNA. <See *Medicare Claims Processing Manual*, Chapter 4 § 250.3.3.1>
 - a. By not electing Method II, the CAH will retain the pass-through exemption for outpatient professional services provided by the CRNA, as well as inpatient and swing bed CRNA professional services.
 - b. A CAH may receive pass-through payment for *any* service that a CRNA is legally authorized to perform in the state in which the services are furnished. <42 *C.F.R.* 410.69(b); see *Medicare Claims Processing Manual*, Chapter 4 § 250.3.3.1>
2. Under the CRNA pass-through exemption, both the technical and professional fees for the anesthesia services are billed on the UB04 claim form. <See *Medicare Claims Processing Manual*, Chapter 4 § 250.3.3.1>
 - a. This applies to billing for outpatient services (TOB 85X), inpatient services (TOB 11X), or swing bed services (TOB 018X). <See *Medicare Claims Processing Manual Transmittal 4157*>

- *The facility's anesthesia services are reported using revenue code 037X.*
- *The CRNA professional services are reported using revenue code 0964.*
- *The appropriate HCPCS code is also included on the outpatient claim.*

C. Effect on Payment

1. A CAH may receive a pass-through exemption for anesthesia services provided by a CRNA that is either employed by the CAH or when CRNA services are provided under arrangement with the CAH. <42 *C.F.R.* 412.113(c)>
 - a. The pass-through exemption allows a CAH to be paid for CRNA services under the reasonable cost-based methodology rather than under the MPFS amount.

The CRNA pass-through exemption applies to anesthesia services provided by CRNAs for outpatient, inpatient, and swing bed services.

2. Payment to the CAH will include both the facility and professional anesthesia services. The payment will be based on the usual reasonable cost methodology. <See *Medicare Claims Processing Manual*, Chapter 4 § 250.3.3.1>

D. Loss of or Relinquishing of Pass-Through Exemption

1. The pass-through exemption is withdrawn for outpatient, inpatient, and swing bed CRNA services if:
 - a. The CAH has lost its exemption due to a change in staffing and/or total surgical volume; or,
 - b. The CAH has relinquished its exemption to elect to bill outpatient CRNA services under Method II. <See *Medicare Claims Processing Manual*, Chapter 4 § 250.3.3.2>
2. Billing under Method II for outpatient anesthesia services
 - a. The facility fee is reported with revenue code 037X on the UB04. <See *Medicare Claims Processing Manual*, Chapter 4 § 250.3.3.2>
 - i. The reimbursement for the facility fee is made under the usual reasonable cost methodology.

See the Medicare Claims Processing Manual, Chapter 12 § 50.C. for guidance on medical direction by a physician for anesthesia services.

- b. The professional fees are reported with revenue code 0964 and the appropriate HCPCS code and modifier on the UB04. <See *Medicare Claims Processing Manual*, Chapter 4 § 250.3.3.2>
 - i. The reimbursement for CRNA anesthesia services (HCPCS code range 00100 through 01999) billed under Method II is:
 - a) 100% of the allowed amount for anesthesia that is not medically directed by a physician and reported with modifier -QZ multiplied by 115%; or,
 - b) 50% of the allowed amount for anesthesia that is medically directed by a physician and reported with modifier -QX multiplied by 115%.
3. Billing for inpatient or swing bed anesthesia services
 - a. The facility fee is reported with revenue code 037X on the UB04. <See *Medicare Claims Processing Manual*, Chapter 4 § 250.3.3.2; see *Medicare Claims Processing Manual Transmittal 4157*>

- i. The reimbursement for the facility fee is made under the usual reasonable cost methodology.
- b. The CRNA professional fees are billed to the Part B MAC on the 1500 claim form. <See *Medicare Claims Processing Manual*, Chapter 4 § 250.3.3.2>
- i. The reimbursement for the professional fee will be made under the usual MPFS amount.

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VI. Calculating Patient Responsibility for Outpatient Services

- A. Payments for outpatient services are subject to Part B deductible and coinsurance amounts, excluding those services where the deductible and/or coinsurance are waived based on a statute. <See *Medicare Claims Processing Manual*, Chapter 4, § 250.4>
1. For CY 2023, the Part B deductible is \$226.00. <85 Fed. Reg. 71904>
 2. The patient's coinsurance amount for the facility is 20% of the CAH's reasonable charges. <*Social Security Act* §§ 1883, 1834, 1866; see 42 *C.F.R.* § 410.152(k)(2)>
 - a. The coinsurance amount for outpatient CAH services is not limited by the current Part A inpatient deductible that applies to hospitals paid under OPFS. <See CMS Rural Health Series – Critical Access Hospital Fact Sheet, July 2019 in Module 1>
 3. The patient's coinsurance amount for the physician or NPP fee is 20% of the allowed amount as listed in the MPFS, after applicable reductions based on the modifier reported. <See CMS Rural Health Series – Critical Access Hospital Fact Sheet, March 2020 in Module 1>

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Case Study 1

Facts: An ER physicians' group is contracted by a CAH to provide emergency services. The group consists of four physicians and two nurse practitioners. The group completed the appropriate 855R forms and attestations to reassign their billing rights to the CAH. The MAC was notified by the CAH that it could bill under Method II for the ER group, beginning on January 1st. The ER coding team reviews the practitioner's and facility nursing documentation and assigns the appropriate diagnosis codes, procedure codes, E/M codes, and applicable modifiers. Each clinical department is responsible for submitting its charges with applicable HCPCS codes. The HIM coding team completes a final review of all charges, diagnosis codes, and HCPCS codes for edits prior to billing.

A patient presents to the ER and is seen by the nurse practitioner. The coder assigns a facility E/M level 99283 and a professional E/M level 99284. No other procedures were performed in the ER. The coder enters the following information for the ER visit into the patient's account, which is reflected on the claim:

450	ER Facility	99283	020120	1	250.00
981	ER Professional	99284	020120	1	350.00

The CAH's outpatient interim rate is .40. The MPFS payment rate for 99284 is \$119.65. The patient has met the Part B deductible for 2021.

- In this example, what is the patient's coinsurance amount for these two charges as billed?
 - How much will the MAC pay the CAH for its services under Method II as billed?
-
- Is there a risk of overpayment based on the information submitted by the coder?
 - If so, what could have prevented the overpayments by the patient and Medicare?

B. Waiver of Deductible and/or Coinsurance

1. Laboratory services

- a. In most circumstances, patients receiving laboratory services in a CAH are not financially liable for deductible or coinsurance amounts when laboratory tests are listed in the Clinical Laboratory Fee Schedule. < *Medicare Claims Processing Manual/Transmittal 2581* >

2. Preventive services

- a. Application of the deductible and/or coinsurance for screening and preventive services varies.
- b. The Patient Protection and Affordable Care Act (ACA) waived the deductible and coinsurance for Medicare covered preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B.

See the Medicare Claims Processing Manual, Chapter 18 for a complete list of preventive services and patient financial liability.

Link: MLN Publications under Medicare Related Sites – General

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VII. Calculating Patient Responsibility for Inpatient Services

A. Benefit Periods

1. The inpatient deductible and coinsurance are based on a “benefit period” concept.
 - a. The benefit period begins to run when the patient is first admitted to a hospital or SNF for inpatient care. The benefit period ends when the patient has not been an inpatient of a hospital or SNF for 60 consecutive days. <42 C.F.R. §§ 409.60(a), 409.60(b)>
 - i. SNF admissions and discharges affect the benefit period determination regardless if the beneficiary’s SNF care qualified for Medicare coverage. <Medicare General Information, Eligibility, and Entitlement Manual, Chapter 3 § 10.4.3.2 (Example 3)>

A benefit period can be as short as 61 days and there can be multiple benefit periods in a calendar year, resulting in payment of the deductible multiples times in a single calendar year.

B. Deductible and Coinsurance Amounts

1. The first 60 inpatient hospitalization days of a benefit period are considered full benefit days and the patient is only responsible for paying the inpatient deductible. <42 C.F.R. § 409.61(a)(1)(i)>

- a. For CY 2023, the inpatient deductible is \$1,600 per benefit period. < *Medicare General Information, Eligibility, and Entitlement*, Chapter 3 § 10.3>
 - b. The deductible is based on the calendar year in which the benefit period began. < *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 3 § 10.3>
2. Inpatient hospitalization days 61 to 90 in a benefit period are considered coinsurance days and the patient pays a daily coinsurance. <42 *C.F.R.* § 409.61(a)(1)(ii)>
- a. For CY 2023, the daily coinsurance is \$400 (25% X \$1600) per day. < *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 3 § 10.3>
3. Lifetime reserve days
- a. Medicare beneficiaries have 60 "lifetime reserve days" that may be used after the full benefit and coinsurance days for a specific benefit period have been used. <42 *C.F.R.* §409.61(a)(2)>
- Full benefit and coinsurance days are renewed each benefit period; however, once the 60 lifetime reserve days are used, they are exhausted forever.*
- b. For each lifetime reserve day, the patient is responsible for a daily coinsurance. < *Medicare General Information, Eligibility, and Entitlement Manual*, Chapter 3 §§ 10.2.1, 10.3>
 - i. For CY 2023, the lifetime reserve day coinsurance is \$800 (50% X \$1600) per day. < *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 3 § 10.3>
 - c. Beneficiary deemed not to use lifetime reserve days
 - i. In general, if the billed charges for which the beneficiary would be responsible are less than or equal to the amount he or she would pay using lifetime reserve days, the beneficiary will be deemed not to use his or her lifetime reserve days. < *Medicare Benefit Policy Manual*, Chapter 5 § 30.1 (1)>
 - d. Election not to use lifetime reserve days
 - i. Hospitals are required to notify beneficiaries that they may elect not to use their lifetime reserve days for all or part of a stay. < *Medicare Benefit Policy Manual*, Chapter 5 § 30.1, *MLN Matters Article SE0663*>

- a) Ideally, the notice should be given when the beneficiary has five regular coinsurance days left and is expected to be hospitalized beyond that period.
 - b) CMS provides model language for use by beneficiaries in making an election not to use lifetime reserve days. < *Medicare Benefit Policy Manual*, Chapter 5 § 40.1 >
 - c) A retroactive election not to use lifetime reserve days may be made if certain criteria are met. < *Medicare Benefit Policy Manual*, Chapter 5 § 30.3 >
- ii. If the beneficiary elects not to use lifetime reserve days, then the hospital may bill the patient for any services provided after the beneficiary's full benefit days and coinsurance days are exhausted. <42 *C.F.R.* §409.65(a)(4)>

NOTE: Calculation of the patient's responsibility for swing bed services will be discussed in Module 12.

Case Study 2

Facts: A Medicare beneficiary who had not been hospitalized yet in 2023 was appropriately admitted to the CAH and after unforeseen complications, stayed in the CAH for 8 days (Admission #1). The patient was discharged from Admission #1 to a skilled nursing facility (SNF) for 64 days. Thirty days after leaving the SNF, the patient was admitted (Admission #2) to the CAH for a four-day stay and then discharged to home. All services were provided during 2023.

- What is the beneficiary's total deductible and coinsurance liability for Admission #1?
- What is the beneficiary's total deductible and coinsurance liability for Admission #2?

Modified Facts: The patient is admitted for a third time (Admission #3) 65 days after discharge from Admission #2. The length of stay for Admission #3 was 3 days.

- What is the beneficiary's total deductible and coinsurance liability for Admission #3?

CASE STUDIES WITH ANALYSIS

Case Study 1

Facts: An ER physicians' group is contracted by a CAH to provide emergency services. The group consists of four physicians and two nurse practitioners. The group completed the appropriate 855R forms and attestations to reassign their billing rights to the CAH. The MAC was notified by the CAH that it could bill under Method II for the ER group, beginning on January 1st. The ER coding team reviews the practitioner's and facility nursing documentation and assigns the appropriate diagnoses codes, procedure codes, E/M codes, and applicable modifiers. Each clinical department is responsible for submitting its charges with applicable HCPCS codes. The HIM coding team completes a final review of all charges, diagnosis codes, and HCPCS codes for edits prior to billing.

A patient presents to the ER and is seen by the nurse practitioner. The coder assigns a facility E/M level 99283 and a professional E/M level 99284. No other procedures were performed in the ER. The coder enters the following information for the ER visit into the patient's account, which is reflected on the claim:

450	ER Facility	99283 020120	1	250.00
981	ER Professional	99284 020120	1	350.00

The CAH's outpatient interim rate is .40. The MPFS payment rate for 99284 is \$121.32. The patient has met the Part B deductible for 2023.

- In this example, what is the patient's coinsurance amount for these two charges as billed?
- How much will the MAC pay the CAH for its services under Method II as billed?

Analysis:

Patient responsibility = \$73.93

- Facility: $250.00 \times .20 = \$50.00$
- Professional: $121.32 \times .20 = \$24.62$

Medicare = \$161.08

- Facility: $250.00 \times .40 [X 1.01] = \$101.00 [- 50] = \$51.00$
- Professional: $121.32 - 24.62 = \$96.70 [X 1.15] = \111.21

- Is there a risk of overpayment based on the information submitted by the coder?
- If so, what could have prevented the overpayments by the patient and Medicare?

Analysis: When services are provided by non-physician practitioners, the applicable modifier must also be reported to trigger the reduction in the patient's coinsurance and the MPFS payment Medicare. In this example, modifier -GF (services rendered by an NP, PA, or CNS) should have been reported on the professional E/M code (99284). MPFS payment would have been reduced by 15% prior to calculating coinsurance and Medicare payment.

MPFS Reduction: $121.32 \times .85 = \$103.12$

Patient: $103.12 \times .20 = \$20.62$

Medicare: $103.21 - 20.34 = \$82.78 [\times 1.15] = \95.20

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Case Study 2

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- What is the beneficiary's total deductible and coinsurance liability for Admission #1?
- What is the beneficiary's total deductible and coinsurance liability for Admission #2?

Analysis: For Admission #1, the patient would pay the deductible of \$1,600 on day one of the stay. This would cover all 8 days of the first admission, leaving 52 full benefit days remaining in that benefit period. Since there was no 60-day break between the patient's discharge from the SNF and Admission #2, the second admission is within the same benefit period. Therefore, all 4 days of Admission #2 would also be covered under the deductible paid for Admission #1, leaving 48 full benefit days remaining in that benefit period.

Modified Facts: The patient is admitted for a third time (Admission #3) 65 days after discharge from Admission #2. The length of stay for Admission #3 was 3 days.

- What is the beneficiary's total deductible and coinsurance liability for Admission #3?

Analysis: For Admission #3, the patient would pay the deductible of \$1,600. The patient began a new benefit period after the 60-day break between Admissions #2 and #3.
<Medicare General Information, Eligibility and Entitlement Manual, Chapter 3 § 10.1 and 10.3>

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Title 42

§ 413.70 Payment for services of a CAH.

(a) *Payment for inpatient services furnished by a CAH (other than services of distinct part units).*

- (1) Effective for cost reporting periods beginning on or after January 1, 2004, payment for inpatient services of a CAH, other than services of a distinct part unit of the CAH and other than the items included in the incentive payment described in paragraph (a)(5) of this section and subject to the adjustments described in paragraph (a)(6) of this section, is 101 percent of the reasonable costs of the CAH in providing CAH services to its inpatients, as determined in accordance with section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in this part and in part 415 of this chapter, except that the following payment principles are excluded when determining payment for CAH inpatient services:
 - (i) Lesser of cost or charges;
 - (ii) Ceilings on hospital operating costs;
 - (iii) Reasonable compensation equivalent (RCE) limits for physician services to providers; and
 - (iv) The payment window provisions for preadmission services, specified in § 412.2(c)(5) of this subchapter and § 413.40(c)(2) of this part.
- (2) Except as specified in paragraph (a)(3) of this section, payment to a CAH for inpatient services does not include any costs of physician services or other professional services to CAH inpatients, and is subject to the Part A hospital deductible and coinsurance, as determined under subpart G of part 409 of this chapter.
- (3) If a CAH meets the criteria in § 412.113(c) of this subchapter for pass-through of costs of anesthesia services furnished by qualified nonphysician anesthetists employed by the CAH or obtained under arrangements, payment to the CAH for the costs of those services is made in accordance with § 412.113(c).
- (4) Payment for inpatient services of distinct part psychiatric or rehabilitation units is described in paragraph (e) of this section.
- (5) A qualifying CAH receives an incentive payment for the reasonable costs of purchasing certified EHR technology in a cost reporting period during a payment year as determined under § 495.106 of this chapter in lieu of payment for such reasonable costs under paragraph (a)(1) of this section.
- (6)
 - (i) For cost reporting periods beginning in or after FY 2015, if a CAH is not a qualifying CAH for the applicable EHR reporting period, as defined in §§ 495.4 and 495.106(a) of this chapter, then notwithstanding the percentage applicable in paragraph (a)(1) of this

section, the reasonable costs of the CAH in providing CAH services to its inpatients are adjusted by the following applicable percentage:

- (A) For cost reporting periods beginning in FY 2015, 100.66 percent.
 - (B) For cost reporting periods beginning in FY 2016, 100.33 percent.
 - (C) For cost reporting periods beginning in FY 2017 and each subsequent fiscal year, 100 percent.
- (ii) The Secretary may on a case-by-case basis, exempt a CAH that is not a qualifying CAH from the application of the payment adjustment under paragraph (a)(6)(i) of this section if the Secretary determines that compliance with the requirement for being a meaningful user would result in a significant hardship for the CAH. In order to be considered for an exception, a CAH must submit an application demonstrating that it meets one or more of the criteria specified in this paragraph (a)(6) for the applicable payment adjustment year no later than November 30 after the close of the applicable EHR reporting period, or a later date specified by CMS. The Secretary may grant an exception for one or more of the following:
- (A) During any 90-day period from the beginning of the cost reporting period that begins in the fiscal year before the payment adjustment year to November 30 after the end of the payment adjustment year, or a later date specified by CMS, the hospital was located in an area without sufficient Internet access to comply with the meaningful use objectives requiring Internet connectivity, and faced insurmountable barriers to obtaining such Internet connectivity.
 - (B) A CAH that faces extreme and uncontrollable circumstances that prevent it from becoming a meaningful EHR user during the payment adjustment year.
 - (C) The CAH is new in the payment adjustment year and has not previously operated (under previous or present ownership). This exception expires beginning with the first Federal fiscal year that begins on or after the hospital has had at least one 12-month (or longer) cost reporting period after they accept their first Medicare-covered patient. For the purposes of this exception, the following CAHs are not considered new CAHs:
 - (1) A CAH that builds new or replacement facilities at the same or another location even if coincidental with a change of ownership, a change in management, or a lease arrangement.
 - (2) A CAH that closes and subsequently reopens.
 - (3) A CAH that has been converted from an eligible hospital as defined at § 495.4 of this chapter.
- (iii) *Exception for decertified EHR technology.* Beginning with the fiscal year 2018 payment adjustment year, the Secretary shall exempt a CAH that is not a qualifying CAH from the application of the payment adjustment under paragraph (a)(6)(i) of this section if the Secretary determines that compliance with the requirement for being a meaningful EHR user is not possible because the certified EHR technology used by the CAH has been decertified under ONC's Health IT Certification Program. In order to be considered for an exception, a CAH must submit an application, in the manner specified by CMS, demonstrating that the certified EHR technology was decertified during the 12-month period preceding the applicable EHR reporting period for the payment adjustment year, or during the applicable EHR reporting period for the payment adjustment year, and that the CAH made a good faith effort to obtain another certified EHR technology for that EHR

reporting period. Applications requesting this exception must be submitted by November 30 after the end of the applicable payment adjustment year, or a later date specified by CMS.

- (iv) Exceptions granted under paragraphs (a)(6)(ii) and (iii) of this section are subject to annual renewal, but in no case may a CAH be granted such an exception for more than 5 years.
- (7) There is no administrative or judicial review under sections 1869 and 1878 of the Act otherwise of the following:
- (i) The methodology and standards for determining the amount of payment under paragraph (a)(5) of this section, including the calculation of reasonable costs under § 495.106(c) of this chapter.
 - (ii) The methodology and standards for determining the amount of payment adjustments made under paragraph (a)(6).
 - (iii) The methodology and standards for determining a CAH to be a qualifying CAH under § 495.106 of this chapter.
 - (iv) The methodology and standards for determining if the hardship exemption applies to a CAH under paragraph (a)(6)(ii) of this section.
 - (v) The specification of the cost reporting periods, payment years, or fiscal years as applied under this paragraph.
- (b) *Payment for outpatient services furnished by CAH -*
- (1) *General.*
 - (i) Unless the CAH elects to be paid for services to its outpatients under the method specified in paragraph (b)(3) of this section, the amount of payment for outpatient services of a CAH is determined under paragraph (b)(2) of this section.
 - (ii) Except as specified in paragraph (b)(6) of this section, payment to a CAH for outpatient services does not include any costs of physician services or other professional services to CAH outpatients.
 - (2) *Reasonable costs for facility services.*
 - (i) Effective for cost reporting periods beginning on or after January 1, 2004, payment for outpatient services of a CAH is 101 percent of the reasonable costs of the CAH in providing CAH services to its outpatients, as determined in accordance with section 1861(v)(1)(A) of the Act and the applicable principles of cost reimbursement in this part and in part 415 of this chapter, except that the following payment principles are excluded when determining payment for CAH outpatient services:
 - (A) Lesser of cost or charges; and
 - (B) RCE limits.
 - (ii) Payment to a CAH under paragraph (b)(2) of this section does not include any costs of physician services or other professional services to CAH outpatients and, other than for clinical diagnostic laboratory tests, is subject to the Part B deductible and coinsurance amounts as determined under §§ 410.152(k), 410.160, and 410.161 of this chapter.
 - (iii) [Reserved]

- (3) *Election to be paid reasonable costs for facility services plus fee schedule for professional services.*
- (i) A CAH may elect to be paid for outpatient services in any cost reporting period beginning on or after July 1, 2004 under the method described in paragraphs (b)(3)(ii) and (b)(3)(iii) of this section.
- (A)
- (1) *For cost reporting periods beginning before October 1, 2010.* The election must be made in writing, made on an annual basis, and delivered to the contractor or MAC servicing the CAH at least 30 days before the start of the cost reporting period for which the election is made. An election, once made for a cost reporting period, remains in effect for all of that period.
- (2) *For cost reporting periods beginning on or after October 1, 2010.* If a CAH had elected the method specified in paragraph (b)(3)(i) of this section in its most recent cost reporting period beginning prior to October 1, 2010, that election remains in effect for all of that period and for all subsequent cost reporting periods, unless the CAH submits a termination request to the contractor or MAC servicing the CAH at least 30 days before the start of the next cost reporting period. However, for cost reporting periods beginning in October 2010 and November 2010, if a CAH wishes to terminate its previous election, the CAH must submit a termination request to the contractor or MAC servicing the CAH prior to December 1, 2010. If a CAH had no election in effect in its most recent preceding cost reporting period and chooses to elect the method specified in paragraph (b)(3)(i) of this section on or after October 1, 2010, the election must be made in writing and delivered to the contractor or MAC servicing the CAH at least 30 days before the start of the first cost reporting period for which the election is made. Once the election is made, it remains in effect for all of that period and for all subsequent cost reporting periods unless the CAH submits a termination request to the contractor or MAC servicing the CAH at least 30 days before the start of the next cost reporting period.
- (B) An election of the payment method specified under paragraph (b)(3)(i) of this section applies to all services furnished to outpatients by a physician or other practitioner who has reassigned his or her rights to bill for those services to the CAH in accordance with subpart F of part 424 of this chapter. If a physician or other practitioner does not reassign his or her billing rights to the CAH in accordance with subpart F of part 424 of this chapter, payment for the physician's or practitioner's services furnished to CAH outpatients will be made on a fee schedule or other applicable basis as specified in subpart B of part 414 of this subchapter.
- (C) In the case of a CAH that made an election under this section before November 1, 2003, for a cost reporting period beginning before December 1, 2003, the rules in paragraph (b)(3)(i)(B) of this section are applicable to cost reporting periods beginning on or after July 1, 2001.
- (D) An election made under paragraph (b)(3)(i) of this section is effective as provided for under paragraph (b)(3)(i)(A) or paragraph (b)(3)(i)(C) of this section and does not apply to an election that was terminated prior to the start of the cost reporting period for which it would otherwise apply.
- (ii) If the CAH elects payment under this method, payment to the CAH for each outpatient visit will be the sum of the following:

- (A) Effective for cost reporting periods beginning on or after January 1, 2004, for facility services not including any services for which payment may be made under paragraph (b)(3)(ii)(B) of this section, 101 percent of the reasonable costs of the services as determined under paragraph (b)(2)(i) of this section; and
- (B) For professional services that are furnished by a physician or other practitioner who has reassigned his or her rights to bill for those services to the CAH in accordance with part 424, subpart F of this chapter, and that would otherwise be payable to the physician or other practitioner if the rights to bill for them had not been reassigned, 115 percent of the amounts that otherwise would be paid for the service if the CAH had not elected payment under this method. Effective for primary care services furnished by primary care practitioners (as defined in § 414.80(a)) and major surgical procedures furnished by general surgeons in health professional shortage areas (as defined in § 414.2) furnished on or after January 1, 2011 and before January 1, 2016, incentive payments specified under § 414.80 and § 414.67(b), respectively, of this title must not be included in determining payment made under this paragraph.
- (iii) Payment to a CAH, other than for clinical diagnostic laboratory tests, is subject to the Part B deductible and coinsurance amounts, as determined under §§ 410.152(k), 410.160, and 410.161 of this chapter.
- (4) *Costs of certain emergency room on-call providers.*
- (i) Effective for cost reporting periods beginning on or after October 1, 2001, the reasonable costs of outpatient CAH services under paragraph (b) of this section may include amounts for reasonable compensation and related costs for an emergency room physician who is on call but who is not present on the premises of the CAH involved, is not otherwise furnishing physicians' services, and is not on call at any other provider or facility. Effective for costs incurred for services furnished on or after January 1, 2005, the payment amount of 101 percent of the reasonable costs of outpatient CAH services may also include amounts for reasonable compensation and related costs for the following emergency room providers who are on call but who are not present on the premises of the CAH involved, are not otherwise furnishing physicians' services, and are not on call at any other provider or facility: physician assistants, nurse practitioners, and clinical nurse specialists.
- (ii) For purposes of this paragraph (b)(4) -
- (A) "Amounts for reasonable compensation and related costs" means all allowable costs of compensating emergency room physicians, physician assistants, nurse practitioners, and clinical nurse specialists who are on call to the extent that the costs are found to be reasonable under the rules specified in paragraph (b)(2) of this section and the applicable sections of part 413. Costs of compensating these specified medical emergency room staff are allowable only if the costs are incurred under written contracts that require the physician, physician assistant, nurse practitioner, or clinical nurse specialist to come to the CAH when the physician's or other practitioner's presence is medically required.
- (B) Effective for costs incurred on or after January 1, 2005, an "emergency room physician, physician assistant, nurse practitioner, or clinical nurse specialist who is on call" means a doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist, with training or experience in emergency care who is immediately available by telephone or radio contact, and is available onsite within the timeframes specified in § 485.618(d) of this chapter.
- (5) *Costs of ambulance services.*

- (i)
- (A) Effective for services furnished on or after December 21, 2000 and on or before December 31, 2003, payment for ambulance services furnished by a CAH or an entity that is owned and operated by a CAH is the reasonable costs of the CAH or the entity in furnishing those services, but 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.
 - (B) Effective for cost reporting periods beginning on or after January 1, 2004 and on or before September 30, 2011, payment for ambulance services furnished by a CAH or an entity that is owned and operated by a CAH is 101 percent of the reasonable costs of the CAH or the entity in furnishing those services, but 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.
 - (C) Effective for cost reporting periods beginning on or after October 1, 2011 and on or before September 30, 2019, payment for ambulance services furnished by a CAH or an entity that is owned and operated by a CAH is 101 percent of the reasonable costs of the CAH or the entity in furnishing those services, but 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. If there is no provider or supplier of ambulance services located within a 35-mile drive of the CAH and there is an entity that is owned and operated by a CAH that is more than a 35-mile drive from the CAH, payment for ambulance services furnished by that entity is 101 percent of the reasonable costs of the entity in furnishing those services, but only if the entity is the closest provider or supplier of ambulance services to the CAH.
 - (D) Effective for cost reporting periods beginning on or after October 1, 2019, payment for ambulance services furnished by a CAH or by a CAH-owned and operated entity is 101 percent of the reasonable costs of the CAH or the entity in furnishing those services, but 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, excluding ambulance providers or suppliers that are not legally authorized to furnish ambulance services to transport individuals to or from the CAH. If there is no provider or supplier of ambulance services located within a 35-mile drive of the CAH and there is an entity that is owned and operated by a CAH that is more than a 35-mile drive from the CAH, payment for ambulance services furnished by that entity is 101 percent of the reasonable costs of the entity in furnishing those services, but only if the entity is the closest provider or supplier of ambulance services to the CAH.
- (ii) For purposes of paragraph (b)(5) of this section, the distance between the CAH or the 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 closest provider or supplier of ambulance services are garaged. An improved road for this purpose 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 will be considered to include the paved surface up to the front entrance of the hospital and the front entrance of the garage.
- (6) If a CAH meets the criteria in § 412.113(c) of this subchapter for pass-through of costs of anesthesia services furnished by nonphysician anesthetists employed by the CAH or obtained under arrangement, payment to the CAH for the costs of those services is made in accordance with § 412.113(c) of this chapter.
- (7) *Payment for clinical diagnostic laboratory tests included as outpatient CAH services.*

- (i) Payment for clinical diagnostic laboratory tests is not subject to the Medicare Part B deductible and coinsurance amounts.
 - (ii) Subject to the provisions of paragraphs (b)(7)(iii) through (b)(7)(vi) of this section, payment to a CAH for clinical diagnostic laboratory tests will be made at 101 percent of reasonable costs of the services as determined in accordance paragraph (b)(2)(i) of this section.
 - (iii) For services furnished before July 1, 2009, payment to a CAH for clinical diagnostic laboratory tests will be made under paragraph (b)(7)(ii) of this section only if the individual is an outpatient of the CAH, as defined in § 410.2 of this chapter, and is physically present in the CAH at the time the specimen is collected.
 - (iv) Except as provided in paragraphs (b)(7)(iii) and (b)(7)(v) of this section, payment to a CAH for clinical diagnostic laboratory tests will be made under paragraph (b)(7)(ii) of this section only if the individual is an outpatient of the CAH, as defined in § 410.2 of this chapter, without regard to whether the individual is physically present in the CAH at the time the specimen is collected and at least one of the following conditions is met:
 - (A) The individual is receiving outpatient services in the CAH on the same day the specimen is collected; or
 - (B) The specimen is collected by an employee of the CAH.
 - (v) Notwithstanding paragraph (b)(7)(iv) of this section, payment for outpatient clinical diagnostic laboratory tests will not be made under paragraph (b)(7)(ii) of this section if the billing rules under § 411.15(p) of this chapter apply.
 - (vi) Payment for clinical diagnostic laboratory tests for which payment may not be made under paragraph (b)(7)(iii) or paragraph (b)(7)(iv) of this section will be made in accordance with the provisions of sections 1833(a)(1)(D) and 1833(a)(2)(D) of the Act.
- (c) *Final payment based on cost report.* Final payment to the CAH for CAH facility services to inpatients and outpatients furnished during a cost reporting is based on a cost report for that period, as required under § 413.20(b).
- (d) *Periodic interim payments.* Subject to the provisions of § 413.64(h), a CAH receiving payments under this section may elect to receive periodic interim payments (PIP) for Part A inpatient CAH services, effective for payments made on or after July 1, 2004. Payment is made biweekly under the PIP method unless the CAH requests a longer fixed interval (not to exceed one month) between payments. The biweekly interim payment amount is based on the total estimated Medicare payment (after estimated beneficiary deductibles and coinsurance) for the cost reporting period. Each payment is made 2 weeks after the end of a biweekly period of service, as described in § 413.64(h)(6). These PIP provisions are further described in § 413.64(h)(6). Under certain circumstances that are described in § 413.64(g), a CAH that is not receiving PIP may request an accelerated payment.
- (e) *Payment for service of distinct part psychiatric and rehabilitation units of CAHS.* Payment for inpatient services of distinct part psychiatric units of CAHs -
- (1) For cost reporting periods beginning before January 1, 2005, payment is made on a reasonable cost basis, subject to the provisions of § 413.40.
 - (2) For cost reporting periods beginning on or after January 1, 2005, payment is made in accordance with regulations governing inpatient psychiatric facilities at subpart N (§ 412.400 through § 412.432) of Part 412 of this subchapter.

- (3) Payment for inpatient services of distinct part rehabilitation units of CAHs is made in accordance with regulations governing the inpatient rehabilitation facilities prospective payment system at subpart P (§ 412.600 through § 412.632) of part 412 of this subchapter.

[65 FR 47109, Aug. 1, 2000]

EDITORIAL NOTE

For FEDERAL REGISTER citations affecting § 413.70, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at www.govinfo.gov.

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Title 42

§ 410.152 Amounts of payment.

(a) *General provisions -*

- (1) *Exclusion from incurred expenses.* As used in this section, “incurred expenses” are expenses incurred by an individual, during his or her coverage period, for covered Part B services, excluding the following:
 - (i) Expenses incurred for services for which the beneficiary is entitled to have payment made under Medicare Part A or would be so entitled except for the application of the Part A deductible and coinsurance requirements.
 - (ii) Expenses incurred in meeting the Part B blood deductible (§ 410.161).
 - (iii) In the case of services payable under a formula that takes into account reasonable charges, reasonable costs, customary charges, customary (insofar as reasonable) charges, charges related to reasonable costs, fair compensation, a pre-treatment prospective payment rate, or a standard overhead amount, or any combination of two or more of these factors, expenses in excess of any factor taken into account under that formula.
 - (iv) Expenses in excess of the outpatient mental health treatment limitation described in § 410.155.
 - (v) In the case of expenses incurred for outpatient physical therapy services including speech-language pathology services, the expenses excluded are from the incurred expenses under § 410.60(e). In the case of expenses incurred for outpatient occupational therapy including speech-language pathology services, the expenses excluded are from the incurred expenses under § 410.59(e).
- (2) *Other applicable provisions.* Medicare Part B pays for incurred expenses the amounts specified in paragraphs (b) through (k) of this section, subject to the following:
 - (i) The principles and procedures for determining reasonable costs and reasonable charges and the conditions for Medicare payment, as set forth in parts 405 (subparts E and X), 413, and 424 of this chapter.
 - (ii) The Part B annual deductible (§ 410.160).
 - (iii) The special rules for payment to health maintenance organizations (HMOs), health care prepayment plans (HCPPs), and competitive medical plans (CMPs) that are set forth in part 417 of this chapter. (A prepayment organization that does not qualify as an HMO, CMP, or HCPP is paid in accordance with paragraph (b)(4) of this section.)

- (b) *Basic rules for payment.* Except as specified in paragraphs (c) through (h) of this section, Medicare Part B pays the following amounts:
- (1) For services furnished by, or under arrangements made by, a provider other than a nominal charge provider, whichever of the following is less:
 - (i) 80 percent of the reasonable cost of the services.
 - (ii) The reasonable cost of, or the customary charges for, the services, whichever is less, minus 20 percent of the customary (insofar as reasonable) charges for the services.
 - (2) For services furnished by, or under arrangements made by, a nominal charge provider, 80 percent of fair compensation.
 - (3) For emergency outpatient hospital services furnished by a nonparticipating hospital that is eligible to receive payment for those services under subpart G of part 424 of this chapter, the amount specified in paragraph (b)(1) of this section.
 - (4) For services furnished by a person or an entity other than those specified in paragraphs (b)(1) through (b)(3) of this section, 80 percent of the reasonable charges or 80 percent of the payment amount computed on any other payment basis for the services.
- (c) *Amount of payment: Home health services other than durable medical equipment (DME).* For home health services other than DME furnished by, or under arrangements made by, a participating HHA, Medicare Part B pays the following amounts:
- (1) For services furnished by an HHA that is a nominal charge provider, 100 percent of fair compensation.
 - (2) For services furnished by an HHA that is not a nominal charge provider, the lesser of the reasonable cost of the services and the customary charges for the services.
- (d) *Amount of payment: DME furnished as a home health service -*
- (1) *Basic rule.* Except as specified in paragraph (d)(2) of this section -
 - (i) For DME furnished by an HHA that is a nominal charge provider, Medicare Part B pays 80 percent of fair compensation.
 - (ii) For DME furnished by an HHA that is not a nominal charge provider, Medicare Part B pays the lesser of the following:
 - (A) 80 percent of the reasonable cost of the service.
 - (B) The reasonable cost of, or the customary charge for, the service, whichever is less, minus 20 percent of the customary (insofar as reasonable) charge for the service.
 - (2) *Exception.* If the DME is used DME purchased by or on behalf of the beneficiary at a price at least 25 percent less than the reasonable charge for new equipment -
 - (i) For used DME furnished by an HHA that is a nominal charge provider, Medicare Part B pays 100 percent of fair compensation.
 - (ii) For used DME furnished by an HHA that is not a nominal charge provider, Medicare Part B pays 100 percent of the reasonable cost of, or the customary charge for, the services, whichever is less.
- (e) *Amount of payment: Renal dialysis services, supplies, and equipment.* Effective for services furnished on or after August 1, 1983, Medicare Part B pays for the institutional dialysis services specified in § 409.250 and the home dialysis services, supplies, and equipment specified in §

409.252, as follows:

- (1) Except as provided in paragraph (d)(2) of this section, 80 percent of the per treatment prospective reimbursement rate established under § 413.170 of this chapter, for outpatient maintenance dialysis furnished by ESRD facilities approved in accordance with part 494 of this chapter.
 - (2) *Exception.* If a home dialysis patient elects to obtain home dialysis supplies or equipment (or both) from a party other than an approved ESRD facility, payment is in accordance with paragraph (b)(4) of this section.
- (f) *Amount of payment: Rural health clinic (RHC) and Federally qualified health center (FQHC) services.* Medicare Part B pays, for services by a participating RHC or FQHC that is authorized to bill under the reasonable cost system, 80 percent of the costs determined under subpart X of part 405 of this chapter, to the extent those costs are reasonable and related to the cost of furnishing RHC or FQHC services or reasonable on the basis of other tests specified by CMS.
- (g) *Amount of payment: Used durable medical equipment furnished by other than an HHA.* Medicare Part B pays the following amounts for used DME purchased by or on behalf of the beneficiary at a price at least 25 percent less than the reasonable charge for comparable new equipment:
- (1) For used DME furnished by, or under arrangements made by, a nominal charge provider, 100 percent of fair compensation.
 - (2) For used DME furnished by or under arrangements made by a provider that is not a nominal charge provider, 100 percent of the reasonable cost of the service or the customary charge for the service, whichever is less.
 - (3) For used DME furnished by other than a provider, 100 percent of the reasonable charge.
- (h) *Amount of payment: Pneumococcal vaccine.* Medicare Part B pays for pneumococcal vaccine and its administration as follows:
- (1) For services furnished by a nominal charge provider, 100 percent of fair compensation.
 - (2) For services furnished by a provider that is not a nominal charge provider, the reasonable cost of the services or the customary charge for the service, whichever is less.
 - (3) For services furnished by other than a provider, a rural health clinic or a Federally qualified health center, 100 percent of the reasonable charge.
 - (4) For services furnished by a rural health clinic or a Federally qualified health center, 100 percent of the reasonable cost.
- (i) *Amount of payment: ASC facility services.*
- (1) For ASC facility services furnished on or after July 1, 1987 and before January 1, 2008, in connection with the surgical procedures specified in part 416 of this chapter, Medicare Part B pays 80 percent of a standard overhead amount as specified in § 416.120(c) of this chapter, except that, for screening flexible sigmoidoscopies and screening colonoscopies, Part B coinsurance is 25 percent of the standard overhead amount and Medicare Part B pays 75 percent of the standard overhead amount.
 - (2) For ASC services furnished on or after January 1, 2008, in connection with the covered surgical procedures specified in § 416.166 of this subchapter, except as provided in paragraphs (i)(2)(i), (i)(2)(ii), and (l) of this section, Medicare Part B pays the lesser of 80 percent of the actual charge or 80 percent of the prospective payment amount, geographically

adjusted, if applicable, as determined under Subpart F of Part 416 of this subchapter. Part B coinsurance is 20 percent of the actual charge or 20 percent of the prospective payment amount, geographically adjusted, if applicable

- (i) If the limitation described in § 416.167(b)(3) of this subchapter applies, Medicare pays 80 percent of the amount determined under Subpart B of Part 414 of this subchapter and Part B coinsurance is 20 percent of the applicable payment amount, except as provided in paragraph (l) of this section.
 - (ii) Between January 1, 2008 and December 31, 2010, Medicare Part B pays 75 percent of the applicable payment amount for screening flexible sigmoidoscopies and screening colonoscopies, and Part B coinsurance is 25 percent of the applicable payment amount.
- (j) *Amount of payment: services of Federally funded health facilities prior to October 1, 1991.* Medicare Part B pays 80 percent of charges related to the reasonable costs that a Federally funded health facility incurs in furnishing the services. See § 411.8(b)(6) of this chapter.
- (k) *Amount of payment: Outpatient CAH services.*
- (1) Payment for CAH outpatient services is the reasonable cost of the CAH in providing these services, as determined in accordance with section 1861(v)(1)(A) of the Act, with § 413.70(b) and (c) of this chapter, and with the applicable principles of cost reimbursement in part 413 and in part 415 of this chapter.
 - (2) Payment for CAH outpatient services is subject to the applicable Medicare Part B deductible and coinsurance amounts, except as described in § 413.70(b)(2)(iii) of this chapter, with Part B coinsurance being calculated as 20 percent of the customary (insofar as reasonable) charges of the CAH for the services.
- (l) *Amount of payment: Preventive services.* Medicare Part B pays 100 percent of the Medicare payment amount established under the applicable payment methodology for the service setting for providers and suppliers for the following preventive services:
- (1) Pneumococcal (as specified in paragraph (h) of this section), influenza, hepatitis B, and COVID-19 vaccine and administration.
 - (2) Screening mammography.
 - (3) Screening pap tests and screening pelvic exam.
 - (4) Prostate cancer screening tests (excluding digital rectal examinations).
 - (5) Colorectal cancer screening tests (excluding barium enemas).
 - (6) Bone mass measurement.
 - (7) Medical nutrition therapy (MNT) services.
 - (8) Cardiovascular screening blood tests.
 - (9) Diabetes screening tests.
 - (10) Ultrasound screening for abdominal aortic aneurysm (AAA).
 - (11) Additional preventive services identified for coverage through the national coverage determination (NCD) process.
 - (12) Initial Preventive Physical Examination (IPPE).
 - (13) Annual Wellness Visit (AWV), providing Personalized Prevention Plan Services (PPPS).

EDITORIAL NOTE

For FEDERAL REGISTER citations affecting § 410.152, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at www.govinfo.gov.

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- Do not report non-covered line items as part of the required reporting of value codes 50, 51 and 52 for covered visits (i.e., where all increments are non-covered and there are no covered charges for the line item, since these line items are either part of an already counted partially covered visit, or an entirely non-covered visit); and
- Never split a single increment into a covered and non-covered portion.

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

(Rev. 3019, Issued: 08-07-14, Effective: 01-01-12, ICD-10: Upon Implementation of ICD- 10, Implementation: 09-08-14, ICD-10: Upon Implementation of ICD- 10)

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 A/B MAC (A) on an annual basis 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 for the CAH.

Effective for cost reporting periods beginning on or after October 1, 2010 if a CAH elected the optional method for its most recent cost reporting period beginning before October 1, 2010 or chooses to elect the optional method on or after October 1, 2010, that election remains in place until it is terminated, an annual election is no longer required. If a CAH elects the optional method on or after October 1, 2010, it must submit its request in writing to its A/B MAC (A) at least 30 days before the start of the first cost reporting period for which the election is effective. That election will not terminate unless the CAH submits a termination request to its A/B MAC (A) at least 30 days before the start of its next cost reporting period.

The Medicare Prescription Drugs, Improvement, and Modernization Act (MMA) of 2003, changed the requirement that each practitioner rendering a service at a CAH that has elected the optional method, reassign their billing rights to that CAH. This provision allows each practitioner to choose whether to reassign billing rights to the CAH or file claims for professional services through their A/B MAC (B). The reassignment will remain in effect for that entire cost reporting period.

The individual practitioner must certify, using the Form CMS-855R, if he/she wishes to reassign their billing rights. The CAH must then forward a copy of Form CMS-855R to the A/B MAC (A), and the A/B MACs (B) must have the practitioner sign an attestation that clearly states that the practitioner will not bill the A/B MAC (A) or A/B MAC (B) for any services rendered at the CAH once the reassignment has been given to the CAH. This “attestation” will remain at the CAH.

For CAHs that elected the optional method before November 1, 2003, the provision is effective beginning on or after July 1, 2001. For CAHs electing the optional method on or after November 1, 2003, the provision is effective for cost reporting periods beginning on or after July 1, 2004. Under this election, a CAH will receive payment from their A/B MAC (A) for professional services furnished in that CAH's outpatient department. Professional services are those furnished by all licensed professionals who otherwise would be entitled to bill the A/B MAC (B) under Part B.

Payment to the CAH for each outpatient visit (reassigned billing) will be the sum of the following:

- For facility services, not including physician or other practitioner services, payment will be based on 101 percent of the reasonable costs of the services. List the facility service(s) rendered to outpatients using the appropriate revenue code. The A/B MAC will pay 101 percent of the reasonable costs for the outpatient services less applicable Part B deductible and coinsurance amounts, plus:
- Show the professional services separately, along with the appropriate HCPCS code (physician or other practitioner) in one of the following revenue codes - 096X, 097X, or 098X.

The A/B MAC (A) uses the Medicare Physician Fee Schedule (MPFS) amounts to pay for all the physician/nonphysician practitioner services rendered in a CAH that elected the optional method. Payment is based on the lesser of the actual charge or the facility-specific MPFS amount less deductible and coinsurance times 1.15; and

• **AK - Service rendered in a CAH by a non-participating physician**

For a non-participating physician service, a CAH must place modifier AK on the claim. Payment is based on the lesser of the actual charge or a reduced fee schedule amount of 95 percent. Payment is calculated as follows:

- $[(\text{facility-specific MPFS amount} \times \text{the non-participating physician reduction } (0.95)) \text{ minus } (\text{deductible and coinsurance}) \times 1.15]$.

• **GF - Services rendered by a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA)**

GF - Services rendered in a CAH by a nurse practitioner (NP), clinical nurse specialist (CNS), certified registered nurse (CRN) or physician assistant (PA). (The "GF" modifier is not to be used for CRNA services. If a claim is received and it has the "GF" modifier for certified registered nurse anesthetist (CRNA) services, the claim is returned to the provider.) Also, while this national "GF" modifier includes CRNs, there is no benefit under Medicare law that authorizes payment to CRNs for their services. Accordingly, if a claim is received and it has the "GF" modifier for CRN services, no Medicare payment should be made.

Services billed with the “GF” modifier are paid based on the lesser of the actual charge or a reduced fee schedule amount of 85 percent. Payment is calculated **as follows:**

- $[(\text{facility-specific MPFS amount times the nonphysician practitioner services reduction (0.85) minus (deductible and coinsurance)})] \text{ times } 1.15.$

• **SB - Services rendered in a CAH by a certified nurse-midwife**

For dates of service prior to January 1, 2011, certified nurse-midwife services billed with the “SB” modifier are paid based on the lesser of the actual charge or a reduced fee schedule amount of 65 percent. Payment is calculated **as follows:**

For dates of service on or after January 1, 2011, Medicare covers the services of a certified nurse-midwife. The “SB” modifier is used to bill for the services and payment is based on the lesser of the actual charge or 100 percent of the MPFS. MPFS Payment is calculated **as follows:**

- $[(\text{facility-specific MPFS amount}) \text{ minus (deductible and coinsurance)}] \text{ times } 1.15.$
- **AH - Services rendered in a CAH by a clinical psychologist**
Payment for the services of a clinical psychologist is based on the lesser of the actual charge or 100 percent of the MPFS. Payment is calculated as follows:
 - $[(\text{facility-specific MPFS amount}) \text{ minus (deductible and coinsurance)}] \text{ times } 1.15.$
- **AE - Services rendered in a CAH by a nutrition professional/registered dietitian.**

Services billed with the “AE” modifier are paid based on the lesser of the actual charge or a reduced fee schedule amount of 85 percent. Payment is calculated **as follows:**

- $[(\text{facility-specific MPFS amount times the registered dietitian reduction (0.85) minus (deductible and coinsurance)})] \text{ times } 1.15.$

Outpatient services, including ASC type services, rendered in an all-inclusive rate provider should be billed using the 85X type of bill (TOB). Non-patient laboratory specimens are billed on TOB 14X.

MPFS rates contained in the HHH abstract file are used for payment of all physician/professional services rendered in a CAH that has elected the optional method. If a HCPCS code has a facility rate and a non-facility rate, the facility rate is paid. See Chapter 23 of Pub. 100-04, section 50.1 for the record layout for the HHH abstract file.

4	<p>Global test only. Only the professional component of this service qualifies for the bonus payment.</p> <p>ACTION: Return the service as unprocessable. Instruct the provider to re-bill the service as separate professional and technical component procedure codes.</p>
5	<p>Incident to codes.</p> <p>ACTION: Do not pay the bonus.</p>
6	<p>Laboratory physician interpretation codes.</p> <p>ACTION: Pay the bonus</p>
7	<p>Physical therapy service.</p> <p>ACTION: Do not pay the bonus.</p>
8	<p>Physician interpretation codes.</p> <p>ACTION: Pay the bonus.</p>
9	<p>Concept of PC/TC does not apply.</p> <p>ACTION: Do not pay the bonus.</p>

NOTE: Codes that have a status of “X” on the CORF extract Medicare Physician Fee Schedule Database (MFSDDB) have been assigned PC/TC indicator 9 and are not considered physician services for MFSDDB payment purposes. Therefore, neither the HPSA bonus nor the physician bonus payment (5 percent) will be paid for these codes.

250.3 – Payment for Anesthesia in a Critical Access Hospital (CAH)
 (Rev 41, 12-08-03)

Payment for anesthesia services is based on the HCPCS FILE, the Anesthesia Conversion Factor File, and the CORF extract of the MPFS Summary File.

250.3.1 – Anesthesia File
 (Rev. 41, 12-08-03)

Conversion Factor File = MU00.@BF12390.MPFS.CY04.ANES.V1023

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

Data Element Name	Picture	Location	Length
Locality Name	X (30)	19-48	30
Anesthesia CF 2002	99V99	74-77	4

250.3.2 – Physician Rendering Anesthesia in a Hospital Outpatient Setting

(Rev. 2452, Issued: 04-26-12, Effective: 01-10-12, Implementation: 10-01-12)

When a medically necessary anesthesia service is furnished within a HPSA area by a physician, a HPSA bonus is payable. In addition to using the PC/TC indicator on the CORF extract of the MPFS Summary File to identify HPSA services, pay physicians the HPSA bonus when CPT codes 00100 through 01999 are billed with the following modifiers: QY, QK, AA, or GC and “QB” or “QU” in revenue code 963. Modifier QB or QU must be submitted to receive payment of the HPSA bonus for claims with dates of service prior to January 01, 2006. Effective for claims with dates of service on or after January 01, 2006, the modifier AQ, physician providing a service in a health professional shortage area, may be required to receive the HPSA bonus. Refer to §250.2.2 of this chapter for more information on when modifier AQ is required.

The modifiers signify that a physician performed an anesthesia service. Using the Anesthesia File (See Section above) the physician service will be 115 percent times the payment amount to be paid to a CAH on Method II payment plus 10 percent HPSA bonus payment.

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 100% of the allowed amount.

Modifiers QK and QY result in physician payment at 50% of the allowed amount.

Data elements needed to calculate payment:

- HCPCS plus Modifier,
- Base Units,
- Time units, based on standard 15 minute intervals,
- Locality specific anesthesia Conversion factor, and
- Allowed amount minus applicable deductions and coinsurance amount.

Formula 1: Calculate payment for a physician performing anesthesia alone

HCPCS = xxxxx

Modifier = AA

Base Units = 4

Anesthesia Time is 60 minutes. Anesthesia time units = 4 (60/15)

Sum of Base Units plus Time Units = 4 + 4 = 8

Locality specific Anesthesia conversion factor = \$17.00 (varies by localities)

Coinsurance = 20%

Example 1: Physician personally performs the anesthesia case

Base Units plus time units - 4+4=8

Total units multiplied by the anesthesia conversion factor times .80

$8 \times \$17 = (\$136.00 - (\text{deductible}^*) \times .80 = \108.80

Payment amount times 115 percent for the CAH method II payment.

$\$108.80 \times 1.15 = \125.12 (Payment amount)

$\$125.12 \times .10 = \12.51 (HPSA bonus payment)

*Assume the Part B deductible has already been met for the calendar year

Formula 2: Calculate the payment for the physician's medical direction service when the physician directs two concurrent cases involving CRNAs. The medical direction allowance is 50% of the allowance for the anesthesia service personally performed by the physician.

HCPCS = xxxxx

Modifier = QK

Base Units = 4

Time Units 60/15=4

Sum of base units plus time units = 8

Locality specific anesthesia conversion factor = \$17(varies by localities)

Coinsurance = 20 %

(Allowed amount adjusted for applicable deductions and coinsurance and to reflect payment percentage for medical direction).

Example 2: Physician medically directs two concurrent cases involving CRNAs Base units plus time - 4+4=8

Total units multiplied by the anesthesia conversion factor times .50 equal allowed amount minus any remaining deductible

$8 \times \$17 = \$136 \times .50 = \$68.00 - (\text{deductible}^*) = \68.00

Allowed amount Times 80 percent times 1.15

$\$68.00 \times .80 = \$54.40 \times 1.15 = 62.56$ (Payment amount)

$\$62.56 \times .10 = \6.26 (HPSA bonus payment)

*Assume the deductible has already been met for the calendar year.

NOTE: For specific guidance on payment for Anesthesia and Teaching Services please review the following sections:

- Payment for Anesthesiology Services Pub.100-04, Chapter 12, Section 50
- Teaching Physician Services Pub.100-04, Chapter 12, Section 100.1.2 (4) Anesthesia.

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Attachment - Business Requirements

Pub. 100-04	Transmittal: 4157	Date: November 2, 2018	Change Request: 10962
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SUBJECT: Hospital and Critical Access Hospital (CAH) Swing-Bed Manual Revisions and Shared Systems Changes

EFFECTIVE DATE: April 1, 2019

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: April 1, 2019

I. GENERAL INFORMATION

A. Background: Critical Access Hospital (CAH) swing-bed services are not subject to the skilled nursing facility (SNF) prospective payment system. Instead, CAHs are paid based on 101 percent of reasonable cost for swing-bed services. As is the case with CAH inpatient services, CAH swing-bed services are subject to the hospital bundling requirements at section 1862(a)(14) of the Social Security Act and in the regulations at 42 CFR § 411.15(m). Therefore, because CAH swing-bed services are subject to the hospital bundling requirements, CMS is clarifying that nonprofessional services provided to a CAH swing-bed patient must be included on the CAH's swing-bed bill.

In addition, certified registered nurse anesthetist (CRNA) pass-through payments (see 42 CFR § 412.113 (c)) provide qualifying hospitals and CAHs with reasonable cost-based payments for CRNA services. CMS is clarifying that qualifying hospitals and CAHs are eligible to receive pass-through payments for CRNA services provided to hospital and CAH swing-bed patients since these patients are inpatients for this purpose. CRNA pass-through services provided to swing-bed patients must be included on the hospital's or CAH's swing-bed bill.

CMS is also revising manual language related to CRNA pass-through payments to clarify existing policy.

B. Policy: The intention of this CR is to update policy manual, Pub. 100-04, Medicare Claims Processing Manual. In the 2001 "Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities-Update; Final Rule" 66 Fed. Reg. 39593 (July 31, 2001), CMS clarified that swing-bed hospitals (this also includes CAHs) are subject to hospital bundling (see section 1862(a)(14) of the Social Security Act and 42 CFR § 411.15(m)).

Additionally, pass-through payments may be made for CRNA services furnished to inpatients of a hospital or CAH that qualify for such payments. (Note: Per 69 Fed. Reg. 49096 (Aug. 11, 2004), a swing-bed is a bed that is available for use to provide acute inpatient care or SNF-level care.) Furthermore, the regulations (see 42 CFR § 412.113 (c)(2)(i)(D)) state that under the pass-through provision, a CRNA must agree in writing not to bill Medicare for his or her patient care to Medicare beneficiaries. Accordingly, provided a hospital or CAH has satisfied the requirements for CRNA pass-through payments at 42 CFR § 412.113(c), the fact that a beneficiary is receiving services in a swing-bed in the hospital or CAH should not preclude the hospital or CAH from receiving pass-through payments for CRNA services furnished to that patient.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility			
		A/B MAC	D M E	Shared- System Maintainers	Other

Medicare Claims Processing Manual

Chapter 4 - Part B Hospital

(Including Inpatient Hospital Part B and OPPOS)

250.3.3.1 - Payment for CRNA Pass-Through Services

(Rev. 4157, Issued: 11-02-18, Effective: 04-01-19, Implementation: 04-01-19)

CAHs are eligible to receive CRNA pass-through payments (“pass-through exemption”) for both inpatient and outpatient services if they meet criteria discussed at 42 CFR § 412.113(c) of the regulations. CRNA pass-through payments and the Method II election for outpatient CAH services are applied as described below. Note that for CAHs that have a CRNA pass-through exemption, all CRNA services provided to CAH swing-bed patients must be included on the CAH swing-bed bill. (See MCPM, Ch. 3, 60 and 100.2 for more information)

If a CAH meets the criteria for a pass-through exemption *and* is interested in selecting Method II *for its physicians and/or other practitioners*, it can choose *Method II* for all outpatient professionals except the CRNA, and still retain the approved CRNA *pass-through* exemption for both inpatient and outpatient *CRNA* professional services.

Alternatively, *a* CAH, with an approved *pass-through* exemption, can choose to give up its *pass-through* exemption for both inpatient and outpatient *CRNA* professional services in order to include its CRNA outpatient professional services under Method II. By choosing to include the CRNA under Method II for outpatient services, *the CAH* 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 A/B MAC (B) for the CRNA inpatient professional services. All A/B MAC (A) payments for CRNA services are subject to cost settlement.

Provider Billing Requirements for *CRNA Pass-Through*

TOBs = 85X and 11X *and 18X*

Revenue Code 037X for CRNA technical services

Revenue Code 0964 for Professional services

Anesthesia HCPCS codes and for any HCPCS codes for services the CRNA is legally authorized to perform in the state in which the services are furnished

Reimbursement

Revenue Code 37X, CRNA technical service = Cost Reimbursement (*101 percent of reasonable cost*)

Revenue Code 0964, CRNA professional service = Cost Reimbursement (*100 percent of reasonable cost*) for both inpatient (*including swing-bed*) and outpatient

Deductible and coinsurance apply.

Note that effective January 1, 2013, qualifying rural hospitals and CAHs are eligible to receive CRNA pass-through payments for services that the CRNA is legally authorized to perform in the state in which the services are furnished.

250.3.3.2 - Payment for CRNA *Services* (Method II CAH only)
(Rev. 4157, Issued: 11-02-18, Effective: 04-01-19, Implementation: 04-01-19)

Provider Billing Requirements for Method II CRNA - Gave up Pass-Through Exemption (or never had exemption)

TOB = 85X

Revenue Code = 037X for CRNA technical service

Revenue Code = 0964 for CRNA professional service

HCPCS Code for services the CRNA is legally authorized to perform in the state in which the services are furnished

Reimbursement - For dates of service on or after July 1, 2007

Revenue Code 037X for CRNA technical service = *Cost Reimbursement (101 percent of reasonable cost)*

Revenue Code 0964 for CRNA professional service = *Based on 100 percent of the allowed amount when not medically directed or 50 percent of the allowed amount when medically directed.*

Providers bill a “QZ” modifier for non-medically directed CRNA services. Deductible and coinsurance apply.

How to calculate payment for anesthesia claims based on the formula - For dates of service on or after July 1, 2007

**Identify anesthesia claims by HCPCS code range from 00100 through 01999
 Non-medically directed CRNA**

(Sum of base units plus time (anesthesia time divided by 15)) times conversion factor minus (deductible and coinsurance) times 1.15

Medically directed CRNA

(Sum of base units plus time (anesthesia time divided by 15)) times conversion factor times medically directed reduction (50 %) minus (deductible and coinsurance) times 1.15

Note that effective January 1, 2013, qualifying rural hospitals and CAHs are eligible to receive CRNA pass-through payments for services that the CRNA is legally authorized to perform in the state in which the services are furnished.

Reimbursement - For dates of service prior to July 1, 2007

Revenue Code 037X for CRNA technical service = cost reimbursement

Revenue Code 0964 for CRNA professional service = 115% times 80% (not medically directed) or 115% times 50% (medically directed) of allowed amount (Use Anesthesia formula) for outpatient CRNA professional services.

Providers a “QZ” modifier for non-medically directed CRNA services. Deductible and coinsurance apply.

How to calculate payment for anesthesia claims based on the formula - For dates of service prior to July 1, 2007

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 when not 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 of base units and time

Sum of base units and time times the conversion factor = allowed amount

Source

Number of minutes = Number of units on the claim (Units field of the UB04) Base Units = Anesthesia HCPCS

Conversion Factor = File - MU00.@BF12390.MPFS.CYXX.ANES.V1023

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Medicare Claims Processing Manual, Chapter 4**250.4 - CAH Outpatient Services Part B Deductible and Coinsurance
(Rev. 1070, Issued: 09-29-06, Effective: 01-01-07, Implementation: 01-02-07)**

Payment for outpatient services of a CAH is subject to applicable Medicare Part B deductible and coinsurance amounts unless waived based on statute.

For information on the application of deductible and coinsurance for screening and preventive services, see chapter 18 of Pub. 100-04, Medicare Claims Processing Manual.

Payments for clinical diagnostic laboratory tests furnished to CAH outpatients on or after November 29, 1999, are made on a reasonable cost basis with no beneficiary cost-sharing - no coinsurance, deductible, copayment, or any other cost-sharing.

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