

Chapter 28

Critical Access Hospital – (CAH)

This chapter contains basic information and only applies to programs outlined in your organization's participation agreement with South Country Health Alliance. CAH providers should refer to http://www.ugsmedicare.com/provider_education/training.asp for the most up-to-date and detailed information.

Effective January 1, 2010, to comply with uniform commercial payer standards, MHCP is no longer accepting CAH Method II professional services in the 837I (institutional) format. This change affects only billing to MHCP. CAHs should continue billing Medicare as they have in the past.

South Country Health Alliance has implemented this process for all PMAP/ MNCare programs effective April 1, 2010. SeniorCare Complete (MSHO) and AbilityCare (SNBC) programs will not be impacted by this change.

CAH Eligibility

A CAH is a facility that is designated as a CAH by the State in which it is located and meets the following criteria:

- Is a rural public, non-profit or for-profit hospital; or is a hospital that was closed during the 10 year period from November 29, 1998 through November 29, 1999 the previous ten years; or is a rural health clinic that was downsized from a hospital.
- Is a facility located in a State that has established a State plan with CMS for the Medicare Rural Hospital Flexibility Program.
- Is located more than a 35-mile drive from any other hospital or CAH (in mountainous terrain or in areas with only secondary roads available, the mileage criterion is 15 miles); **or** is certified by the State in the State plan as being a **necessary provider** of health care services to residents in the area.
- Makes available 24-hour emergency care services 7 days per week.
- Provides not more than 15 beds for acute (hospital level) inpatient care. An exception to the 15-bed requirement is made for swing-bed facilities, which are allowed to have up to 25 inpatient beds that can be used interchangeably for acute or SNF-level care, provided that not more than 15 beds are used at any one time for acute care.

- Provides an annual average length of stay of 96 hours per patient for acute care patients.

Reimbursement and Billing

An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally a person is considered an inpatient if formally admitted as an inpatient with the expectation that he will remain at least overnight.

A CAH may provide and bill for all hospital inpatient services that are deemed reasonable and medically necessary according to the rules and guidelines governing inpatient services provided by acute care hospitals.

Payment for inpatient CAH services is subject to Part A deductible and coinsurance requirement. Inpatient services should be billed as an 11X type of bill.

One and Three Day Window Provision

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

Outpatient Care

A hospital outpatient is a person who has not been admitted by the hospital as an inpatient but is registered on the hospital records as an outpatient and receives services (rather than supplies alone) from the hospital.

A CAH may provide and bill for all hospital outpatient services that are deemed reasonable and medically necessary according to the rules and guidelines governing outpatient services provided by acute care hospitals.

Payment for Outpatient Services Furnished by a CAH

For cost reporting periods beginning on or after October 1, 2001, the CAH will be paid under the method in item 1 below unless it elects to be paid under the method in item 2. If a CAH elects payment under item 2 (cost-based facility payment plus fee schedule for professional services) for a cost reporting period, that election is effective for all of the cost reporting period to which it applies. If a CAH elects payment under the elective method (cost-based facility payment plus fee schedule for professional services) for a cost reporting period, that election is effective for the entire cost reporting period to which it applies. If the CAH wishes to make a new election or change a previous

election, that election should be made in writing by the CAH, to the appropriate FI, at least 30 days in advance of the beginning of the affected cost reporting period.

Outpatient Payment Methods

Method I (Standard)

Cost-based Facility Services, with Billing of Carrier for Professional Services.—Payment for outpatient CAH services under this method will be made for 80 percent of the reasonable cost of the CAH in furnishing those services, after application of the Part B deductible. Payment for professional medical services furnished in a CAH to CAH outpatients is made by the South Country Health Alliance on a fee schedule, charge, or other fee basis, as would apply if the services had been furnished in a hospital outpatient department. For purposes of CAH payment, professional medical services are defined as services provided by a physician or other practitioner, for example a physician assistant or nurse practitioner that could be billed directly to a carrier under Part B of Medicare.

In general, payment for professional medical service, under the cost-based CAH payment plus professional services method, should be made on the same basis as would apply if the services had been furnished in the outpatient department of a hospital.

Bill type 85X should be used for all outpatient services including ASC. Referenced diagnostic services will continue to be billed on a 14X type of bill.

Method II (Optional Method for Outpatient Services)

Method II billing allows hospitals to include professional charges for outpatient services on the hospital claims submitted to Fiscal Intermediaries or A/B MACs on a UB04 or electronic equivalent. Inpatient professional fees continue to be submitted to the Part B Carrier or A/B MAC on a Form 1500 or electronic equivalent. Because there are no bundling provisions for hospital services provided prior to inpatient admission, hospitals are instructed to bill inpatient and outpatient services on separate claims, even if they occur on the same day.

The corresponding inpatient and outpatient professional fees should be billed separately as well, to the extent that the services incorporated into the billing codes for the inpatient and outpatient services do not overlap, and can correctly be billed on the same day. It is appropriate to bill evaluation and management services related to outpatient observation on the hospital claim if the patient subsequently is discharged. However, per CPT coding guidelines, evaluation and management services provided in sites that are related to observation status on the date of inpatient admission should not be reported separately.

Cost-Based Facility Services Plus 115% Fee Schedule Payment for Professional Services.—The BIPA legislation on payment for professional services at 115 percent of

what would otherwise be paid under the fee schedule is effective for services furnished on or after July 1, 2001. A CAH may elect to be paid for outpatient services in any cost reporting period under this method by filing a written election with the intermediary 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 and applies to all CAH services furnished in the CAH outpatient department during that period. Under this election a CAH will receive payment for professional services received in that CAH's outpatient department (all licensed professionals who otherwise would be entitled to bill the carrier under Part B). Payment to the CAH for each outpatient visit will be the sum of the following:

- For facility services, not including physician or other practitioner, payment will be based on 101 percent of the reasonable costs of the services. On the Form CMS-1450, (or electronic equivalent) list the facility service(s) rendered to outpatients along with the appropriate revenue code. Pay the amount equal to the lesser of 80 percent of 101 percent of the reasonable costs of its outpatient services, or the 101 percent of the outpatient services less applicable Part B deductible and coinsurance amounts.
- On a separate line, list the professional services, along with the appropriate HCPC code (physician or other practitioner) and one of the following revenue codes - 96X, 97X, or 98X. Payment will be 115 percent of the physician fee schedule, after applicable Part B deductible and coinsurance The Medicare Physician Fee Schedule (MPFS) supplementary file, established for use by the CORF, and the CORF Abstract File, will be used to pay for all the physician/professional services rendered in a CAH that elected the all-inclusive method. South County Health Alliance will pay 115 percent of whatever Medicare would pay of the physician fee schedule. (The fee schedule amount, after applicable deductions, will be multiplied by 1.15 percent.) Payment for non-physician practitioners will be 115 percent of 85 percent of the physician fee schedule. If a professional service is performed by a non-physician, for example, Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist, place the **GF** modifier on the applicable line. You will receive 115 percent of 85 percent of the Physician Fee Schedule for these services. **The GF modifier is not to be used for CRNA services.**

Note: Per The Medicare Prescription Drug Improvement and Modernization Act of 2003 the Secretary is not able to require all physicians providing services in a CAH to assign their billing rights to the CAH in order for the CAH to be able to be paid on the basis of 115% of the MPFS for the professional services provided by the physician. However, a CAH would not receive payment based on the 115% of the MPFS for any individual physician who did not assign its billing rights to the CAH. Outpatient services, including ASC, rendered in an all-inclusive rate provider method should be billed using the 85X type of bill.