2024 Indian Health Service Partnership Conference

Critical Access Hospitals (CAH): Understanding Designation, Billing and Reimbursement

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NOVITAS SOLUTIONS

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Acronym List

Acronym	Definition
CAH	Critical Access Hospital
CMS	Centers for Medicare & Medicaid Services
CNS	Clinical Nurse Specialist
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetists
E&M	Evaluation and Management
FAQ	Frequently Asked Questions
HCPCS	Healthcare Common Procedure Coding System
LCD	Local Coverage Determination
MLN	Medicare Learning Network
MPFS	Medicare Physician Fee Schedule
MOON	Medicare Outpatient Observation Notice

Acronym List Two

Acronym	Definition
NCD	National Coverage Determination
OT	Occupational Therapy
PECOS	Provider, Enrollment, Chain, and Ownership System
PPS	Prospective Payment System
PT	Physical Therapy
RTP	Return to Provider
SLP	Speech Language Pathology
SNF	Skilled Nursing Facility
TOB	Type of Bill
UB-04	Universal Billing Form 04

Agenda

- CAH Overview
- Method I and II Overview and Billing
- CAH Specialty Services and Billing
- References and Resources
- 2024 Updates, References and Resources
- Top RTP and Reject Claims Submission Errors and Resolutions

Critical Access Hospitals (CAH)

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Critical Access Hospital

- CAH Definition:
  - A designation given to eligible rural hospitals by the CMS
  - CAH program is a federal program established in 1997 as part of the Balanced Budget Act
- CAH Purpose:
  - CAHs aim to offer small hospitals in rural areas to serve residents that would otherwise be a long distance from emergency care

CAH Overview

- 24-hour emergency care services, 7-days a week
- Using either on-site or on-call staff, with specific on-site response timeframes for on-call staff
- Maintain no more than 25 beds for inpatient beds or swing bed care
- May operate rehabilitation and psychiatric distinct parts of up to 10 beds each
- Provide acute inpatient care for a period that does not exceed, as determined on an annual average basis, 96 hours per patient
- Coverage of inpatient and outpatient services is the same for CAHs and PPS hospitals:
  - The only difference is CAHs are cost-reimbursed
- Medicare Part A and Part B deductible and coinsurance apply

CAH Split Billing

- Definition:
  - There are times when an outpatient claim may cross over the provider's fiscal year end, the federal fiscal year end, or calendar year end
- A calendar year is the one-year period that begins on January 1 and ends on December 31
- Outpatient split billing is only required for services that span the calendar year end

CAH Type of Bills

- Outpatient:
  - 851 – Admit to Discharge
  - 141 – Non-Patient, Reference Laboratory Services
  - 857/147 – Adjustment
  - 858/148 – Cancel
  - 850 – No payment
- Inpatient:
  - 111 – Admit to Discharge
  - 117 – Adjustment
  - 118 – Cancel
  - 110 – No payment
  - 12X – Part B Only/Ancillary

Bundling

- Definition:
  - Bundling of payments for services provided to outpatients who later are admitted as inpatients
- CAHs are exempt from the one and three-day bundling window provisions that apply to PPS hospitals
- Outpatient CAH services are billed and paid separately from inpatient services
- Outpatient services provided to a beneficiary who then becomes an inpatient are not bundled to the inpatient bill, even if they are provided during same encounter

Inpatient CAH Services

- Definition:
  - Inpatient care is medical treatment administered to a patient whose condition requires treatment in a hospital or other health care facility, and the patient is formally admitted to the facility by a doctor
- Physician order and certification for inpatient admission in accordance with the regulations:
  - Certification begins with order for admission
  - Expected to be discharged or transferred within 96 hours
- Payment made at 101 percent of reasonable costs:
  - Co-insurance is based off of the billed charges
- Payment for inpatient CAH services are subject to Part A deductible and coinsurance
- Benefit periods apply to Part A services
- Facility charges billed to Part A on a UB-04 or the electronic equivalent
- Professional services billed to Part B on the CMS-1500 claim form or the electronic equivalent
- All charges are combined:
  - Code under revenue code 0100
  - TOB 11X
  - No HCPCS
- Inpatient services are billed from admission through discharge:
  - Unless split billing is required for calendar year end

Benefit Period

- Benefit period – A period of time measuring the use of hospital insurance benefits:
  - A benefit period begins the first day the patient is admitted to hospital or SNF after entitlement to hospital insurance begins
  - A benefit period ends when a patient is not an inpatient for 60 consecutive days or remains in a non-covered level of care:
    - Benefits renewed for full and coinsurance days only
- Beneficiaries have 60 lifetime reserve days that they have the option to use:
  - IHS elects not to utilize lifetime reserve days (LTR) days
  - Once these are exhausted, they are not renewed
- Counting an inpatient day:
  - Date of admission counted
  - Date of discharge not counted

Inpatient Services Benefit Information

- Obtain Part A benefit patient information during admission or registration interview of the beneficiary:
  - Obtain beneficiary's signature on authorization to release information and request for payment
  - Verify beneficiary's Medicare eligibility by utilizing:
    - Novitasphere Portal (JH)
    - Health Insurance Query Access (HIQA)
    - HIPAA (Health Insurance Portability and Accountability Act) Eligibility Transaction System (HETS)
    - Interactive Voice Response (IVR) (JH)
    - Fiscal Intermediary Standard System (FISS) (JH)
  - Determine if Medicare is primary or secondary:
    - Complete Medicare Secondary Payer Questionnaire (MSPQ):
      - MSPQ is required for every inpatient and outpatient visit:
        - Exception to outpatient if reoccurring; such as therapy
  - Provide written notices:
    - An Important Message From Medicare
    - Hospital Issued Notice of Non-coverage (HINN) (if applicable)

Benefit Period Deductible and Coinsurance Costs

- A benefit period begins the first day the beneficiary is admitted to an acute care hospital after Medicare entitlement to hospital insurance begins
- A benefit period ends when a beneficiary is not an inpatient for 60 consecutive days or remains in a non-covered level of care:
  - Benefits renew for full and coinsurance days only
- Beneficiaries have 60 lifetime reserve days (LTR) to use:
  - IHS elects not to utilize LTR days
  - Once these are exhausted, they are not renewed

Year	Inpatient Hospital Deductible, 1st-60th Days (60 Full Days)	Inpatient Hospital Coinsurance, 61st-90th Days (30 Coinsurance Days)
2024	$1,632	$408/per day
2023	$1,600	$400/per day

Calculating Days in a Benefit Period

Admission	Discharge	Days Used	Remaining Benefit Days Full- Co-Days 60-30
09/10	09/20	10	50 – 30 (subtract 10 full days)
10/05	10/25	20	30 – 30 (subtract 20 full days)
12/10	12/30	20	10 – 30 (subtract 20 full days)
02/25	03/21	25	0 – 15 (subtract 10 full days and 15 co-days)
05/10	05/30	20	0 – 0 (subtract 15 co-days; 5 days non-covered)

- Full: Reimbursed in full
- CO: Coinsurance
- Understanding the Part A Benefit Period (Spell of Illness)

Inpatient Claim Requirements

- TOB:
  - 111 – Acute and CAH
- Appropriate Revenue Codes:
  - 0100 – Inpatient accommodation
  - 0001 – Total charge
- VC 80 – Covered days:
  - Includes the total number of covered days during the billing period
  - Excludes any days classified as non-covered:
    - Day of discharge
    - Day of death
- VC 81 – Non-covered days (if applicable):
  - Benefits are exhausted:
  - Non-covered level of care
  - Leave of absence
- VC 82 – Co-insurance days (if applicable):
  - Covered inpatient days (61st-90th)
- Date Range
- Units

Reason Code 12206/12302/15202/19902

- RTP error:
  - The sum of covered and non-covered days does not equal the days calculated between the statement covers "from' and 'through' date
- Research:
  - Verify covered and non-covered days on the claim, and the statement ‘from and through’ dates.
- Reason code action:
  - If the from and through dates match, the claim must show one day.
  - If the patient status code is a discharge status, the through date is not included in the count
  - If the claim is a same day transfer:
    - Count the day as a non-covered
    - Charges are listed as covered
- Reminder:
  - Use the appropriate VC to report days:
    - 80 Covered days
    - 81 Non-covered days
    - 82 Co-insurance days
  - Verify the information through the Novitasphere and/or IVR for the most current benefit days available
- Reference:
  - Reason Code Article 15202
  - Reason Code 12206 Article

Discharge Status Codes

- Definition:
  - A patient discharge status code is a two-digit code that identifies where the patient is at the conclusion of a health care facility encounter or at the end of a billing cycle (the 'through' date of a claim)
- Patient status codes appear in FL 17 to indicate the discharge destination at the date service ended
- Proper discharge/transfer patient status codes are required:
  - Impacts correct claims processing
  - Correct claims payment
  - Correct processing of subsequent claims
- Occurrence code 55 must be used with Discharge Status code 20 (expired)
- Discharge Status Codes

Additional Inpatient Claim Requirements

- Point of Origin
- Type of Admission
- Patient Status
- Admitting Diagnosis
- Total Charge

Under Arrangement Policy

- Medicare does not pay any provider other than the inpatient hospital for services provided to the beneficiary while the beneficiary is an inpatient of the hospital:
  - All items and non-physician services provided to inpatients must be furnished:
    - Directly by the hospital
    - Billed by the hospital under arrangements through the submission of the Part A claim to Medicare
- Services provided by another hospital during inpatient stay under arrangement must be billed by inpatient hospital:
  - Example: Patient needs Magnetic Resonance Imaging (MRI) scan; however, hospital does not have the equipment. Patient transported by ambulance to private hospital for MRI and then returned by ambulance to inpatient hospital. Inpatient hospital would include on their bill
- Inpatient claim should include:
  - All services rendered to the beneficiary directly, or
  - All services provided under arrangement, on an outpatient basis, at another hospital
- Inpatient hospital will reimburse the other hospital and transportation provided the amount that was determined and agreed upon by all parties involved
- Outpatient services may not be separately billed by the other hospital or the transportation provider
- SE17033 - Medicare Does Not Pay Acute-Care Hospitals for Outpatient Services They Provide to Beneficiaries in a Covered Part A Inpatient Stay at Other Facilities

Vaccines During Inpatient Stay

- When vaccines are provided to an inpatient of a hospital, they are covered under the vaccine benefit
- Hospitals bill the vaccine (administration, vaccine, and A6 Condition Code) under TOB 12X using the discharge date of the hospital stay or the date benefits are exhausted:
  - Influenza (administration and vaccine)
  - Pneumococcal (administration and vaccine)
  - COVID-19 (at this time administration)
  - mAb (Monoclonal antibody infusion administration at this time)

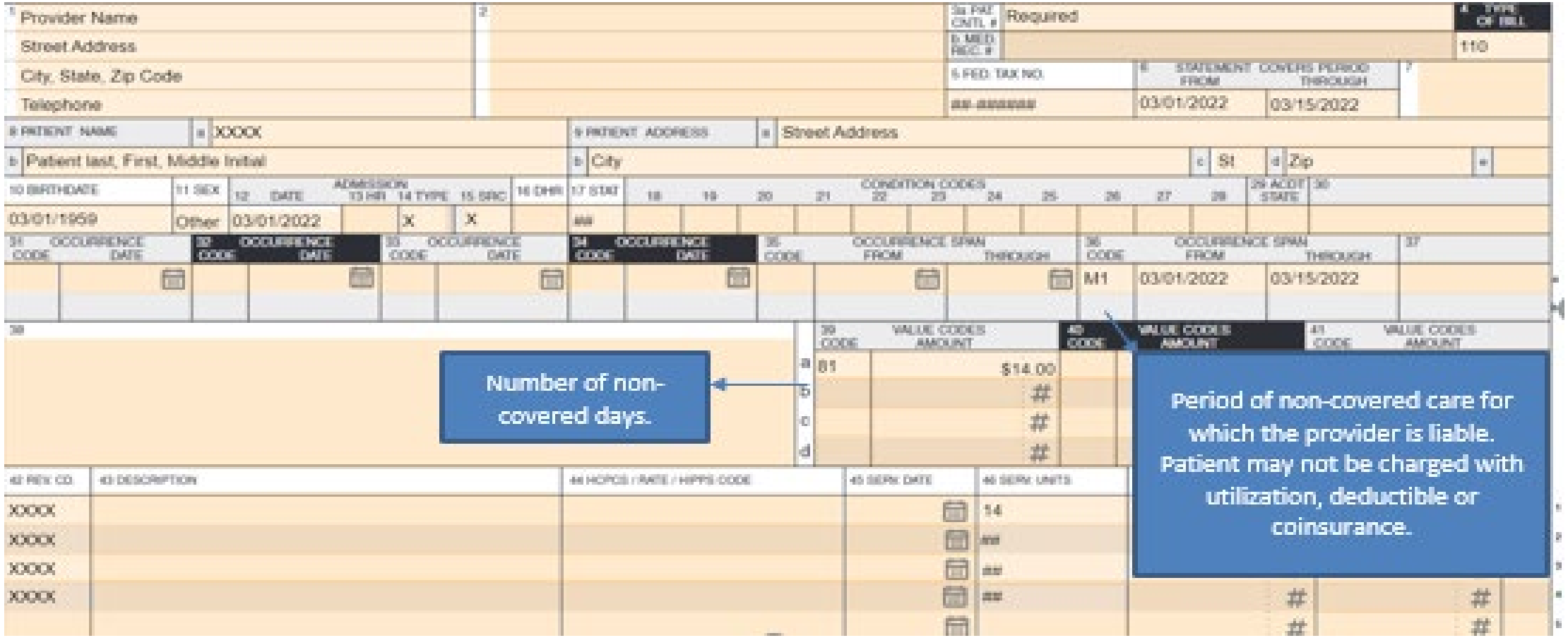
Social Admits

- CMS states that an 11X or 12X TOB is not billable to Medicare for social admits
- Social admits may include:
  - Situations in which the family is unable to pick up the patient and the patient is placed back into room as a convenience to provide a meal are not covered
  - Patient is scheduled for surgery but lives too far to come to the facility the morning of scheduled surgery

No-Pay Bills

- Required on inpatient claims to track benefit period
- Filed when:
  - Inpatient benefit days are exhausted
  - Determination made after patient dismissed that inpatient stay was not medically necessary
  - Denial from Medicare needed for supplemental insurance
- Report 110 TOB
- Entire stay should be entered as non-covered
- Append M1 Occurrence Span Code:
  - Do not include the discharge date
- Total units should equal the total number of days
- Non-covered units should equal the total days
- Total charge should equal the rate times the total number of units
- Non-covered charge should equal the rate times the number of non-covered days
- Add a brief, clear and concise explanation for filing a no payment claim
- Once the 110 claim has processed, submit 12X TOB for covered Part B services furnished to the inpatient:
- Billing Acute Inpatient Non-covered Provider Liable Days

Provider Fully Liable Billing Example



Provider Liable Billing Order

- FISS requires provider liable claims must be billed in sequential order
- Prior claim must process first before filing your next claim:
  - 11x first claim
  - 12x second claim
  - 13x third claim
- Claims that are billed out of order will be return to provider (RTP) for corrections

Inpatient Ancillary Overview

- Definition:
  - Certain inpatient CAH ancillary services are covered under Medicare Part B when coverage is no longer provided under Medicare Part A:
    - Has no Part A eligibility/entitlement
    - Inpatient stay is not medically necessary, determined to be receiving a non-covered level of care
    - Patient has no days available for the inpatient stay (benefits have exhausted) Ancillary services cannot be billed if there is any Part A payment made
- Physician services and the non-physician medical and other health services covered under Medicare Part B when furnished by a participating IHS provider to an inpatient of the CAH:
  - Only if payment for these services cannot be made under Medicare Part A
- All charges, except therapies, telehealth originating site facility fee, PPV, influenza vaccine, hepatitis B vaccine and COVID-19 vaccine administrations are combined into one ancillary charge

Ancillary Reimbursement

- Ancillary claims are submitted when a patient is admitted into a facility and:
  - Has no Part A eligibility/entitlement
  - Inpatient stay is not medically necessary
  - Patient has no days available for the inpatient stay (benefits have exhausted) Ancillary services cannot be billed if there is any Part A payment made
- Inpatient Part B ancillary reimbursement::
  - CAH:
    - 101 percent of the all-inclusive facility-specific per diem rate
- Claim requirements:
  - TOB:
    - 121 – CAH
  - Appropriate Revenue Code:
    - 0240:
      - All charges excluding therapies, telehealth site fee, flu, pneumonia, COVID-19 and mAb ((Monoclonal antibody infusion)
  - HCPCS not required
  - Date of service
  - Units (count discharge date on an ancillary claim)
  - Total Charge

CAH Swing Bed Definition

- Definition:
  - A swing bed hospital is a hospital or CAH participating in Medicare that has CMS approval to provide post-hospital SNF care and meets certain requirements
  - Medicare Part A (the hospital insurance program) covers post-hospital extended care services furnished in a swing bed hospital

CAH Swing Bed Overview

- CAHs approved to furnish swing bed services may use their beds as needed to furnish either acute or post-hospital SNF-level care:
  - Services are itemized:
    - Appropriate revenue code that describes the service
    - TOB 18X
- Included in 25 bed limit
- Paid at 101 percent of reasonable costs
- Exempt from SNF-PPS
- Three-day qualifying hospital stay
- Not required to report revenue code 0022 or HIPPS codes
- Split billing required for calendar year end

CAH Swing Bed Ancillary Overview

- Swing bed patients revert to being inpatient hospital Part B patients when not eligible for Part A services:
  - Drop below skilled level of care
  - Exhaust Part A benefits
  - No qualifying hospital stay
- CAH swing-bed Medicare Part B inpatient ancillary bills revert to inpatient Medicare Part B ancillary bills:
  - Submitted under the regular hospital (or CAH) provider number (not the swing-bed provider number)
  - Revenue code 0240:
    - No HCPCS
  - TOB 12X
- Payment made at 101 percent of reasonable costs

Method I and II Overview and Billing

Method I: Outpatient

- Definition:
  - A CAH that elects Method I bills the MAC for facility services only
  - Facility outpatient charges billed to Part A on a UB-04 or the electronic equivalent:
    - Reimbursed at 101 percent of reasonable cost minus Part B deductible and coinsurance provisions
  - Professional services billed to Part B on the CMS-1500 claim form or the electronic equivalent:
    - Reimbursed under the MPFS minus Part B deductible and coinsurance provisions

Method II Election

- Definition:
  - Method II includes payment for professional services at 115 percent of what would otherwise be paid under the MPFS
- Method II only applies to outpatient services
- New elections:
  - Must be made in writing
  - At least 30 days in advance of beginning of affected cost-report period
  - Submit list of practitioners by specialty
- Practitioners rendering services at a Method II CAH, may elect to reassign their billing rights to that CAH:
  - Under this election, a CAH will receive payment from the Part A MAC for professional services furnished in their outpatient department
  - The PECOS Individual Physicians/Non-Physicians or paper CMS-855I application section 4F, should be submitted in order to reassign their benefits to the CAH
- Note: The paper Reassignment of Medicare Benefits (CMS-855R) application expired and is no longer accepted starting November 1, 2023

Maintaining Method II Election

- Method II remains in place until election is terminated
- No annual updates
- Notice to terminate must be made in writing at least 30 days prior to beginning of cost reporting period
- CAHs needs to submit the PECOS Individual Physicians/Non-Physicians or paper CMS-855I application section 4F, for new physicians reassigning their benefits and electing Method II to the CAH:
  - Include specialty information
- References:
  - Completing the Form Tutorial (JH) Physician and Non-Physician Practitioners paper CMS-855I
  - Medicare Enrollment Forms (JH)

Method II: Practitioner Election

- Definition:
  - Practitioners rendering services at a Method II CAH may elect to reassign their rights to the CAH
  - Not all practitioners have to reassign benefits for hospital to become a CAH
  - Practitioner types eligible to reassign billing rights to the CAH are listed below

- Doctor of Medicine or Osteopathy
- Dental Surgery (specialty 19)
- Podiatric Medicine (specialty 48)
- Optometry (specialty 41)
- Chiropractic Medicine (specialty 35)
- Certified Clinical Nurse Specialist (specialty 89)
- Nurse Practitioner (specialty 50)
- Clinical Psychologist (specialty 68)

- Certified Nurse Midwife (specialty 42)
- Licensed Clinical Social Worker (specialty 80)
- CRNA (specialty 43)
- Registered Dietician Nutritional Professional (specialty 71)
- Physician Assistant (specialty 97)
- Marriage and Family Therapists (specialty E1)
- Mental Health Counselors (specialty E2)

Method II: Practitioner Attestation

- Definition:
  - For each physician or practitioner who agrees to be included under the Optional Payment Method (Method II) and reassigns benefits accordingly
- Practitioners choosing to reassign benefits to hospital must sign attestation:
  - States that practitioner will not bill Part B for any services provided to hospital outpatients
  - Attestation remains on file at CAH:
    - No standard form, CAH will need to create attestation

Method II: Outpatient

- Definition:
  - A CAH that elects Method II bills the MAC for both facility services and professional services furnished to its outpatients by a physician or practitioner who has reassigned his or her billing rights to the CAH
- Include professional fees for outpatient hospital services on the UB-04 or the electronic equivalent:
  - No professional fees would be billed on the CMS 1500:
    - If professional fees are filed on the CMS 1500, they would be overpayments
- Professional services are reimbursed at 115 percent of the MPFS
- NPP services are reimbursed at 115 percent of allowed percentage

Billing Method II

- Only applicable for services provided in outpatient department of CAH (85X TOB)
- Professional fees are billed with revenue codes 096X, 097X or 098X, with appropriate HCPCS and charges:
  - Only applicable for physician/practitioners who have reassigned their benefits to the CAH:
    - Cannot bill professional fees on the CMS 1500
- HCPCS code definition must correspond to revenue category:
  - Codes for professional services used when HCPCS specify global, technical and professional services
- Attending/Rendering provider is required:
  - Each Physician/Practitioner reassigning benefits to a CAH must be enrolled as a valid Part B Physician/Practitioner
- Line level rendering Physician/Practitioner NPI:
  - Required when both facility and professional services billed
- The line level rendering provider is required when the rendering provider is different from the rendering provider reported on the claim level

CAH Specialty Services and Billing

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CAH Observation Services

- Definition:
  - Observation care is a well-defined set of specific, clinically appropriate services, which includes ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital
- Medicare Claims Processing Manual, Pub. 100-04, Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPPS), Section 290 – "Outpatient Observation Services"
- Must be patient specific and not part of CAH internal protocol:
  - Including same day surgical procedures
- An order must be written to substantiate the medical necessity for observation care:
  - Must clearly differentiate between an inpatient admission and outpatient observation
  - Dated, timed, and signed
- Observation services include ongoing short-term treatment, assessment and reassessment to make a decision concerning a patient's admission or discharge

Observation and Medical Necessity

- Observation services begin and end with an order by a physician or other qualified licensed practitioner:
  - The order for observation services must be written prior to initiation of the service, as documented by a dated and timed order in the patient's medical record
  - The order may not be backdated
  - Orders should be clear for the level of care intended, such as "admit to inpatient" or "place in observation"
- Observation is only medically necessary when:
  - Patient's current condition requires outpatient hospital services
  - There is a significant risk of deterioration in the immediate future
- Observation services for the convenience of the patient or others are not medically necessary
- Standard recovery:
  - General standing orders for observation for outpatient surgery are not recognized
  - Hospitals should not report recovery time as observation care

Observation Billing

- All charges, except therapies, telehealth originating site facility fee, PPV, influenza virus vaccine, hepatitis B vaccine, and hospital-based ambulance services are combined :
  - Report revenue code 0510
  - Reimbursed at facility-specific daily rate for each day of observation:
    - Each date of observation requires a separate line item billing
  - TOB 85X
- MOON (Medicare Outpatient Observation Notice:
  - Issued to inform Medicare beneficiaries (including health plan enrollees) that they are outpatients receiving observation services and are not inpatients of a hospital or CAH
- Must use the OMB-approved MOON:
  - CMS-10611
  - MOON FAQs

CAH Laboratory Services

- Definition:
  - A clinical diagnostic test
- Patient is considered to be receiving services from the CAH if:
  - Individual must either be receiving outpatient services in the CAH on the same day the specimen is collected, or
  - Specimen must be collected by an employee of the CAH
- Laboratory billing:
  - Bill tests that meet definition of hospital outpatient with TOB 85X:
    - Encounter and labs would be one combined for one charge
  - Non-patient (reference) tests are to be billed with TOB 14X
- SNF labs:
  - Lab services billed by SNF if patient is in Part A SNF stay
  - CAH may bill Medicare directly for Part B SNF patients:
    - TOB 85X if hospital employee draws lab specimen or if SNF is hospital-based
    - TOB 14X if non-hospital based or if SNF employee draws specimen

CAH Ambulance Services

- Definition:
  - For a CAH or a CAH-owned and operated entity to be paid 101 percent of reasonable costs for its ambulance services, there can be no other provider or supplier of ambulance services located within a 35-mile drive of the CAH
- CAH ambulance paid under ambulance fee schedule or at 101 percent of cost, depending on ambulance location in relation to CAH and other ambulance providers:
  - If another ambulance is within 35 miles of CAH, CAH ambulance paid on ambulance fee schedule
- If CAH-based ambulance and non-CAH ambulance are both beyond 35 miles from hospital, payment rate is determined by which is closer:
  - CAH-based ambulance closer to CAH = 101 percent of reasonable cost
  - Non-CAH-based ambulance closer to CAH = ambulance fee schedule
- Use condition code B2 (CAH ambulance attestation) to indicate CAH ambulance meets fee schedule exemption criteria to receive cost reimbursement
- Provider Specialty-Ambulance (JH)

Ambulance Medicare Coverage Policy

The Medicare payment benefit for ambulance services is a restricted policy

- Ambulance services are covered only if furnished to a beneficiary whose medical condition at the time of transport is such that transportation by other means would endanger the patient's health:
  - A patient must have a health problem to the degree that transport, such as a wheelchair van or private car, could put the patient's health and safety at risk
  - Not covered when the patient's condition permits transport in any type of vehicle other than an ambulance
- Medicare coverage and reimbursement depends on the beneficiary's condition at the actual time of transport regardless of diagnosis
- Patient must require the transportation and level of service provided

CAH Therapy Services Requirements

- Definition and Requirements:
  - Physical medicine and rehabilitative services are designed to improve, restore, or compensate for loss of physical functioning following disease, injury or loss of a body part
  - Services must be reasonable and medically necessary for the patient condition and type of therapy being rendered
  - Patient is under the care of a physician/NPP
- Billing:
  - TOB: 85X or 12X
  - Revenue codes:
    - 044X for Speech Therapy
    - 043X for Occupational Therapy
    - 042X for Physical Therapy
  - Appropriate Therapy HCPCS:
  - Appropriate therapy plan modifiers
- Reference:
  - Provider specialty: Therapy (JH)

References and Resources

General Resources

- CMS CAH Fact Sheet:
  - Booklet reviews and defines several CAH topics
- CMS CAH Webpage:
  - Provides basic information about being certified as a CAH provider
- State Operation Manual, Pub. 100-07, Chapter 2 – The Certification Process:
  - CAH certification information
- Novitas CAH Specialty Page JH:
  - Central location for all CAH links, resources and references
- Novitas Medical Policy Search JH:
  - Self service tool to search NCDs, LCDs and Local Coverage Articles
- Novitas Claims Issue Log JH:
  - Provides the most current status of identified claim processing issues
- Comprehensive Error Rate Testing (CERT):
  - Central location for all CERT links, resources and references

2024 Updates, References and Resources

Billing Requirements for Intensive Outpatient Program (IOP) Services

Who

- Hospital outpatient departments
- Critical access hospitals (CAHs)
- Community mental health centers (CMHCs)

When

- Effective Date: January 1, 2024
- Implementation Date: January 2, 2024

What

- New condition code 92 identifies claims for IOP services

- Key information:
  - Effective January 1, 2024, Medicare covers and pays for IOP services for individuals with mental health needs when furnished by hospital outpatient departments, and Community Mental Health Centers (CMHCs)
  - IOP provides treatment at a level more intense than outpatient day treatment or psychosocial rehabilitation, but less intense than a partial hospitalization program (PHP)
  - Hospitals (including CAHs) and CMHCs must use condition code 92 on all claims for IOP services
  - Payment for IOP services you bill with condition code 92 based on:
    - OPPS for OPPS hospitals submitting claims on type of bill (TOB) 013x
    - OPPS for CMHCs using TOB 076X
    - 101% of reasonable cost for CAHs using TOB 085x
    - Current payment methods for non-OPPS hospitals using TOB 013x
- References:
  - Medicare Learning Network (MLN) Matters Article: MM13222: New Condition Code 92: Billing Requirements for Intensive Outpatient Program Services
  - Intensive outpatient program (IOP) billing requirements for institutional services (JH)

IOP Services Certification and Plan of Care

- FQHC and GFT FQHC IOP Certification and Plan of Care Requirements
- Pursuant to an individualized patient written plan of treatment established:
  - Periodically reviewed by a physician
  - Diagnosis
  - Type
  - Amount
  - Frequency
  - Duration of the items and services provided under the plan
  - Goals for treatment under the plan
- Physician certification and plan of care requirements required for IOP furnished in the FQHC and GFT FQHC settings require physicians to certify that an individual needs IOP services for a minimum of 9 hours per week of therapeutic services as evidenced in their plan of care
- Certification would require documentation to include that the patient requires such services for a minimum of 9 hours per week
- This determination must occur no less frequently than every other month

IHS Billing Requirements for IOP Services

- IHS will follow all IOP guidelines set forth in MM 13222 and CR 13496, reimbursement is the difference and one encounter per day
- IHS IOP Payment Rate:
  - IOP services furnished by IHS hospital based, reimbursement is the All-inclusive Rate (AIR) per day
- Billing IOP services furnished by IHS acute hospitals and critical access hospitals (CAH):
  - Type of bill (TOB); 13X and 85X
  - Revenue code 0510
  - HCPCS codes describing IOP services are listed in Appendix A as List A Primary Services and List B Services:
    - For a list of IOP services, see Attachment A for both List A Primary Services and List B Services
- At least one IOP service from List A Primary Services must be included on the claim for payment:
- Multiple Visits:
  - Visits with more than one health professional and multiple visits with the same health professional that take place during the same day at a single location within the hospital (including the hospital-based satellite) constitute a single visit
  - The only exception to the "all-inclusive" encounter is when the patient has an emergency room visit on the same day with an unrelated condition
- References:
  - Medicare Learning Network (MLN) Matters Article: MM13222: New Condition Code 92: Billing Requirements for Intensive Outpatient Program Services
  - Change Request (CR) 13496 - Enforcing Billing Requirements for Intensive Outpatient Program (IOP) Services with New Condition Code 92 - Additional Publication Update

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

Who

- Physicians and non physicians in Method II CAHs

When

- Effective Date: January 1, 2024
- Implementation Date: February 26, 2024

What

- Payment methodology for MFTs and MHCs when performed by a Method II CAH provider

- Key information:
  - Physicians and/or non-physician practitioners have reassigned their benefits to the Method II CAH:
- References:
  - Change Request (CR) 13502 - Payment for Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs) in a Method II Critical Access Hospital (CAH)

Billing MFTs and MHCs Services

- Tribal and IHS hospitals:
  - Part A outpatient billing:
    - Can bill the AIR for services provided
    - Revenue Code 0510:
      - Appropriate HCPCS
  - Part B (Provider Based Clinic) billing:
    - Associated with a hospital
    - Can bill the professional l services
- IHS, Tribal or Urban not-provided-based (free-standing ambulatory) clinic billing:
  - Not Provider-based is not associated with a hospital
  - Part B: can bill the professional services
- FQHC and GFT FQHC billing:
  - Billed on UB-04
  - Revenue code:
    - 0900
  - G0469 or G0470
  - Appropriate qualifying HCPCS
  - Same as Clinical Psychologist, Clinical Social Worker bill under mental/behavior health services

Top RTP and Reject Claims Submission Errors and Resolutions

NOVITAS SOLUTIONS

IHS/Tribal CAH RTP Claim Submission Reason Codes

JH Reason Code	Description
34963	See slides
32415	Condition code 'A6' is required when billing for an influenza virus, pneumococcal vaccinations or COVID-19 administrations
31325	The claim was submitted with total covered charges equal to zero and condition code 20 or 21 is not present
U5065	The Medicare Beneficiary Identifier (MBI) effective or end date is not within the claim dates of service
31644	The claim was submitted with modifier 'GY' on a revenue line for ambulance with covered charges: Verify the usage of GY modifier, if you feel the service is not medically necessary and should be non-covered; you must show non-covered charges, correct and resubmit claim

Reason Code 34963

- Description:
  - The attending physician on claim page 03 is invalid
  - The attending physician NPI is present, but the first four digits of the last name do not match PECOS
  - The claim has a through date of service equal or greater than the termination date of the physician
- Resolution:
  - Confirm the attending provider's name is the physician or NPP who certified the plan of care for the services on the claim and then validate the provider's name and NPI in PECOS
  - If you don't have PECOS access, you can use the order and referring data set at data.cms.gov to verify the physician's name and spelling as seen in PECOS:
    - It is recommended to search by the provider's NPI to correctly display the information
    - Use PECOS or data.cms.gov only for validation to obtain the correct information for editing
  - Correct the reported physician information and resubmit your institutional claim

Example for Reason Code 34963

- Example 1:
  - Provider's NPI: XXXXXXXXX
  - Provider's name: John Smith
  - System editing: J Smit
- Example 2:
  - Provider's NPI: XXXXXXXXX
  - Provider's name: John Smith Jones or Smith-Jones
  - System editing: J Smit
- References:
  - MLN Matter Article (MM) 12889 New Fiscal Intermediary Shared System Edit to Validate Attending Provider NPI – Phase 2 for a list of physician and non-physician practitioner (NPP) specialties eligible as an attending physician and who must be enrolled in PECOS in an approved status
  - New Fiscal Intermediary Shared System (FISS) consistency edit to validate attending physician NPI (JH)
  - Reason code 34963 (JH)
  - Resolve claim return reason code 34963 for outpatient therapy services (JH)

IHS/Tribal CAH Top Reject Claim Submission Reason Codes

JH Reason Code	Description
39929	Line-item reject; revenue code 0510 with lab or diagnostic x ray services Verify services provided: Patient had a face-to-face encounter; use E&M HCPCS Patient returned for labs/procedure or diagnostic service (meaning the patient has had an initial visit that requires follow up service), use HCPCS 99211 (lab or diagnostic HCPCS will not process with 0510 revenue code) Non-patient labs will be billed with 14X type of bill with appropriate HCPCS
38111/38105	Duplicate submission
U5200	Not entitled to Medicare
U5210	Services after benefits terminated

Verify Eligibility

- Verify patient eligibility for your date(s) of service prior to submitting your claim:
  - Novitasphere Portal (JH)
  - Interactive Voice Response (IVR) (JH)
  - Fiscal Intermediary Standard System (FISS):
    - FISS Manual, Chapter 2, Section 2.2 (JH)
  - HIPAA (Health Insurance Portability and Accountability Act) Eligibility Transaction System (HETS)

Key Takeaways

01 Provided an understanding of the CAH background and designation, and provided references, resources for future utilization

02 Identified the difference between Method I and Method II billing methods

03 Reviewed Method II billing

04 Discussed specialty services and billing

05 Reviewed top claim submission errors and resolutions

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