NOVITAS SOLUTIONS

Understanding Critical Access Hospital, Critical Access Hospital Swing Bed and Swing Bed Billing

Partnership

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Acronym List

Acronym	Definition
AMA	American Medical Association
ARD	Assessment Reference Date
BBA	Bipartisan Budget Act
CAH	Critical Access Hospital
CMS	Centers for Medicare & Medicaid Services
CNS	Clinical Nurse Specialist
CC	Condition Code
CP	Clinical Psychologist
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetists
CSW	Clinical Social Worker
CWF	Common Working Files

Acronym List 2

Acronym	Definition
DO	Doctor of Osteopathy
DPM	Doctor of Podiatric Medicine
E/M	Evaluation and Management
ERA	Electronic Remittance Advice
FAQ	Frequently Asked Questions
HCPCS	Healthcare Common Procedure Coding System
HIPPS	Health Insurance Prospective Payment System
LCD	Local Coverage Determination
LOA	Leave of Absence
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MD	Medical Doctor

Acronym List 3

Acronym	Definition
MLN	Medicare Learning Network
MPFS	Medicare Physician Fee Schedule
NCD	National Coverage Determination
NP	Nurse Practitioner
NPI	National Provider Identifier
NPP	Nurse Physician Practitioner
OC	Occurrence Code
OD	Doctors of Optometry
OSC	Occurrence Span Code
OT	Occupational Therapy
PA	Physicians Assistant
PPS	Prospective Payment System

Acronym List 4

Acronym	Definition
PT	Physical Therapy
RTP	Return to Provider
RUG	Resource Utilization Group
SLP	Speech Language Pathology
SNF	Skilled Nursing Facility
TOB	Type of Bill
UB-04	Universal Billing Form 04
VC	Value Code

Agenda

- CAH Overview
- Method I Overview and Billing
- Method II Overview
- Method II Billing
- Method II Modifiers
- CAH Specialty Services and Billing
- CAH Therapy Services
- CAH Swing Bed Overview
- SNF/Swing Bed Overview and Billing
- SNF/Swing Bed Coverage Requirements
- SNF/Swing Bed General Billing Requirements
- References and Resources

Novitas Solutions IHS Education

- Education specific to Indian Health Services (IHS) providers in Medicare Administrative Contractor Jurisdiction H (JH), which includes:
  - (1) tribally owned and operated facilities electing to bill as IHS
  - (2) tribally operated IHS facilities
  - (3) IHS owned and operated facilities
  - (4) tribally owned and IHS operated facilities
- Tribally owned and operated facilities electing to bill the MAC serving their specific geographic location should look to that MAC for guidance on billing.

CAH Overview

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
- Outpatient split bill at calendar year end

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
- Outpatient split billing is not required for services that span the provider or federal fiscal year end

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:
  - Unless the CAH is wholly owned or operated by a non-CAH hospital
- 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 to regulations:
  - Certification begins with order for admission
  - Expected to be discharged or transferred within 96 hours
- Payment made at 101 percent of reasonable costs:
  - All charges are combined and reported under revenue code 0100 (all-inclusive room and board plus ancillary) on TOB 11X (hospital inpatient). Inpatient services are billed from admission through discharge
- 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
- Split billing is required for provider fiscal year end

Calculating Days in a Benefit Period – Acute Care Hospital

Admission	Discharge	Days Used	Remaining Benefit Days Full-CO-Days 60-30
01/10/2018	01/20/2018	10	50-30
02/05/2018	02/25/2018	20	30-30
04/10/2018	04/30/2018	20	10-30
06/10/2018	07/05/2018	25	0-15
09/01/2018	09/21/2018	20	0-0 (5 days non-covered)

- Full: Reimbursed in full
- CO: Coinsurance

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

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

Patient Status Codes

Status	Definition
01	Discharge to Home or Self Care
02	Discharged/Transferred to a Short -term General Hospital for Inpatient Care
03	Discharged/Transferred to SNF
04	Discharged/Transferred to Intermediate Care Facility
05	Discharged/Transferred to a Designated Cancer Center or Children's Hospital
06	Discharged/Transferred to home for care under Home Health
07	Left Against Medical Advice or Discontinue Care
09	Admitted as an Inpatient to this Hospital
20	Expired
30	Still Patient or Expected to Return for Outpatient Services

- Note: Not an all inclusive list

Arranged Services During Inpatient Stay

- 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

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

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
- Change Request 3452

CAH Type of Bills

- Outpatient:
  - 851 – Admit to Discharge
  - 857/147 – Adjustment
  - 85Q/14Q – Reopening
  - 858/148 – Cancel
  - 850 – No payment
- Inpatient:
  - 111 – Admit to Discharge
  - 117 – Adjustment or Interim Bill
  - 118 – Cancel
  - 110 – No payment
  - 12X – Part B Only/Ancillary

Method I 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

All charges, except therapies, telehealth originating site facility fee, PPV, influenza virus vaccine, hepatitis B vaccine, and hospital-based ambulance services are combined and reported under revenue code 0510 (clinic visit) on TOB 85X (CAH)

Method II Overview

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 the their outpatient department
  - The individual practitioner must complete and submit the CMS-855R – "Reassignment of Medicare Benefits" form to reassign their billing rights

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 need to submit the CMS-855R – "Reassignment of Medicare Benefits" for new physicians electing Method II:
  - Include specialty information
- References:
  - Completing the Reassignment of Medicare Benefits (CMS-855R) Form Tutorial
  - Medicare Enrollment Forms

Method II: Practitioner Election

- Definition:
  - Practitioners rendering services at a Method II CAH, may elect to reassign their billing rights to that CAH
- Not all practitioners have to reassign benefits in order for the hospital to become a Method II CAH

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
- Professional services are reimbursed at 115 percent of the MPFS

Method II Billing

Method II Billing

- 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
- 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

Global Surgical Days for CAH Method II

- Definition:
  - The global surgical package, also called global surgery, includes all the necessary services normally furnished by a surgeon before, during, and after a procedure
- MM10425:
  - Effective: July 1, 2018
  - Implementation: July 2, 2018
- Key Points:
  - Physicians and non-physician practitioners billing on TOB 85X for professional services rendered in a Method II CAH have the option of reassigning their billing rights to the CAH:
    - ✓ When billing rights are reassigned to the Method II CAH, payment is made to the CAH for professional services (using revenue codes 096X, 097X or 098X) based on the MPFS supplemental file
  - Global surgical package includes all necessary services normally furnished by a surgeon before, during and after a procedure
  - Medicare payment for the surgical procedure includes the pre-operative, intra-operative and post-operative services routinely performed by the surgeon or by members of the same group with the same specialty
  - CAH Method II providers should follow the same guidelines as per Part B physician services:
    - ✓ Medicare Claims Processing Manual, Pub. 100-04, Chapter 12 – Physicians/Nonphysician Practitioners

Global Surgery Modifiers Webpage

Global Surgery Modifiers

The following modifiers are used by physicians to indicate a billed service is not part of a global surgical package and is eligible for separate reimbursement:

Modifier	Description	References
24	**Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period**: The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(*s*) unrelated to the original procedure. This circumstance may be reported by adding the modifier 24 to the appropriate level of E/M service.	Modifier 24 Fact Sheet
25	**Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service**: It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or be beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (*see Evaluation and Management Services Guidelines for instructions on determining level of E/M service*). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform major surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.	Modifier 25 Fact Sheet Modifier 25 Tips
57	**Decision for Surgery**: An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.	Modifier 57 Fact Sheet

Global Surgery Days

- Verify global surgery days using the [Physician Fee Schedule Code Search]

Results

Procedure Code	66984	**State**	Texas	**Modifier**	No Modifier
Effective Date	01-01-2018	**Locality**	Galveston (15)	**Description**	Cataract surg w/iol 1 stage

Please click on the icon for a description of any field or indicator

Fee Schedule Amount

Participating Provider	662.54
Non-Participating Provider	629.41
Limiting Charge Amount	723.82

View Limiting Charge Amounts for EHR, eRX and PQRS

When performed in a facility setting

Participating Provider	662.54
Non-Participating Provider	629.41
Limiting Charge Amount	723.82

View Limiting Charge Amounts for EHR, eRX and PQRS

Status Indicators

Surgery & Procedures

Professional/Technical Component	0
Global Days	090
Pre-Operative %	0.1
Intra-Operative %	0.7
Post-Operative %	0.2
Multiple Procedures	2
Bilateral Surgery	1
Assistant at Surgery	1
Team Surgeons	0
Co Surgeons	0
Physician Supervision of Diagnostic Procedures	09
Multiple Therapy Amount	0.00
Conversion factor	35.9996
Update Factor	1.0050

	A
	1
	9
	9
	8.52
	9.11
	9.11
Malpractice	0.60

Geographic Practice Cost Indices

Work	1.020
Practice	1.011
Malpractice	0.839

Global Days: 090

Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount

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Global Surgery Indicators

Global Surgery Days	Definition
0 to 10	Minor surgery
90	Major surgery
XXX	Global surgery concept doesn’t apply
YYY	Contractor priced
ZZZ	Add-on codes are always billed with another procedure Defined in CPT with a +

Method II Modifiers

Modifiers Defined

- Definition:
  - AMA CPT Manual: "A modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance in its definition or code but not changed in its definition or code"
- Purpose:
  - Modifiers enable health care professionals to effectively respond to payment policy requirements
- Review modifier definitions in the CPT and HCPCS manuals:
  - Proper selection of the correct modifier is essential
- Novitas' Modifiers Complete Listing

Method II: Modifiers AK, GF and SB

- Modifier AK used to identify services provided by non-participating physician:
  - 115 percent of lesser of charge or 95 percent of MPFS for these services
- Modifier GF used to identify services provided by NP, PA or CNS:
  - GF modifier is not to be used for CRNA services
  - 115 percent of lesser of charge or 85 percent of MPFS for these services
- Modifier SB used to identify services provided by certified nurse-midwife:
  - 115 percent of lesser of charge or 65 percent of MPFS for these services

Method II: Modifiers AH, AE and AJ

- Modifier AH used to identify services provided by clinical psychologist:
  - 115 percent of lesser of charge or 100 percent of MPFS for these services
- Modifier AE used to identify services provided by nutritional professional or registered dietician:
  - 115 percent of lesser of charge or 85 percent of MPFS for these services
- Modifier AJ used to identify services provided by Licensed Clinical Social Workers (LCSW):
  - 80 percent of lesser of charge or 75 percent of the amount determined for the payment of psychologist:
    - ✓ (Facility specific MPFS amount times the LCSW reduction (75 percent)) minus (deductible and coinsurance) times 115 percent

Method II: Assistant at Surgery

- Assistant at Surgery modifiers:
  - Physician, PA, NP or CNS:
    - ✓ Modifier 80 – Assistant surgeon
    - ✓ Modifier 81 – Minimum assistant surgeon
    - ✓ Modifier 82 – Assistant surgeon (qualified resident surgeon not available)
  - PA, NP or CNS:
    - ✓ Modifier AS – PA, NP or CNS
      - When AS is used, must also have 80, 81 or 82
- Co-Surgeon modifier:
  - Modifier 62 – Two surgeons
  - Used on a single surgical procedure code:
    - ✓ Can have two line items with same code and modifier if both physicians reassign benefits under Method II

Method II: Modifiers 54 and 55

- Modifier 54 is used for global surgical split care for surgical care only:
  - TOB: 85X
  - Revenue codes: 096X, 097X, or 098X
- Modifier 55 is used for global surgical split care for postoperative management only:
  - TOB: 85X
  - Revenue codes: 096X, 097X, or 098X

Method II: Anesthesia and Modifiers

- HCPCS: 00100 through 01999
- Units: base units plus time in 15 minute increments (excluding 01995 and 01996)
- Revenue code: 0963
- 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
- If reporting multiple modifiers, the medical direction modifier should be listed first

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CAH Specialty Services and Billing

CAH Ambulance Services

- Definition:
  - For an IHS CAH or an IHS 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 IHS CAH
- CAH ambulance paid under ambulance fee schedule or at 101 percent of cost, depending on ambulance location in relation to IHS CAH and other ambulance providers:
  - TOB-85X
  - Revenue Code-054X
  - HCPCS-appropriate for services
  - Use condition code B2 (CAH ambulance attestation) to indicate IHS CAH ambulance meets fee schedule exemption criteria to receive cost reimbursement

CAH Ambulance Services With Encounter

- If an outpatient encounter occurs at the same time a covered ambulance service is provided:
  - Clinic visit (encounter):
    - ✓ Revenue Code-051X
    - ✓ HCPCS-appropriate for visit
  - Ambulance service:
    - ✓ Revenue Code-054X
    - ✓ HCPCS-appropriate for services

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
- Covered CAH outpatient laboratory service charges are combined with all other outpatient charges for the date of service and reported under revenue code 0510 (clinic visit) on TOB 85X. Payment is based on 101 percent of the facility specific per visit rate
- Swing-bed laboratory service charges are combined with all other swing bed charges in IHS CAHs and are billed under revenue code 0100 (all-inclusive room and board plus ancillary) on TOB 18X. Payment is made on a cost based per diem amount

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
- Observation charges including all services during observation, except therapies, telehealth originating site facility fee, PPV, influenza virus vaccine, hepatitis B vaccine, and hospital-based ambulance services are combined:
  - Revenue code 0510 (clinic visit):
    - ✓ Appropriate HCPCS
  - TOB 85X
  - Units-Per day

Medicare Outpatient Observation Notice (MOON) Instructions

- Definition:
  - 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
- MM9935:
  - Effective: February 21, 2017
  - Implementation: February 21, 2017
- Key Points:
  - Alterations to the MOON is prohibited, it must remain two pages:
    - ✓ May add logos, but cannot move text to another page
  - Must add:
    - ✓ Patients name
    - ✓ Patients number
    - ✓ Reason patient is in observation
  - Retain the original signed MOON in the beneficiary's medical record

Hospital Delivery of the MOON

- Must use the Office of Management and Budget (OMB)-approved MOON:
  - CMS-10611
- Provide both standardized written, as well as oral notification
- Must include the reason the individual is receiving observation services
- Hospitals or CAHs must obtain the signature of the individual or an individual acting on behalf of the patient:
  - Electronic issuance is permitted
  - A paper copy of the MOON must be given regardless if paper or electronic issuance
- Beneficiary refusal to sign:
  - Staff member who presented the written notification will sign and give the date and time of refusal (date of notice receipt)
- MOON FAQs

CAH Therapy Services

CAH Therapy Services

- Definition:
  - Therapy services are skilled services furnished according to the CMS standards and conditions
  - These include outpatient PT, OT and SLP services
- Purpose:
  - 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

CAH Therapy Requirements

- Patient is under the care of a physician/NPP:
  - Physician/NPP certifies the plan of care
  - Evidence of physician/NPP involvement:
    - ✓ Examples:
      - A signed and dated order or referral
      - Conference notes
      - Team meeting notes
- Reference:
  - Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance

CAH Coverage for Therapy

- In order for services to be covered:
  - Must have a benefit category in the federal statute
  - Must not be excluded
  - Must be reasonable and medically necessary:
    - ✓ Type
    - ✓ Frequency
    - ✓ Duration
    - ✓ Patient's functional limitations are documented in terms that are objective and measurable
    - ✓ Relate directly to a written treatment plan
- Services require the skills of a therapist, which include:
  - Expertise and knowledge
  - Clinical judgment and decision making abilities

CAH Providers/Practitioners Who Can Render Therapy Services

- Medicare covers therapy services **personally** performed **only** by one of the following:
  - Licensed Physical Therapy professional:
    - ✓ Licensed physical therapy assistant (PTA) when appropriately supervised by a licensed PT:
      - Private practice must have direct supervision
      - PTA cannot enroll in the Medicare program
  - Licensed Occupational Therapy professional:
    - ✓ Licensed occupational therapy assistant (OTA) when appropriately supervised by a licensed OT:
      - Private practice must have direct supervision
      - OTA cannot enroll in the Medicare program
    - ✓ Direct supervision in the office setting:
      - The therapist must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure
      - It does not mean the therapist must be present in the room when the procedure is performed

CAH Additional Providers/Practitioners Who Can Render Therapy Services

- Medical Doctor (MD), Doctor of Osteopathy (DO), Doctors of Optometry (ODs) or Doctor of Podiatric Medicine (DPM) performing services within their licenses' scope of practice and their training and competency
- Qualified NPPs performing services within their licenses' scope of practice and their training and competency:
  - Advanced Nurse Practitioners (ANPs)
  - Physician Assistants (PAs)
  - Clinical Nurse Specialists (CNS)

CAH Additional Providers/Practitioners Who Can Render Therapy Services (cont.)

- Qualified personnel when appropriately supervised by physician (MD, DO, OD, DPM) or qualified NPP, and when all conditions of billing services "incident to" a physician have been met:
  - Qualified personnel providing PT or OT services "incident to" the services of a physician/NPP must have met the educational and degree requirements of a licensed therapy professional (PT, OT) from an accredited PT/OT licensing board, but are not required to be licensed
  - The services of a physical therapy assistants (PTA) or occupational therapy assistants (OTA) shall not be billed as services "incident to" or under direct supervision of a physician/non-physician provider (NPP) service, because they do not meet the qualifications of a therapist
- Therapy services must be performed by a qualified person:
  - Therapy services not performed by a qualified person should not be submitted to Medicare

CAH Therapy Billing

- TOB: 85X or 12X
- Revenue codes:
  - 044X for Speech Therapy
  - 043X for Occupational Therapy
  - 042X for Physical Therapy
- Appropriate Therapy HCPCS:
  - Generally range from 92520 through 97763 and G0451 through G9186
  - Annual Therapy Code List and Dispositions
- IHS CAH therapy is billed and reimbursed separately from the all inclusive outpatient services
- Therapy services furnished to a single individual by providers that bill Medicare Part A are required to be billed monthly:
  - When an inpatient stay during a month when therapy outpatient services are rendered, one bill for repetitive services should be submitted for the entire month as long as the provider uses occurrence span code 74 on the monthly repetitive bill

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CAH Therapy Modifiers

Value	Description
GP	Services delivered under a PT plan of care
GO	Services delivered under a OT plan of care
GN	Services delivered under a SLP plan of care
KX	Confirmation that services are medically necessary above the therapy threshold

CAH Medical Necessity of Therapy

- Definition:
  - Medical Necessity defined in Title XVIII of the Social Security Act, section 1862(a)(1)(a)
  - This section allows coverage and payment of those services considered to be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member
- Concept of “Reasonable and Necessary”:
  - Restorative/Rehabilitative Therapy:
    - ✓ Goal/Purpose is to improve and restore
  - L35036 - Therapy and Rehabilitation Services (PT, OT)
  - Maintenance Therapy:
    - ✓ Treatment by a therapist is necessary to maintain, prevent or slow further deterioration
    - ✓ Cannot be safely carried out by beneficiary, family member, caregiver or unskilled personnel

CAH Services not Medically Necessary

- Services that do not meet Medical Necessity:
  - Require the completion of the Advance Beneficiary Notice of Non-coverage (ABN) prior to the services being rendered
  - Proper ABN modifier will need to be submitted on the claim
- References:
  - Advance Beneficiary Notice of Non-coverage (ABN)
  - Outpatient Therapy Services and Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131 FAQs

CAH Order or Referral

- An order or referral provides evidence of:
  - Patient need for care
  - Patient is under care of a physician/NPP
  - Physician is involved in care and available to certify plan
- Payment is dependent on the certification of the plan of care rather than the order

KX Modifier Usage

- Use of the KX Modifier is an attestation that:
  - Services are reasonable and necessary above the threshold amount
  - Confirmation that services are medically necessary as justified by appropriate documentation in the medical record
  - Allows payment for the approved therapy services, even though they are above the therapy threshold amount
- Must be added to each claim line identified as a therapy service when the therapy threshold exceptions meet all medically necessary guidelines and must follow the required therapy modifiers GO, GP and GN
- Therapy services submitted without the KX modifier, for claims above the therapy threshold, will deny
- References:
  - Therapy threshold and other therapy payment policies
  - Therapy Services

Annual Update to the Per-Beneficiary Therapy Amounts

- Effective for dates of services rendered January 1, 2019:
  - The annual per-beneficiary incurred expense amounts, now known as the KX modifier thresholds, and related policy:
    - ✓ The KX modifier threshold amount for physical therapy (PT) and speech-language pathology (SLP) services combined is $2,040
    - ✓ The KX modifier threshold amount for occupational therapy (OT) is $2,040
    - ✓ For CY 2018 (and each successive calendar year until 2028, at which time it is indexed annually by the Medicare Economic Index (MEI), this now-termed Medical Review (MR) threshold amount is $3,000 for PT and SLP services combined and $3,000 for OT services
  - Annual Update to the Per-Beneficiary Therapy Amounts

Removal of Functional Reporting Requirements and Therapy Provisions

- MM11120:
  - Effective: January 1, 2019
  - Implementation: February 26, 2019
- Key Points:
  - Effective for dates of service on or after January 1, 2019, HCPCS G-codes and severity modifiers for functional reporting are no longer required on claims for therapy services
  - Effective for dates of service on or after January 1, 2018, providers of therapy services shall continue to report the KX modifier on claims as applicable

CAH Swing Bed Overview

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 Coverage

- CAHs approved to furnish swing bed services may use their beds as needed to furnish either acute or post-hospital SNF-level care:
  - Included in 25 bed limit
  - Paid at 101 percent of reasonable costs
  - Exempt from SNF-PPS
  - Three-day qualifying hospital stay
  - SNF-PPS Consolidated Billing provisions do not apply
  - Split billing required for provider fiscal year and calendar year end
  - Ancillary hospital services provided during skilled Part A stay included on swing bed claim
  - 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 Billing

- Swing Bed facilities will have a separate Medicare Provider number
- Services are itemized and billed with the appropriate revenue code that describes the service on TOB 18X (hospital swing-bed)
- CAH swing-bed providers are not required to report revenue code 0022 or HIPPS codes
- IHS CAH swing-bed Medicare Part B inpatient ancillary bills revert to inpatient Medicare Part B ancillary bills and are submitted under the regular hospital (or CAH) provider number (not the swing-bed provider number) with revenue code 0240 (all inclusive ancillary) on TOB 12X (inpatient Part B)

Swing Bed Overview and Billing

SNF/Swing Bed Coverage Requirements

SNF/Swing Bed Inpatient Care

- Definition:
  - Patients who need skilled nursing or rehabilitative care following an inpatient hospital stay:
    - ✓ Facility can be freestanding or swing bed (part of a hospital)
    - ✓ Technical and medical requirements must be met
- For SNF/Swing Bed information:
  - Provider Specialty: Skilled Nursing Facility Part A
  - SNF PPS Homepage
  - SNF PPS Fact Sheet
  - SNF Billing Reference
  - Medicare Benefit Policy Manual, Pub.100-02, Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance
  - Medicare Claims Processing Manual, Pub. 100-04, Chapter 6 - SNF Inpatient Part A Billing and SNF Consolidated Billing
  - Medicare Claims Processing Manual, Publication 100-04, Chapter 7 - SNF Part B Billing (Including Inpatient Part B and Outpatient Fee Schedule)

Technical Coverage Requirements

- Beneficiary must:
  - Be enrolled in Medicare Part A
  - Receive services in a Medicare-certified SNF/Swing Bed
  - Have SNF/Swing Bed days remaining in benefit period/spell of illness
  - Have a 3-day qualifying hospital stay
  - Meet the 30-day transfer rule (if applicable)

Benefit Period/Spell of Illness

- Definition:
  - Period of consecutive days where a SNF/Swing Bed can be paid for covered services furnished to the beneficiary for a spell of illness
  - Begins the day the beneficiary is admitted as an inpatient to a SNF/Swing Bed
  - Ends when no inpatient or SNF/Swing Bed care is performed for 60 consecutive days:
    - ✓ 60 days begins with the day of discharge
  - A new benefit period will begin after a 60 day break from any inpatient admission

Benefit Period Days

- SNF/Swing Bed coverage is 100 benefit days per benefit period:
  - 20 full
  - 80 coinsurance:
    - ✓ 2019 daily coinsurance is $170.50 per day
- Date of admission counted:
  - Day begins at midnight and ends 24 hours later:
    - ✓ Midnight to midnight census
  - Part of a day counts as a full day:
    - ✓ Day of admission
    - ✓ Day beneficiary returns from a LOA
- Date of discharge not counted:
  - Day of discharge/death or a day on which a beneficiary begins a LOA is not counted as a day:
    - ✓ Unless discharge/death occur on the day of admission

3-Day Qualifying Stay

- Required three consecutive day inpatient hospital stay begins the day the beneficiary is formally admitted as an inpatient to the hospital
- The following do not count for the required three consecutive day stay:
  - Date of discharge from hospital
  - Emergency department or outpatient care, including observation care
- Exceptions:
  - Extended care services include SNF/Swing Bed care for beneficiaries disenrolling from MA plans as a result of a MA plan termination when they do not have a 3-day hospital stay before SNF/Swing Bed admission, if admitted to the SNF/Swing Bed before the effective date of disenrollment

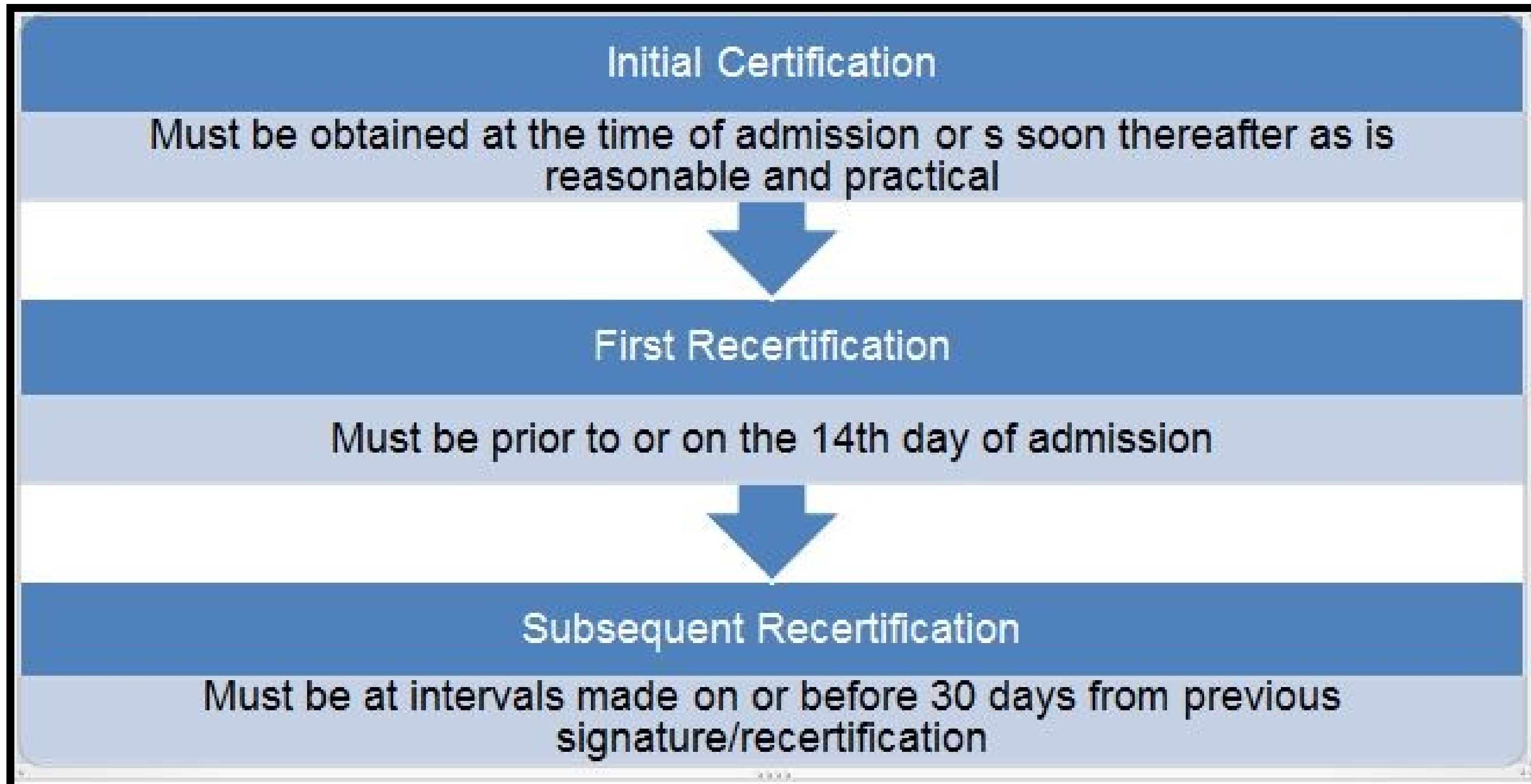
Medical Requirements

- Requires skilled nursing or skilled rehabilitation services ordered by a physician:
  - Must be for a medical condition treated for during the 3-day qualifying hospital stay or for a condition that arose during that hospital stay or while patient received Medicare covered SNF/Swing Bed care
- Skilled nursing services or skilled rehabilitation services (or a combination of these services) must be needed and provided on a daily basis (seven days-a-week):
  - If an inpatient stay is based solely on the need for skilled rehabilitation services daily basis requirement is met if services received at least five days-a-week
- Can only be provided on an inpatient basis in a SNF/Swing Bed
- Services must be reasonable and necessary for the treatment of the patient's specific illness or injury and in terms of how often they are received and how long they last

Certification/Recertification

- Certification/Recertification statement must:
  - Contain need for skilled services that can only be provided in SNF/Swing Bed on a daily basis for a condition patient was treated for in prior hospital stay
  - Include practitioner's dated signature:
    - ✓ Print name if signature is illegible
- Recertification should also include:
  - Reason for continued SNF/Swing Bed care
  - Expected length of stay
  - Explanation if continued need for services is for a condition that arose after SNF/Swing Bed admission
  - Any plans for home care
- Eligible practitioners to complete the certification/recertification:
  - Physician
  - Nurse practitioner
  - Clinical nurse specialist
  - Physician assistant:
    - ✓ Not directly or indirectly employed by SNF/Swing Bed, but working with physician

Timing of Certification and Recertifications



- Note: Delayed certifications or recertifications may be honored if there was an isolated oversight or lapse

What is Required to Meet Medical Requirements

Must be for a medical condition treated for during the 3-day qualifying hospital stay or for a condition that arose during that hospital stay or while patient received Medicare covered SNF/Swing Bed care

Skilled services required at least five days a week

Can only be provided on an inpatient basis in a SNF/Swing Bed

Services must be reasonable and necessary for the treatment of the patient's specific illness or injury

SNF/Swing Bed General Billing Requirements

Frequency of Billing

- Inpatient Part A:
  - Upon discharge
  - When benefits exhaust
  - No longer requires skilled level of care
  - Monthly

TOB and Date of Admission Requirements

- 18X – Swing Bed
- 12X – Swing Bed ancillary billed under regular hospital (or CAH) provider number not the Swing Bed number:
  - Revenue Code 0240 all charges on one line
- Date of admission is the date the patient was admitted to the Swing Bed

Code listings are not all inclusive

Patient Status Codes

- Proper discharge/transfer patient status codes are required for:
  - Correct claims processing
  - Correct claims payment
  - Correct processing of subsequent claims
- Common patient status codes:
  - 01 – Discharge to home or self care
  - 02 – Discharged/transferred to a short-term general hospital for inpatient care
  - 20 – Expired
  - 30 – Still patient or expected to return for outpatient services

Code listings are not all inclusive

Condition Code (CC)

- Definition:
  - Corresponding code to describe conditions or events that apply to the claim
- 56 – Medical appropriateness:
  - SNF/Swing Bed admission was delayed more than 30 days after the hospital discharge because the condition made it inappropriate to begin active care with that period
- 57 – SNF/Swing Bed readmission:
  - Patient was previously receiving Medicare covered SNF/Swing Bed care within 30 days of this readmission
- 58 – Terminated MA enrollee:
  - Patient is a terminated enrollee in a MA plan whose 3-day inpatient hospital stay was waived

Code listings are not all inclusive

Occurrence Code (OC)

- Definition:
  - Significant events related to claim
- 22 – Date active care ended:
  - Represents date patient dropped to a lower level of care
  - Through date on the claim must to be the date of OC 22 if care is not returned to skilled level in the same month
- 50 – ARD:
  - Required for each assessment period presented on the claim with revenue code 0022
  - Not required with default HIPPS code AAA00
- 55 – Date of death:
  - Discharge date must be the same date

Code listings are not all inclusive

Occurrence Code 50 – Assessment Reference Date (ARD)

- Required on inpatient SNF/Swing Bed claims
- Required for each assessment period presented on the claim with revenue code 0022
- Not required with default HIPPS code AAA00
- Only one OC 50 is necessary if the RUG used is one of the following ("xxx" is varying digits):
  - xxx05, xxx06, xxx12, xxx13, xxx14, xxx15, xxx16, xxx17, xxx24, xxx25, xxx26, xxx34, xxx35, xxx36, xxx44, xxx45, xxx46, xxx54, xxx55, and xxx56

Occurrence Span Code (OSC)

- Definition:
  - Significant dates related to claim
- 70 – Hospital qualifying stay dates:
  - Required on all inpatient SNF/Swing Bed claims:
    - ✓ Exceptions:
      - ➢ Reporting CC 58 for when the patient is a terminated enrollee in a MA plan whose 3-day qualifying stay was waived
- 74 – From and through dates of a period at a non-covered level of care or LOA in an otherwise covered stay:
  - Report with revenue code 0180 with units matching the number of non-covered days
- 78 – SNF/Swing Bed prior stay dates:
  - From and through dates of any SNF/Swing Bed stay that ended within 60 days of a hospital or SNF/Swing Bed admission

Code listings are not all inclusive

Revenue Code

- Report for each charge billed
- Codes that identify the accommodations furnished and ancillary services provided, including 0022 for the assessment:
  - Revenue code 0022:
    - ✓ Indicates you are submitting the claim under the SNF/Swing Bed PPS
    - ✓ Use as often as necessary to indicate different rate codes
    - ✓ Total charges report as zero (0)
  - Revenue code 0180 is used to report the LOA
- List in ascending numeric sequence except for the final entry, which must be 0001
- Total charges line 0001 must equal the sum of the individual total charges lines

Code listings are not all inclusive

HCPCS/CPT Code/Rate/HIPPS Code

- Inpatient:
  - HCPCS/CPT are not required
  - Rate is required:
    - ✓ Accommodation revenue codes
    - ✓ HIPPS rate code:
      - ➢ Five-digit code consisting of a three-digit RUG code and a two-digit Assessment Indicator (AI) code:
        - » AI describes the assessment that determined the RUG code
      - ➢ Certain HIPPS codes require additional rehabilitation therapy ancillary revenue codes

Units of Service and Total Charges

- Units of service:
  - Inpatient:
    - ✓ Based on the number of inpatient days
    - ✓ Number of times a service was rendered during the stay
    - ✓ Number of covered days for each HIPPS rate code
- Total charges:
  - Revenue code lines 0022 and 0180 will be zero (0)
  - Charges as appropriate for other services

Diagnosis Code

- Required for inpatient and outpatient claims:
  - Must be the full International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM)
  - Principal, admitting and any additional diagnoses may be reported

Ancillary Billing

- Ancillary billing occurs when one of the following situations exists:
  - Benefits are exhausted
  - Patient drops to a non-skilled level of care
- Swing Bed ancillary billed under regular hospital (or CAH) provider number not the Swing Bed number:
  - Revenue Code 0240 all charges on one line
- Submit after no-pay or rejected Part A SNF/Swing Bed claim processes

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, Chapter 2 – The Certification Process:
  - CAH certification information
- Novitas CAH Specialty Page:
  - Central location for all CAH links, resources and references
- Novitas Medical Policy Search:
  - Self service tool to search NCDs, LCDs and Local Coverage Articles
- Novitas Claims Issue Log:
  - Provides the most current status of identified claim processing issues
- Comprehensive Error Rate Testing (CERT):
  - Central location for all CERT links, resources and references

CAH Method II Resources

- MM7404 – CAH Optional Method Election for Outpatient Services:
  - Information for CAHs electing Method II
- MM8708 – Anesthesiologist/CRNA Related Services in a Method II CAH:
  - Clarifies payment for the specified services
- MM3800 – Billing Requirements for Physician Services Rendered in Method II CAH:
  - Billing and payment information for physician services under Method II
- MM7896 – Pass-through Payments for CRNA Anesthesia Services and Related Care:
  - CRNA pass-through payment information
- MM8387 – Reassignment to Part A CAHs Billing under Method II:
  - Information regarding the reassignment of benefits for physicians and non-physician practitioners

Summary

- Provided an understanding of the CAH background and designation
- Identified the difference between Method I and Method II billing methods
- Reviewed Method II billing
- Discussed specialty services and billing
- Reviewed therapy billing for CAHs
- Discussed CAH Swing Bed requirements
- Provided an understanding of SNF/Swing Bed basics
- Provided a better understanding of the SNF/Swing Bed billing requirements
- Provided references and resources for future utilization