A critical access hospital (CAH) faces many challenges searching for clear guidance on how to appropriately bill for its services. Most of the references and instructions are written for prospective payment system (PPS) hospitals, leaving CAHs wondering what applies to them and feeling lost in the world of CMS transmittals, manuals, regulations, and laws. As an instructor for HCPro’s Medicare Boot Camp® for PPS hospitals and CAHs, I’ve heard many discussions about CAHs, both true and false. In this report, I will set straight the 10 top myths on the topic.

**Background**

Let’s review the basic requirements for a CAH. A CAH is a hospital that is paid under a cost-based payment methodology rather than the prospective payment methodology and must meet the following key criteria:

- Be a current participant in the Medicare program or ceased operations after November 28, 1989, or is now a health clinic after the hospital was downsized
- Be located in a rural area or in an area that is treated as rural based on a state law or regulation
- Be located more than 35 miles from any other hospital (15 miles in mountainous areas or areas with only secondary roads) unless it has been previously designated as a “necessary provider”
- Maintain a maximum of 25 acute care beds, including swing beds, and may have an additional 10 beds each for psychiatric and rehab units
- Have an annual per-patient average length of stay of 96 hours or less
- Furnish 24-hour emergency care with on-site or on-call physicians or nonphysician practitioners with physician oversight
- Meet the Medicare Conditions of Participation (CoP) for CAHs and be certified by CMS as a CAH, not just designated by the state as one

View the CoPs here:  

View the Code of Federal Regulations here:  
[http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=27e901e5ad7c1281f6fe22be913653a1&rgn=div5&view=text&node=42:5.0.1.1.4&eidno=42](http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=27e901e5ad7c1281f6fe22be913653a1&rgn=div5&view=text&node=42:5.0.1.1.4&eidno=42)

As of March 30, CMS reports that there are 1,309 CAHs, and this number continues to grow, although at a slower pace than when the designation...
was introduced to rural hospitals under the Balanced Budget Act in 1997. The cost-based payment methodology has allowed many rural hospitals to remain open after a history of receiving less reimbursement from Medicare, including the final blow in 2000 when outpatient services for Medicare beneficiaries began to be paid under ambulatory payment classifications (APC).

View a map of CAHs throughout the United States here: www.flexmonitoring.org/documents/CAH_03_30_10.pdf

The myths unveiled

Myth #1: The CMS evaluation and management (E/M) code assignment guidelines do not apply to a CAH.

This is false. When APCs were first implemented in 2000, hospitals were allowed to create their own criteria for assigning levels to clinic visits, including visits to the emergency room (ER). CMS introduced 11 guidelines that were to be used by hospitals to create a consistent method for identifying the intensity of the resources used to provide care. According to CMS, the method must:

- Follow the intent of the E/M code by reflecting the level of service provided based on hospital resources (not the physician’s)
- Be clear, documented, and available for outside review
- Be verifiable through external sources
- Be applied consistently across all patients in that specific clinic or emergency department

This means that each hospital can and should create its own method to assign the appropriate level of care.

11 guidelines

When a CAH reports an E/M level for its clinic or ER visit, it is should be cautious and follow the 11 guidelines to validate its individual E/M leveling tool:

1. Does the tool follow the intent/definition of the CPT code?
2. Does the tool allow for the CPT code to reflect the intensity of the hospital’s resources used?
3. Is the tool clear and easy to use?
4. Does the tool only require documentation that is clinically necessary for patient care?
5. Does the tool prevent upcoding or gaming the system?
6. Are the guidelines for using the tool written and well documented?
7. Are the guidelines for using the tool consistent across all patients in that area/unit/clinic?
8. Are the guidelines for using the tool consistent and not changed often based on billing patterns/results (bell-shaped curve)?
9. Are the tool and guidelines for its use available for your fiscal intermediary’s review (including recovery audit contractors)?
10. When the level is audited using the same tool and its guidelines, do you get the same result by either an internal or external auditor?
11. Does the tool meet the HIPAA requirements (data transaction code sets for UB-04)?
Myth #2: The Integrated Outpatient Code Editor (I/OCE) and the National Correct Coding Initiative (NCCI) edits are for PPS hospitals only.

This is partially true. The NCCI edits are part of the OCE, and in both of these systems, some edits have not been “turned on” for CAHs. Although an edit does not apply in the CAH setting, these facilities should be aware of the risks involved because the NCCI edits were implemented to “promote correct coding” and “prevent improper payments” for Medicare Part B outpatient services.

Although a CAH is paid based on the cost of the actual service, the reported costs should not reflect charges related to coding errors. For example, a CAH has created separate charges in the charge description master for a screening colonoscopy (G0121) and a colonoscopy with biopsy (45380). During the same operative session, the screening colonoscopy leads to a biopsy after a polyp was found. Both procedures were billed with the associated HCPCS codes and charges.

For a PPS hospital, the NCCI edits for mutually exclusive code pairs for these two HCPCS codes would indicate that a modifier is not appropriate since these two services could not reasonably be performed together during the same session, and the higher-weighted procedure would not be paid. However, the NCCI mutually exclusive edit for this scenario is not turned on for a CAH. Therefore, if both HCPCS codes are billed on the same date of service with the associated charges, the fiscal intermediary (FI)/Medicare administrative contractor (MAC) could inappropriately pay for both codes when only one should have been billed if the coding was correct. In addition, the patient would pay coinsurance on both charges rather than the most appropriate one. CAHs should audit claims for correct coding prior to billing to prevent overpayments by the FI/MAC and the patient.

Myth #3: Diagnostic and procedural coding rules do not apply in CAHs since the codes do not impact reimbursement.

This is definitely false. The Official Coding Guidelines for ICD-9-CM, AHA Coding Clinic, CPT guidelines, and the AMA CPT Assistant apply in all settings, regardless of the type of payment a facility receives. Although coding facilitates payments, it’s also used to produce meaningful statistics to evaluate utilization patterns, monitor healthcare costs, and provide the basis for research and identifying quality care.

CAHs participate in all aspects of data collection; therefore, it is important for them to employ properly trained staff to review the medical record documentation and accurately assign all diagnostic and procedural codes. Also, keep in mind that other payers may use the coding to assign payment under a modified MS-DRG or APC reimbursement system. It is imperative that all providers who practice in a CAH provide complete and consistent documentation to aid in correct code assignment to facilitate accurate payments.
Myth #4: Since observation services are not paid for under the APC system (packaged payment or payment as part of a composite), CAHs are at less risk of receiving overpayments for those services. This is false. In fact, CAHs may be at higher risk in this area because they can be paid cost for each hour of observation, up to 48 hours and regardless of whether an E/M or surgical service was provided prior to observation. In a PPS hospital, observation hours are always “packaged” and never receive separate reimbursement. To trigger a composite payment, a PPS hospital must have at least eight hours of observation and meet other specific criteria.

CAHs must, however, follow the same rules as a PPS hospital for providing medically necessary observation and carving out time for procedures that require active monitoring. This includes services such as some drug infusions, MRIs with contrast, endoscopy, and other monitored procedures. Billing observation hours can no longer be an automated process. Hospitals that generate billable hours of observation solely based on a change in the medical service and/or discharge time in their information system may be at risk. The information system does not have the ability to identify when billable observation hours occur and when the patient is receiving other monitored services. Clinical staff provide the best expertise to identify when active monitoring is occurring and when observation time should not be billed concurrently. Observation beds are not included in the 25-bed limit for CAHs and are not included in the 96-hour annual average acute care patient length of stay. CMS has instructed surveyors to verify that observation beds are being used appropriately and not as a means to bypass the CAH bed and length of stay limits. In addition, the beneficiary will be liable for a coinsurance equal to 20% of the CAH’s outpatient charges, which may have been avoided if the patient had been admitted as an inpatient. Ideally, all hours of observation should be manually reviewed prior to billing to ensure medical necessity and prevent duplicate billing with concurrent procedures.

Myth #5: The direct supervision requirements for outpatient therapeutic services do not apply to CAHs. This is actually true as of March 15. CMS has given CAHs a “waiver” for meeting the requirements for CY 2010; however, CMS has stated that it will address this further in the rulemaking for CY 2011. Prior to March, CAHs were required to meet the “direct supervision” requirement, which refers to outpatient services being furnished under the direct supervision of a physician or nonphysician practitioner (NPP) who is immediately available to provide assistance and direction throughout the performance of the procedure.

Many rural hospitals realized they would not be able to meet these criteria—specifically, CMS’ definition of “immediately available.” A CAH’s staffing requirements are significantly different than a PPS hospital, and many CAHs have limited medical staff. It is not uncommon for the physician or NPP providing coverage in the ER to provide direct supervision for observation services and other outpatient procedures, particularly in the late evening and early morning hours. In addition, the ER physician or NPP can be on call and...
not on campus as long as that practitioner is always available by phone or radio and can be on-site within 30 minutes, further complicating the issue.

However, in the notice, CMS emphasized the need for quality and safety for services provided to all patients in CAHs. For example, if an ER physician or NPP is involved in responding to a code blue, the provider will not be able to stop what he or she is doing to give immediate assistance to an observation patient. In light of that, CAHs should continue to evaluate the “immediately available” criteria in regards to using ER physicians to provide supervision and also review the FY 2011 OPPS proposed and final rules for any CAH-specific changes to the direct supervision requirements.

Myth #6: CAHs need not apply the medical necessity rules for inpatient and outpatient services because there are costs involved in providing all services, regardless of coverage rules.

This is false. The financial liability protections are provisions of Medicare law that were created to protect all beneficiaries from unexpected personal liability for a noncovered service where the beneficiary might not have been aware that the service was not covered by Medicare. These regulations that protect the beneficiaries were not created based on a payment type. All beneficiaries are afforded the same protections regardless of what type of hospital they are receiving their services at, such as a PPS hospital or a CAH.

For outpatient services, the beneficiary cannot be held financially liable if the service is denied based on a specific statutory reason, such as not medically necessary or the service was ordered more frequently than it is covered, and if the beneficiary did not know in advance that he or she might have to pay out of pocket. Per statute, the hospital is required to screen the service in advance of performing the test and issue an advance beneficiary notice (ABN) for the patient to review. If the patient agrees to the service and signs the ABN stating they will be financially responsible, the hospital can bill the patient for those services. If the hospital chooses not to screen a service that is protected by statute and does not provide an ABN to the patient, the FI/MAC will deny the service and the hospital will be required to write off the charge. This means that the patient will not have any out-of-pocket expense for the service, potentially “inducing a referral” to the hospital inadvertently. Basically, patients could choose that facility over others because there would be no out-of-pocket expense for them.

For inpatient services, the same holds true; however, the form is called a Hospital-Issued Notice of Non-coverage (HINN). Again, if the hospital chooses not to issue an HINN when inpatient services are not medically necessary or could be provided in another setting such as outpatient or the stay is considered to be custodial in nature, the patient will not pay any out-of-pocket expense, thereby potentially inducing a referral. CAHs may have specific staffing issues that preclude them from issuing these types of notices; however, no hospital can “opt out” of medical necessity screening for inpatient or outpatient services.
Myth #7: CAHs do not have to bill patients for self-administered drugs (SAD) provided in the outpatient setting.

This is false. The coverage rules that have been established for drugs given in an outpatient setting include all hospitals, regardless of the payment type. CMS allows each FI/MAC to determine whether a particular drug is considered to be “usually self-administered.” The determination as to whether a drug is considered to be usually self-administered is not patient or hospital specific. Rather, the decision is based on the usual method of administration for all Medicare beneficiaries who use the drug.

Those drugs that are administered by any method other than injection or infusion, excluding those identified by statute, are considered to be self-administered. These include oral drugs, suppositories, topically applied drugs, and drugs administered by a subcutaneous injection, such as insulin or anticoagulants. Each FI/MAC maintains its own list of SADs on the CMS website. Drugs listed on this site, as well as those considered to be SADs based on the route of administration, should be billed with revenue code 637 with the appropriate HCPCS code, and the charges should be listed in the noncovered column to be billed directly to the patient.

Keep in mind that drugs that may be considered self-administered but are so integral to the treatment or procedure that it could not be performed without them should not be billed separately to the patient. An example of an SAD that would be considered “integral to” is eye drops used to dilate the pupils prior to an eye procedure. CMS has suggested that fraud and abuse concerns may arise if a hospital does not bill Medicare patients for noncovered drugs. Hospitals may be at risk of inducing referrals to their facility since the patients would not have any out-of-pocket expenses for SADs.

Myth #8: The three-day rule does not apply to CAHs.

This is true. The regulations state that CAHs must bill their outpatient and inpatient services on separate claims, even if the outpatient encounter, such as an ER, observation, or outpatient surgery, led to the inpatient admission on the same day. CAHs are exempt from the required preadmission packaging edits that PPS hospitals must comply with, according to the Medicare Claims Processing Manual. It is inappropriate for an FI/MAC to request a CAH to “bundle” its related outpatient services into its inpatient admissions. By doing so, the inpatient charges are inappropriately inflated, and this may affect the hospital’s inpatient cost-to-charge ratio and future payments.

In addition, by bundling the outpatient services into the inpatient admission, the outpatient charges are deflated, again impacting future payments. Also, the patient would not be responsible for the usual 20% coinsurance for the outpatient services since they were not billed separately. CAHs that have been requested to bundle any of their outpatient services into their inpatient claims should contact their FI/MAC and possibly their CMS regional office for further discussion of the regulations.
Myth #9: CAHs need not review the IPPS and OPPS proposed and final rules because these rules do not affect their payment.

This is definitely false. It is becoming increasingly common to see references to CAHs in the PPS regulations. Since there is not a proposed and final rule-making process for CAHs alone, changes that affect CAHs are often listed in these regulations. CAHs should be aware of the time frames for reviewing the rules.

For inpatient regulations, the proposed rule is usually published in April and the final rule in August, with implementation of the changes on October 1 of each year, which is the start of the federal fiscal year. For outpatient regulations, the proposed rule is usually published in July and the final rule in November, with implementation on January 1 of each year, which is when changes to the HCPCS codes become effective. During the proposed rule period, hospitals are encouraged to submit comments about whether they agree or disagree and what the potential impact of the proposal would be on their facility. This is the hospital’s chance to be heard, and CMS must take into account all comments prior to finalizing the rule.

An example of the importance of reviewing the IPPS rules is explained in the recently published FY 2011 IPPS proposed rule. Several changes for CAHs are proposed, with the most significant one affecting CAHs that use the optional method billing, more commonly known as Method II billing. Previously, a CAH had to elect this billing method for each physician on an annual basis and submit the necessary paperwork to its FI or MAC 30 days before the start of its cost reporting period. When a CAH missed this deadline, even by a few days, it would in turn miss all of the additional reimbursement for that entire cost reporting period. However, under the proposed rule for cost reporting periods beginning October 1, 2010, once an election is made, it remains in effect until the CAH terminates the election and/or changes occur in the medical staff for which this billing method is being used.

In addition, CMS must create a method to terminate an election, and the CAH must terminate an election at least 30 days prior to the start of its cost reporting period. This is great news for CAHs and will help reduce the paperwork burden and critical deadlines of the annual election. All hospitals, including CAHs, should routinely review the proposed and final rules to anticipate changes that may be forthcoming.

Myth #10: The recovery audit contractors (RAC) will not be looking at CAHs because they will be focusing on the larger providers and DRG payments.

This idea is partially false. During the recent CMS RAC 101 conference call April 28, the CMS RAC project officer stated that RACs are “steering away from” CAHs because of the complexity of opening cost reports. He stated that CMS is currently working to establish how RACs will approach recoupments with CAHs and an open door forum call would be forthcoming when

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that occurs. With that said, keep in mind that when RACs conduct data mining for their approved-issues list, they have been instructed not to review the data based on an individual provider.

Despite the fact that a recoupment process has not been established, if a CAH provides a service that is related to an approved issue, it is as susceptible for a review as a PPS hospital. Although the volume may be greater for a PPS hospital, many CAHs have a very high percentage of Medicare patients, which also places them at risk. In addition, there are a variety of current approved issues that could affect CAHs in the outpatient arena, such as excessive units of services for a transfusion, bronchoscopy, initial IV hydration, a barium swallow, drugs with specific HCPCS codes, and untimed codes.

If a CAH has been inappropriately reimbursed for even one patient who received a service, it can be considered an overpayment upon review and recoupment could be forthcoming, after the process is established. Some other high-risk areas for CAHs to consider auditing include medical necessity for one-day stays and three-day qualifying stays, observation vs. inpatient status, appropriate use of condition code 44, appropriate use of modifiers including -59 and -25, and correct coding of NCCI code pairs. These are currently not approved RAC issues; however, CAHs would be wise to review the regulations and conduct their own audits in preparation for any future reviews.

**Conclusion**

Overall, CAHs aren’t much different from PPS hospitals in regards to following many of the same rules. The biggest difference is the type of payment they receive—cost vs. PPS, bed size, and length of stay limits. In summary, it is the expectation that all hospitals are responsible to provide quality care in a manner that is consistent with the laws and regulations, regardless of their payment designation.

*Editor’s note: Mackaman is an instructor for HCPro’s Medicare Boot Camp®–Hospital Version and Medicare Boot Camp®–Critical Access Hospital Version. A former hospital compliance officer and HIM director, Mackaman has more than 18 years of experience in the healthcare industry, including both inpatient and outpatient PPS and CAH coding, chargemaster, and reimbursement issues.*