Priority Health	BILLING POLICY No. 070
CRITICAL ACCESS HOSPITAL (CAH) METHOD II BILLING	
Date of origin: Dec. 30, 2024	**Review dates: 2/2025**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise stated

DEFINITION

- **Critical Access Hospital (CAH)** – a medical facility providing health care services to rural areas.
- **Method I billing** – standard payment method where the physician or practitioner bills their outpatient professional medical services under the physician fee schedule (PFS).
- **Method II billing** – optional payment method where the CAH bills the facility and the professional outpatient services **only** when the billing rights of the physicians or practitioners have reassigned their billing rights to the CAH.

POLICY SPECIFIC INFORMATION

CAH are a separate provider type which has its own conditions of participation (CoP) and separate payment methods. CoP includes (not all-inclusive listing):

- Has 24/7 emergency services using on-site or on-call staff with specific staff response times
- Doesn't exceed 25 inpatient beds. These beds may be used for inpatient or swing beds.
- Reports an annual average length of stay (LOS) of 96 hours or less, excluding swing bed services and DPU beds
- Location from any other CAH or hospital is greater than a 35-mile drive on primary roads
- Standard staffing which includes:
    - Professional staff to include one or more Doctor of Medicine or osteopathy, may include one or more physician assistants, nurse practitioners or clinical nurse specialists. These staff **must** be available to furnish patient care services at all times.
    - Ancillary personnel which are supervised by professional staff
    - Whenever a patient is inpatient, a registered nurse, clinical nurse specialist or licensed practical nurse is on duty.
- Responsibilities of the Doctor of Medicine or Osteopathy include:
    - Medical direction for health care activities which include consultation for and medical supervision of the healthcare staff
    - In combination with PA/NP, reviews the patient records, provides medical orders and care services to patients
    - Reviews and signs records for all inpatients care for by NP, CNS, CNM or PAs
- If the admitting hospital is a CAH, the 3-day (or 1-day) payment window doesn't apply
- Any outpatient diagnostic services provided during the payment window to a patient by a CAH, or an institution which is wholly owned or operated by a CAH must **not** be bundled into the inpatient admission at the CAH
- Outpatient diagnostic services provided during the payment window to a patient at a CAH that's wholly owned or operated by a non-CAH hospital ARE subject to the 3-day (or 1-day) payment window
- Some examples of diagnostic service revenue codes include (see Medicare claims processing manual chapter 3 for additional details):

- 0254 – Drugs incident to other diagnostic services
- 0255 – Drugs incident to radiology
- 030X – Laboratory
- 031X – Laboratory pathological
- 032X – Radiology diagnostic

Method II billing

- Must be elected (once elected will be effective for the entire cost reporting period) at least 30 days before the start of the cost reporting period.
  - Physicians and Practitioner's must complete the CMS 855I; the CAH must forward the completed form to the MAC and reassign their benefits.
  - This election will remain in place until CAH submits in writing a request of termination at least 30 days before the start of the next reporting period.
- Once physician or practitioner billing rights have been reassigned, the physician or practitioner can't bill for professional services.

Revenue codes for Method II billing

- 096x, 097x, 098x – should be billed with the professional charges
  - HCPCS C-codes should not be billed with these revenue codes

Type of bill

- 85x - used for all outpatient services including services approved as ASC services
- 14x – non-patient lab specimens not meeting the criteria for reasonable cost payment

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the provider. In addition, the provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Modifiers

- GF – Services rendered by a nurse practitioner, clinical nurse specialist or physician assistant
- SB – Services rendered by in a CAH by a certified nurse-midwife

Any applicable value codes, condition codes and occurrence codes must be billed according to Uniform Billing Editor.

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. Get more information on modifier use in our Provider Manual.

Definitions

- **Non-patient laboratory specimen** – a beneficiary that is neither inpatient or an outpatient of a hospital and isn't physically present at the hospital, but has a specimen that's submitted for analysis
- **Primary road** – a numbered federal highway which includes interstates, intrastates, expressways or any other numbered federal or state highway with two or more lanes each way

- **Wholly owned or operated** – the hospital is the sole owner or operator and exclusive responsibility for implementing facility policies.

RESOURCES

- Medicare Part B overpaid and beneficiaries incurred cost-share overcharges of over $1 million for the same professional services (Department of Health and Human Services – Office of the Inspector General)
- Information for Critical Access Hospitals (CMS)
- Type of bill code structure (Noridian Healthcare Solutions)
- Medicare Claims Processing Manual – Chapter 4 – Part B Hospital (CMS)
- Title 42 – Chapter IV – Subchapter G – Part 485 – Subpart F – Conditions of Participation: Critical Access Hospitals (CAHs) (Code of Federal Regulations)

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 14, 2025	Added “Disclaimer” section