Coding in Critical Access Hospitals

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National health policy has been increasingly responsive to the healthcare needs of rural residents and providers. Rural America has a large percentage of the nation's Medicare population, and this percentage continues to grow as residents born in the Baby Boomer generation begin to retire. Rural healthcare system practitioners provide essential acute inpatient, outpatient, and post-acute care, including skilled nursing, psychiatric, home health, and rehabilitation services.

This article takes a closer look at the federal rural health policy initiatives, coding, reimbursement methodology, and quality improvement initiatives for critical access hospitals (CAHs).

Medicare Rural Hospital Flexibility Program

Under the Balanced Budget Act of 1997, the Medicare Rural Hospital Flexibility Program (Flex Program) was created to preserve access to quality healthcare and strengthen the financial performance of rural hospitals. The program consists of a Medicare rural reimbursement system and a state flex grant program administered by the federal Office of Rural Health Policy.

The Medicare Flex Program is a critical national initiative under which individual states may:

- Designate eligible Medicare facilities to become CAHs
- Improve the quality of rural resident healthcare
- Implement rural health community networks and engage in broader federal-level healthcare system infrastructure initiatives

Under a state flex program, CAH providers reside in approved rural regions or are qualified under a special provision that allows qualified hospital providers in urban areas to be treated as rural. CAHs are either more than 35 miles from the nearest hospital or another CAH or more than 15 miles in areas with mountainous terrain or only secondary roads. Facilities must be certified by the Centers for Medicare and Medicaid Services (CMS) and meet Medicare's CAH Conditions of Participation. CAH accreditation is available through the Joint Commission or the American Osteopathic Association's Healthcare Facilities Accreditation Program.

CAHs can provide no more than 25 inpatient beds, which can be used for either inpatient or swing-bed services. In addition, CAHs may operate distinct part units (DPUs) for rehabilitation or psychiatric services, up to 10 beds for each unit. CAHs are required to furnish 24-hour emergency care services and have an average annual length of stay of 96 hours or less, excluding applicable rehabilitation or psychiatric DPU beds.

Facilities that convert to CAHs tend to expand their radiology, laboratory, and outpatient rehabilitation services. Services that may decline following conversion include inpatient surgery and obstetrics.

Most CAH inpatient, outpatient, and swing-bed services are reimbursed under Medicare's reasonable cost payment system. Medicare's prospective payment system is used under CAHs' rehabilitation and psychiatric DPU services. CAHs have two payment method options available:

- **Standard method:** CAH facility services are reimbursed under reasonable costs through the Medicare fiscal intermediary or Part A or B Medicare administrative contractor. Payments for qualified professional services rendered in the outpatient department are made to the physician or practitioner under the Medicare Physician Fee Schedule (MPFS) through the Medicare carrier or Part A or B Medicare administrative contractor.

- **Optional method:** The CAH is reimbursed an all-inclusive payment for outpatient using reasonable costs for facility services plus an amount equal to 115 percent of the allowed amount under MPFS for the qualified professional service. Under this method, a CAH submits the facility and professional service claims to its Medicare fiscal intermediary or Part A or B Medicare administrative contractor, and the physician or other qualified practitioner reassigns his or her billing rights accordingly to the CAH to bill Medicare.

FY2010 Medicare CAH Highlights

The final rule for FY 2010 Hospital Inpatient Prospective Payment System for Acute Care Hospitals included the following CAH policies:

- **CAH-based clinical diagnostic laboratory tests.** For dates of service on or after July 1, 2009, CAHs will receive reasonable cost-based payment for outpatient clinical diagnostic laboratory tests furnished to an individual that is not physically present in the CAH at the time the laboratory specimen is collected. In order to receive reasonable cost payment, the patient must either receive outpatient services in the CAH (or CAH provider-based facility) on the same day the specimen is collected, or the specimen collection must be performed by an employee of the CAH. A modifier will be developed in the future to assist tracking laboratory services reimbursed to CAHs under this revised provision. CAHs should review CMS's final comments in detail to assist with updating and implementing compliant laboratory coding and billing policies.
- **Provider-based status regulation changes** . Effective October 1, 2010, CAH-owned clinical diagnostic laboratory facilities will be required to apply the provider-based status rules to ensure the facility is fully integrated with the main provider in order to receive the reasonable cost-based reimbursement.
- **CAH optional method of payment for outpatient services.** CAHs that select the optional method payment will receive 100 percent of reasonable costs for outpatient services instead of 101 percent. CMS revised the rule to be consistent with the Social Security Act. The change is effective for cost-reporting periods beginning on or after October 1, 2009, and the change does not affect the existing payment policy for the professional component.
- **Redesignated CAHs.** CMS announced redesignation changes of three micropolitan statistical areas to metropolitan statistical areas. CAHs located in these areas will be redesignated as urban and lose their CAH status. CMS has provided a two-year period starting in FY 2010 for affected CAHs to reclassify from urban to rural.

The US Department of Defense has adopted a final payment rule for CAHs under TRICARE, its healthcare program for uniformed service members, retirees, and their families. Effective December 1, 2009, the final rule adopts Medicare's CAH reasonable cost payment methodology for inpatient and outpatient care, reimbursing 101 percent of reasonable costs for inpatient and outpatient care.

CAHs are subject to Medicare's Recovery Audit Contractor (RAC) program and should prepare for the program just like larger healthcare providers. CAHs should focus on RAC operational aspects such as performing internal risk assessments. CAHs also should create a RAC team with affected departments such as HIM, utilization review, and patient finance services.

CAH Quality Data-Reporting Initiatives

The Flex Grant Program, quality improvement organizations, hospital associations, and other CAHs are valuable resources to assist with individual CAH quality improvement initiatives. CAHs have found a variety of effective quality improvement methods such as peer review systems, hospital staff training in quality improvement techniques, and participation in national or state public reporting programs, such as CMS's Hospital Compare.

Although CAHs are not eligible for financial incentive payments under the Medicare Prospective Payment System's Hospital Compare initiative, CAHs have found value in voluntarily reporting inpatient and outpatient quality measures to assess and improve their performance on national standards of care.

Currently CAHs are exempt from reporting Present on Admission and Hospital-Acquired Conditions indicators; however, many CAH coding professionals are involved in reporting this data based on state law requirements. State hospital associations can provide assistance in determining state POA and HAC reporting requirements.

CAH Rural Health Network

Solutions are increasingly evolving to improve limited access to primary, specialty, and preventive healthcare through rural healthcare provider collaboration and an enhanced health information and communications technology infrastructure. The use of telemedicine services is an example of a critical rural health network initiative.

Since access to specialty care is a primary barrier for improving quality of patient care in rural communities, telemedicine is increasingly explored as a viable solution to reduce the geographic barriers to care.

Medicare's coverage policy for telemedicine specifies authorized originating sites, including CAHs and practitioners at a distant site who may furnish covered telehealth services. Currently Medicare-covered telehealth services and CPT codes include:

- Consultations (CPT 99241–99255)
- Office or other outpatient visits (CPT 99201–99215)
- Individual psychotherapy (CPT 90804–90809)
- Pharmacologic management (CPT 90862)
- Psychiatric diagnostic interview examination (CPT 90801)
- End-stage renal disease-related services included in the monthly capitation payment (CPT 90951, 90952, 90954, 90955, 90957, 90958, 90960, and 90961)
- Individual medical nutrition therapy (HCPCS level II code G0270 and CPT 97802–97803)
- Neurobehavioral status examination (CPT 96116)
- Follow-up inpatient telehealth consultations (HCPCS level II G0406–G0408)

The Medicare telemedicine coverage policy specifies that independent renal dialysis facilities are not eligible originating sites.

To comply with Medicare coverage policy, facilities must use interactive audio and video telecommunication to permit real-time communication between the distant site physician or practitioner and the Medicare beneficiary. The coverage policy specifies that the patient must be present and participate in the telehealth visit.

The federal telemedicine demonstration programs in Alaska and Hawaii are exempt from this requirement. In these programs, Medicare payment for telemedicine is permitted when asynchronous "store and forward technology," in single or multimedia formats, is used as a substitute for an interactive telecommunications system.

In addition to reporting the appropriate CPT and HCPCS level II telehealth codes, distant site physicians and practitioners are required to report the telehealth modifier GT, "via interactive audio and video telecommunications system." For states participating in the federal telemedicine demonstration program, the telehealth modifier GQ, "via asynchronous telecommunications system," is reported.

As telemedicine services continue to expand, coding professionals are in the best position to assist in the development of CAH-compliant coding, documentation, and reporting policies. CAH coding professionals should also advocate that their providers submit requests for new services to the list of Medicare telehealth services.

CMS adds and deletes services to the Medicare telehealth services on January 1. Both the public and private sectors may submit requests to add services.

Requests for additional services may be submitted on an ongoing basis. Requests must be submitted and received no later than December 31 of each calendar year to be considered for the following year's proposed rule and comment period. The final changes to policies and payment rates for services paid under the Medicare Physician Fee Schedule for CY 2010 will provide the Medicare telehealth services coding and reporting updates.

Resources

Centers for Medicare and Medicaid Services (CMS). "Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2010 Rates." *Federal Register* 74, no. 165 (Aug. 27, 2009). Available online at www.access.gpo.gov/su_docs/fedreg/a090827c.html.

CMS. Critical Access Hospital Center. Available online at www.cms.hhs.gov/center/cah.asp.

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