Medicare Learning Network
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CMS
Information for Medicare Fee-For-Service Health Care Professionals

MLN Matters Number: MM4234
Related Change Request (CR) #: 4234
Related CR Release Date: January 3, 2006
Effective Date: April 3, 2006
Related CR Transmittal #: R803CP
Implementation Date: April 3, 2006

Administration of Drugs and Biologicals in a Method II Critical Access Hospital (CAH)

Note: This article was updated on February 25, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs) for services related to the administration of drugs and biologicals in Method II Critical Access Hospitals (CAHs)

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 4234, which provides updated instructions regarding the administration of drugs and biologicals in a Method II CAH.

CAUTION – What You Need to Know

CR4234 provides new billing instructions with revised Healthcare Common Procedure Coding System (HCPCS) coding guidance for physician involvement (professional component) in the administration of drugs and biologicals in the outpatient department of a Method II (Optional Method) CAH.

GO – What You Need to Do

See the *Background* section of this article for further details regarding these new billing instructions.

Background

Change Request (CR) 4234 replaces CR3911 (Transmittal 617, rescinded November 8, 2005) and provides updates to the billing requirements for physician involvement (professional component) in the administration of drugs and biologicals in the outpatient department of a Method II CAH.

Both Method I (Standard Method) and Method II CAHs bill for technical services furnished in the outpatient department. However, only Method II CAHs bill the fiscal intermediary (FI) for physician services furnished in the outpatient department:

- Method I is a reasonable (cost-based) facility services method with billing of a carrier for professional services (unless the CAH elects payment under Method II); and
- Method II is the optional method with the billing of a fiscal intermediary (FI) for both facility and professional services. Under Method II, Medicare makes payment for the facility services at the same level that would apply under the reasonable cost method (increasing to 101% for cost reporting periods beginning on or after January 1, 2004), but services of professionals to outpatients are paid at 115% of the amount that would have otherwise been paid under the Medicare Physician Fee Schedule (MPFS).

Note: The Code of Federal Regulation (CFR 42 Section 413.70) provides regulations governing how physician involvement in the administration of drugs and biologicals (other than Low Osmolar Contrast Material (LOCM)) should be billed by a Method II CAH. See the following GPO web site to review 42 CFR 413.70: http://www.gpoaccess.gov/cfr/retrieve.html.

Coding for the Professional Component in the Administration of LOCM

CR4234 instructs the charges for outpatient physician involvement in the administration of Low Osmolar Contrast Material (LOCM) to be submitted on type of bill (TOB) 85X (Critical Access Hospitals), with:

- The appropriate outpatient hospital visit Current Procedural Terminology (CPT) code for evaluation and management (E & M) services, with
- Revenue Code 096X, 097X or 098X (Professional Fees).

Payment is made based on the MPFS. Revenue Codes 096X, 097X, and 098X are defined in Table 2 included in the *Additional Information* section of this article.

Coding for the Technical Component in the Administration of LOCM

The technical component for LOCM may be billed by both Method I and Method II CAHs with revenue code 0636 (Pharmacy – Drugs Requiring Detailed Coding(s)) and one of the following HCPCS codes as appropriate:

HCPCS Code	Long Description
Q9945	Low osmolar contrast material (up to 149 mg/ml iodine concentration, per ml)
Q9946	Low osmolar contrast material (150 - 199 mg/ml iodine concentration, per ml)
Q9947	Low osmolar contrast material (200 - 249 mg/ml iodine concentration, per ml)
Q9948	Low osmolar contrast material (250 - 299 mg/ml iodine concentration, per ml)
Q9949	Low osmolar contrast material (300 - 349 mg/ml iodine concentration, per ml)
Q9950	Low osmolar contrast material (350 - 399 mg/ml iodine concentration, per ml)
Q9951	Low osmolar contrast material (400 or greater mg/ml iodine concentration, per ml)

Table 1: HCPCS Codes for Low Osmolar Contrast Material

Coding for the Administration of Other Drugs and Biologicals

CR4234 further instructs your intermediary to accept the following from a Method II CAH billing for physician involvement for hydration: chemotherapy or LOCM administration; therapeutic or diagnostic injections; and intravenous (IV) infusions (other than hydration), submitted on TOB 85X:

- CPT codes 99201 – 99205 (Office or Other Outpatient Visit New) or CPT codes 99211 – 99215 (Office or Other Outpatient Visit Established); with
- Revenue code 096X, 097X or 098X on TOB 85X.

See Table 3 in the *Additional Information* section of this article for definitions of CPT codes 99201-99205 and 99211-99215.

Note: The *Medicare Claims Processing Manual* (Pub. 100-04, Chapter 3, Section 30.1.3 (Costs of Emergency Room On-Call Providers)) has been revised to reflect that computing reasonable compensation and related costs for emergency room on-call coverage is based on the dates of service, and it is included with CR4234. Previously, this section stated that the computation was based on cost reporting periods, and there are no policy changes related to the revisions in manual Section 30.1.3.

Additional Information

To learn more about fee schedule payment for professional services, see Chapter 4, Section 250.2 (Optional Method for Outpatient Services: Cost-Based Facility Services Plus 115 percent Fee Schedule Payment for Professional Services) of the *Medicare Claims Processing Manual* (Pub. 100-04) at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html on the CMS website.

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R803CP.pdf on the CMS website.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

Professional Fees (Revenue Codes 096X, 097X, and 098X)

Charges for medical professionals that hospitals or third party payers require to be separately identified on the billing form, and services that were not identified separately prior to uniform billing implementation should not be separately identified on the uniform bill.

Revenue Code 096X	Professional Fees	
	Subcategory Number (X)	Standard Abbreviations
	0 - General Classification	PRO FEE
	1 - Psychiatric	PRO FEE/PSYCH
	2 - Ophthalmology	PRO FEE/EYE
	3 - Anesthesiologist (MD)	PRO FEE/ANES MD
	4 - Anesthetist (CRNA)	PRO FEE/ANES CRNA
	9 - Other Professional Fees	OTHER PRO FEE
Revenue Code 097X	Professional Fees - Extension of 096X	
	Subcategory X	Standard Abbreviations
	1 - Laboratory	PRO FEE/LAB
	2 - Radiology - Diagnostic	PRO FEE/RAD/DX
	3 - Radiology - Therapeutic	PRO FEE/RAD/RX
	4 - Radiology - Nuclear Medicine	PRO FEE/NUC MED
	5 - Operating Room	PRO FEE/OR

	6 - Respiratory Therapy	PRO FEE/RESPIR
	7 - Physical Therapy	PRO FEE/PHYSI
	8 - Occupational Therapy	PRO FEE/OCUPA
	9 - Speech Pathology	PRO FEE/SPEECH
Revenue Code 098X	Professional Fees - Extension of 096X & 097X	
	Subcategory Number (X)	Standard Abbreviations
	1 - Emergency Room	PRO FEE/ER
	2 - Outpatient Services	PRO FEE/OUTPT
	3 - Clinic	PRO FEE/CLINIC
	4 - Medical Social Services	PRO FEE/SOC SVC
	5 – EKG	PRO FEE/EKG
	6 – EEG	PRO FEE/EEG
	7 - Hospital Visit PRO	FEE/HOS VIS
	8 - Consultation	PRO FEE/CONSULT
	9 - Private Duty Nurse	FEE/PVT NURSE

Table 2: Professional Fees Revenue Codes 096X, 097X, and 098X Defined

CPT Code	Service Type	Service Description
99201	New patient	Office or other outpatient visit (problem focused)
99202	New patient	Office or other outpatient visit (expanded problem focused)
99203	New patient	Office or other outpatient visit (detailed)
99204	New patient	Office or other outpatient visit (comprehensive, moderate)
99205	New patient	Office or other outpatient visit (comprehensive, high)
99211	Established patient	Office or other outpatient visit (minimal)
99212	Established patient	Office or other outpatient visit (problem focused)
99213	Established patient	Office or other outpatient visit (expanded)
99214	Established patient	Office or other outpatient visit (detailed)
99215	Established patient	Office or other outpatient visit (comprehensive, high)

Table 3: CPT Codes for New Patients (99201-99205) and Established Patients (99211-99215)