CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2719	**Date: June 7, 2013**
	Change Request 7896

SUBJECT: Pass-through Payments for Certified Registered Nurse Anesthetist Anesthesia Services and Related Care

I. SUMMARY OF CHANGES: With this instruction we are clarifying that effective January 1, 2013, qualifying critical access hospitals and rural hospitals are eligible to receive CRNA pass-through payments for services that a CRNA is legally authorized to perform in the state in which the services are furnished.

EFFECTIVE DATE: January 1, 2013
IMPLEMENTATION DATE: September 9, 2013

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/ 100.2/ Payment for CRNA or AA Services
R	4/ 250.3.3.1/ Payment for CRNA Pass-Through Services
R	4/250.3.3.2/ Payment for Anesthesia Services by a CRNA (Method II CAH only)

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Business Requirements
Manual Instruction
**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2719	Date: June 7, 2013	Change Request: 7896

SUBJECT: Pass-through Payments for Certified Registered Nurse Anesthetist Anesthesia Services and Related Care

EFFECTIVE DATE: January 1, 2013
IMPLEMENTATION DATE: September 9, 2013

I. GENERAL INFORMATION

A. Background: Hospitals and Critical Access Hospitals (CAHs) that are physically located in rural areas or that have reclassified as rural are eligible to be paid on a reasonable cost basis for Certified Registered Nurse Anesthetist (CRNA) services if they meet the requirements outlined at 42 Code of Federal Regulations (CFR) 412.113(c). This instruction applies to hospitals and CAHs that are eligible for CRNA pass-through payments and provides clarification concerning which services are eligible for pass-through payments consistent with the regulatory change made in the calendar year 2013 Physician Fee Schedule Final Rule. In that rule, the definition of "Anesthesia and related care" was added to the regulations at 42 CFR 410.69(b). The regulation change is discussed in the November 16, 2012 Federal Register page 69005 (77 FR 69005).

B. Policy: Section 1861(bb) of the Social Security Act defines the term "services of a certified registered nurse anesthetist" to mean "anesthesia services and related care furnished by a certified registered nurse anesthetist (as defined in paragraph (2)) which the nurse anesthetist is legally authorized to perform as such by the State in which the services are furnished." In the calendar year 2013 Physician Fee Schedule Final Rule, we amended the regulations at 42 CFR 410.69(b) by adding a definition of "Anesthesia and related care," which reads "*Anesthesia and related care* means those services that a certified registered nurse anesthetist is legally authorized to perform in the state in which the services are furnished." With this instruction we are clarifying that effective January 1, 2013, qualifying CAHs and rural hospitals are eligible to receive CRNA pass-through payments for services that a CRNA is legally authorized to perform in the state in which the services are furnished.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
7896.1	Effective with dates of service on or after January 1, 2013, Contractors shall note the following: Qualifying CAHs and rural hospitals are eligible to receive CRNA pass-through payments for any services that the CRNA is legally authorized to perform in the state in which the services are furnished.	X	X			X							
7896.2	Effective with dates of service on or after January	X	X			X							

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	1, 2013, Contractors shall reprocess claims brought to their attention.												

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
7896.3	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X			X			

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Renate Dombrowski, 410-786-4645 or Renate-Rockwell.Dombrowski@cms.hhs.gov (Converted CR contact)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

Section B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual
Chapter 3 - Inpatient Hospital Billing

Table of Contents
(Rev.2719, Issued: 06-07-13)

100.2 - Payment for CRNA or AA Services
(Rev.2719, Issued: 06-07-13, Effective: 01-01, 13, Implementation: 09- 09-13)

This section discusses reasonable cost-based payment for CRNA services. Note that effective January 1, 2013, qualifying rural hospitals and CAHs are eligible to receive CRNA pass-through payments for services that the CRNA is legally authorized to perform in the state in which the services are furnished.

Anesthesia services furnished on or after January 1, 1989, and before January 1, 1990, at a rural hospital or CAH by a qualified hospital employed or contracted CRNA or AA can be paid on a reasonable cost basis. The FI determines the hospital's qualification using the following criteria:

- The hospital or CAH must be located in a rural area (as defined for PPS purposes) to be considered.
- As of January 1, 1988, the hospital or CAH employed or contracted with a CRNA or AA. The hospital or CAH may employ or contract with more than one CRNA or AA; however, the total number of hours of service furnished by the anesthetists may not exceed 2,080 hours per year.
- The hospital or CAH must demonstrate that during the 1987 calendar year, its volume of surgical procedures (inpatient and outpatient) requiring anesthesia services did not exceed 250 procedures.
- Each qualified CRNA or AA employed or under contract with the hospital or CAH must agree in writing not to bill on a reasonable charge basis for his or her patient care to Medicare beneficiaries in that hospital or CAH.

To maintain eligibility for reasonable cost-based payment for services furnished on or after January 1, 1990, a hospital or CAH must demonstrate, in addition to the criteria noted above, prior to January 1 of each respective year that for the prior year its volume of surgical procedures requiring anesthesia services did not exceed 500 procedures; or effective October 1, 2002, did not exceed 800 procedures. Effective for calendar years beginning with January 1, 1991, the hospital or CAH must make its election after September 30, but before January 1. The FI determines the number of surgical procedures for the immediately preceding year by summing the number of surgical procedures for the 9-month period ending September 30, annualized for a 12-month period.

If a hospital or CAH did not qualify for reasonable cost-based payment for CRNA or AA services in calendar year 1989, it can qualify in subsequent years if it demonstrates to the Medicare Contractor prior to the start of the calendar year that it met the three criteria noted below:

- The hospital or CAH must be located in a rural area (as defined for PPS purposes) to be considered.
- As of January 1, 1988, the hospital or CAH employed or contracted with a CRNA or AA. The hospital or CAH may employ or contract with more than one CRNA or AA; however, the total number of hours of service furnished by the anesthetists may not exceed 2,080 hours per year.
- Each qualified CRNA or AA employed or under contract with the hospital or CAH has agreed in writing not to bill on a reasonable charge basis for his or her patient care to Medicare beneficiaries in that hospital or CAH.

In addition, the hospital or CAH must provide data for its entire patient population to demonstrate that during calendar year 1987 and the year immediately preceding its election of reasonable cost payments, its volume of surgical procedures (inpatient and outpatient) requiring anesthesia services did not exceed 500 procedures. Effective October 1, 2002, it must demonstrate that it did not exceed 800 procedures.

Effective December 2, 2010, in addition to a hospital or CAH that is located in a rural area (as defined for PPS purposes), a hospital or CAH may be eligible to be paid based on reasonable cost for CRNA or AA services, if the hospital or CAH has reclassified as rural under 42 Code of Federal Regulations 412.103.

To prevent duplicate payments, the FI informs carriers of the names of CRNAs or AAs, the hospitals *and/or CAHs* with which they have agreements, and the effective dates of the agreements. If the CRNA or AA bills Part B for anesthesia services furnished *after* the hospital's *and/or CAH's* election of reasonable cost payments, the carrier must recover the overpayment from the CRNA or AA.

Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

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(Rev.2719, Issued: 06-07-13)

250.3.3.1 - Payment for CRNA Pass-Through Services
(Rev.2719, Issued: 06-07-13, Effective: 01-01, 13, Implementation: 09- 09-13)

If a CAH that meets the criteria for a pass-through exemption is interested in selecting the Method II option, it can choose this option for all outpatient professionals except the CRNA's and still retain the approved CRNAs exemption for both inpatient and outpatient professional services of CRNAs. The CAH, with an approved exemption, can choose to give up its exemption for both inpatient and outpatient professional services of CRNAs in order to include its CRNA outpatient professional services along with those of all other professional services under the Method II option. By choosing to include the CRNAs under the Method II for outpatient services, it loses its CRNA pass-through exemption for not only the outpatient CRNA services, but also the inpatient CRNA services. In this case the CAH would have to bill the Part B carrier for the CRNA inpatient professional services.

All intermediary payments for CRNA services are subject to cost settlement.

If a CAH that meets the criteria for a pass-through exemption is not interested in selecting the Method II option, the CAH can still receive the CRNA pass-through under the Standard Option (Method I). Below are the billing requirements for Method I.

Provider Billing Requirements for Method I

TOBs = 85X and 11X

Revenue Code 037X for CRNA technical services

Revenue Code 0964 for Professional services

HCPCS Code *for services the CRNA is legally authorized to perform in the state in which the services are furnished*

Units = Anesthesia *(if applicable)*

Reimbursement

Revenue Code 37X, CRNA technical service = Cost Reimbursement

Revenue Code 0964, CRNA professional service = Cost Reimbursement for both inpatient and outpatient

Deductible and coinsurance apply.

Note that effective January 1, 2013, qualifying rural hospitals and CAHs are eligible to receive CRNA pass-through payments for services that the CRNA is legally authorized to perform in the state in which the services are furnished.

250.3.3.2 - Payment for Anesthesia Services by a CRNA (Method II CAH only)
(Rev.2719, Issued: 06-07-13, Effective: 01-01, 13, Implementation: 09- 09-13)

Provider Billing Requirements for Method II Receiving the CRNA Pass-Through

TOB = 85X

Revenue Code 037X = CRNA technical service

Revenue Code 0964 = CRNA professional service

HCPCS Code = *for services the CRNA is legally authorized to perform in the state in which the services are furnished*

Units = Anesthesia *(if applicable)*

Reimbursement

Revenue Code 037X, CRNA technical service = cost reimbursement

Revenue Code 0964, CRNA professional service = cost reimbursement

Deductible and coinsurance apply.

Provider Billing Requirements for Method II CRNA – Gave up Pass-Through Exemption (or never had exemption)

TOB = 85X

Revenue Code = 037X for CRNA technical service

Revenue Code = 0964 for CRNA professional service

Reimbursement – For dates of service on or after July 1, 2007

Revenue Code 037X for CRNA technical service = cost reimbursement

Revenue Code 0964 for CRNA professional service = based on 100 percent of the allowed amount when not medically directed or 50 percent of the allowed amount when medically directed.

Providers bill a "QZ" modifier for non-medically directed CRNA services. Deductible and coinsurance apply.

How to calculate payment for anesthesia claims based on the formula – For dates of service on or after July 1, 2007

Identify anesthesia claims by HCPCS code range from 00100 through 01999
Non-medically directed CRNA

(Sum of base units plus time (anesthesia time divided by 15)) times conversion factor minus (deductible and coinsurance) times 1.15

Medically directed CRNA

(Sum of base units plus time (anesthesia time divided by 15)) times conversion factor times medically directed reduction (50 %) minus (deductible and coinsurance) times 1.15

Reimbursement – For dates of service prior to July 1, 2007

Revenue Code 037X for CRNA technical service = cost reimbursement

Revenue Code 0964 for CRNA professional service = 115% times 80% (not medically directed) or 115% times 50% (medically directed) of allowed amount (Use Anesthesia formula) for outpatient CRNA professional services.

Providers a “QZ” modifier for non-medically directed CRNA services. Deductible and coinsurance apply.

How to calculate payment for anesthesia claims based on the formula - For dates of service prior to July 1, 2007

Add the anesthesia code base unit and time units. The time units are calculated by dividing actual anesthesia time (Units field on the UB92) by 15. Multiply the sum of base and time units by the locality specific anesthesia conversion factor (file name below).

The Medicare program pays the CRNA 80% of this allowable charge when not medically directed. Deductible and coinsurance apply.

If the CRNA is medically directed, pay 50% of the allowable charge. Deductible and coinsurance apply.

Base Formula

Number of minutes divided by 15, plus the base units = Sum of base units and time

Sum of base units and time times the conversion factor = allowed amount

Source

Number of minutes = Number of units on the claim (Units field of the UB04) Base Units = Anesthesia HCPCS

Conversion Factor = File – MU00.@BF12390.MPFS.CYXX.ANES.V1023

Note that effective January 1, 2013, qualifying rural hospitals and CAHs are eligible to receive CRNA pass-through payments for services that the CRNA is legally authorized to perform in the state in which the services are furnished.