December 16, 2011

Marilyn Tavenner, RN, BSN, MHA
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

RE: Treatment of physicians using Method 2 billing under the EHR Incentive Programs

Dear Ms. Tavenner:

The American Hospital Association and the National Rural Health Association are concerned that physicians and other eligible professionals in rural areas are being inappropriately barred from participation in the electronic health records (EHR) incentive programs due to improper designation as hospital-based.

In particular, our concern is about physicians and other eligible professionals (EPs) who select Method 2, or the "optional method" to bill for services associated with working in an outpatient setting of a critical access hospital (CAH). Under rules set forward by the Centers for Medicare & Medicaid Services (CMS), certain EPs provide outpatient services paid under the physician fee schedule, but reassign benefits to their affiliated CAHs, who then bill Medicare on behalf of the EPs. We are concerned that EPs following these special billing rules are being inappropriately classified as hospital-based, when, in fact, most of their services are ambulatory and therefore, they should be eligible for the EHR incentive programs. In addition, we are concerned that the covered Medicare Part B charges billed through this process are not being included in the calculation of incentive payments for EPs.

We understand from conversations with CMS staff and published FAQs that when the agency determines whether an EP is hospital-based, it does not include Part B covered charges billed under Method 2 in the analysis. In addition, we understand that these charges are excluded from the calculation of EHR incentive payment amounts. **We urge CMS to correct any analyses that improperly classify these EPs to account for all of their outpatient claims – including those billed on a UB-04. Further, we urge the agency to correct any incentive payment calculations that fail to include Part B covered charges billed under Method 2. If CMS cannot feasibly develop the analytic**

tools to undertake these steps, we ask the agency to establish an alternative process for these EPs to be properly classified and allowed to participate in the EHR incentive program where warranted, and to set their incentive payments based on all of their Part B covered charges, including those billed under Method 2. In either case, CMS should act in time for EPs that qualify for either Medicare or Medicaid EHR incentive programs to benefit during the 2011 payment year.

Method 2 Billing. **Failure to include the Method 2 claims in determining hospital-based status and payment amounts is inconsistent with the regulatory provisions, and would treat the EPs billing using Method 2 differently from other physicians.** By CMS rules, EPs affiliated with CAHs can elect the "optional," or Method 2, payment method, whereby the CAH bills on behalf of the EPs for their **outpatient** services using the combined billing method (see attachment for a description of Method 2). In this situation, the EP's covered professional services are billed on the UB-04 claim, not on the Form 1500. They are still covered professional services furnished by the EP, however, with payment based on the Medicare physician fee schedule and reimbursed under Part B (the payment amount is 115 percent of the physician fee schedule amount).

Method 2 is analogous to other reassignment of benefit relationships, where a hospital may bill outpatient services on behalf of a physician, except that a different claim form is used. For these reasons, these services should be included in CMS's analysis to determine whether a physician is hospital-based, and in the calculation of incentive payments, which are equal to 75 percent of covered charges, up to an annual cap. In the preamble to the final rule, CMS states that it does not consider who submits the claims to be a determinant of whether the EP is hospital-based, but instead looks at the site of service.

It should be noted that when EPs billing under Method 2 for outpatient services provide **inpatient** services, a Form 1500 is commonly used. Therefore, if only the Form 1500 is used in analysis of whether EPs are hospital-based, these EPs will all appear to be hospital-based.

Hospital-based Physician. The regulatory definition of a hospital-based physician is an EP "who furnishes 90 percent or more of his or her covered professional services in a hospital setting (Section 495.4)." The preamble to the rule further states that Section 1848(o)(5)(A) of the Act defines "covered professional services as ... services furnished by an eligible professional for which payment is made under, ***or is based on,*** the Medicare physician fee schedule (p. 44442; emphasis added)." **The definition does not differentiate based on how the services are billed, but whether they are based on the Medicare physician fee schedule.**

The relevant regulatory language governing the Medicare incentive payment amounts is copied below:

> **§ 495.102 Incentive payments to EPs.** (a) *General rules.* (1) Subject to paragraph (b) of this section, in addition to the amount otherwise paid under section 1848 of the Act, there must be paid to a qualifying EP (or to an employer or entity in the cases described in section 1842(b)(6)(A) of the Act) for a payment year an amount equal to 75 percent of the estimated allowed charges for covered professional services furnished by the EP during the payment year. (2) For purposes of this paragraph (a) of this section, the estimated allowed charges for the qualifying EP's covered professional services during the payment year are determined based on claims submitted no later than 2 months after the end of the payment year, and, in the case of a qualifying EP who furnishes covered professional services in more than one practice, are determined based on claims submitted for the EP's covered professional services across all such practices.

The payment amount is tied to "allowed charges for covered professional services … based on claims submitted for the EP's covered professional services across all … practices." **The regulatory language does not make any distinction by claim form used. As noted above, services billed under Method 2 are covered professional services.**

In FAQ 10464, (copied in the attachment), CMS provided some information on how hospital-based physicians are identified, but the agency's response lacked sufficient detail for us to fully understand how the determinations were made. We infer from FAQ 10464 and conversations with CMS staff, however, that the CMS determination is based only on analysis of the 1500 claims forms, and excludes those services billed on the UB-04. We base this inference on the use of the place of service code in the analysis. The place of service does not appear on the UB-04. If our inference is correct, it would explain why physicians whose services are billed by the CAH, but paid based on the Medicare physician fee schedule, would be considered hospital-based even when they are providing many outpatient services.

If CMS is basing the hospital-based determination and incentive amounts only on the 1500 claims forms, we believe this is incorrect. CMS also should include in its analysis and payment calculations those covered services provided by EPs in outpatient settings of a CAH, but billed on a UB-04.

In considering how to incorporate these claims into the EHR incentive program, CMS's approach to identifying services and setting payment amounts for individual physicians billing under the optional method in the Primary Care Incentive Program may be a useful model. The Medicare Change Request #7115 outlines the approach taken to apply a special provision to claims billed under Method 2. The Medicare Learning Network article is available at: http://www.cms.gov/MLNMattersArticles/downloads/MM7115.pdf.

We would welcome any additional information that you can provide on how CMS is incorporating these outpatient claims billed on a UB-04 into its analysis of which

professionals are hospital-based and in the EHR incentive payment calculations. We believe that the regulatory language requires that they be included in both analyses, as these EPs are paid based on the physician fee schedule and are not rendering inpatient or emergency department services.

We ask CMS to remedy this situation as quickly as possible, so that EPs billing under Method 2 can benefit from the EHR incentive programs in 2011. Providers in rural areas offer much needed access to care in areas that are often underserved. These providers also have limited capital resources to support investments in EHRs. The Department of Health and Human Services has confirmed its commitment to supporting EHR adoption nationwide. That commitment should extend especially to rural providers.

If you need more information, please do not hesitate to contact us or Chantal Worzala, AHA director of policy, at cworzala@aha.org or (202) 626-2313.

Sincerely,

/s/
Rick Pollack
Executive Vice President
AHA

/s/
Alan Morgan
Chief Executive Officer
NRHA

cc: Michelle Snyder, Deputy Chief Operating Officer
Rob Tagalicod, Office of E-Health Standards & Services
Elizabeth S. Holland, Director, HIT Initiatives Group
Robert Anthony, Office of E-Health Standards and Services

Attachment

Attachment

Summary of the CAH Optional Payment Method

If a CAH makes the election for the "optional" (Method 2) payment method, practitioners furnishing professional services to a CAH outpatient can choose to reassign billing rights to the CAH. They also attest that by doing so, they agree that they will not bill the Medicare Carrier (using a HCFA 1500) for professional services furnished in the CAH outpatient department. Consequently the CAH, using the "optional" payment method, will submit a UB-04 (HCFA1450) with an outpatient code 085x as reported in the Type of Bill (TOB) -Form Locator (FL) 4 - of the UB-04. The UB-04 will bill the professional services using FL 42 (Revenue Code category) to report professional services using revenue codes 096x through 098x as well as the CPT (level I HCPCS as well as level 2 HCPCS). The UB-04 has on the revenue code line the ability to associate the HCPCS as well as the number of units pertaining to the HCPCS, the date services were rendered, and the amount billed for those services. The CAH will receive reimbursement from Medicare that includes "cost-based" reimbursement for the facility portion of the services (those revenue codes that are not part of the professional codes), as well as, 115 percent of the allowable amount for the professional portion of services as indicated by HCPCS and found in the Medicare Physician Fee Schedule.

The use of UB-04 TOB 085x is deemed an outpatient claim**;** the physicians that make the election under Method 2 agree to forgo billing for their services and must complete a CMS Form 855R (certification of enrollment); and, in doing so, they must attest in writing that they will not bill the Carrier or Part A/B MAC for their outpatient professional services.

FAQ 10464: [EHR Incentive Program] How is hospital-based status determined for eligible professionals in the Medicare and Medicaid EHR Incentive Programs?

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How is hospital-based status determined for eligible professionals in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

A hospital-based eligible professional (EP) is defined as an EP who furnishes 90% or more of their covered professional services in either the inpatient (Place of Service 21) or emergency department (Place of Service 23) of a hospital. Covered professional services are physician fee schedule (PFS) services paid under Section 1848 of the Social Security Act. CMS uses PFS data from the Federal fiscal year immediately preceding the calendar year for which the EHR incentive payment is made (that is, the "payment year") to determine what percentage of covered professional services occurred in either the

inpatient (Place of Service 21) or emergency department (Place of Service 23) of a hospital. The percentage determination is made based on total number of Medicare allowed services for which the EP was reimbursed, with each unit of a CPT billing code counting as a single service. States will use claims and/or encounter data (or equivalent data sources at the State's option) to make this determination for Medicaid. States may use data from either the prior fiscal or calendar year.

EPs can learn whether or not they are considered hospital based for the Medicare EHR Incentive Program by registering now for the Medicare EHR Incentive Program. For the Medicaid EHR Incentive Program, EPs should contact their states for more information.