

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13799	Date: May 28, 2026
	Change Request 14482

SUBJECT: Updates to Publication 100-04, Chapter 4, Section 250.3.3.1 and 250.18 of the Internet Only Manual (IOM) for Critical Access Hospital (CAH) Line Level Rendering Providers

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the Internet Only Manual (IOM) Publication 100-04, Chapter 4, Section 250.3.3.1 and 250.18.

EFFECTIVE DATE: June 29, 2026

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: June 29, 2026

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	4/Table Of Contents
R	4/250/250.3.3.1/Payment for CRNA Pass-through Services
N	4/250/250.18/CAH Method II Line Level Rendering Provider Billing

III. FUNDING:

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 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.

IV. ATTACHMENTS:

**Business Requirements
Manual Instruction**

Attachment - Business Requirements

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I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the Internet Only Manual (IOM) Publication 100-04, Chapter 4, Section 250.3.3.1 and 250.18.

II. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) is aware of HIPAA compliance issues and that some Critical Access Hospitals (CAHs) are not billing professional services with rendering NPIs at the line level as instructed in Change Request (CR) 7578, *“Fiscal Intermediary Shared System (FISS) and Common Working File (CWF) System Enhancement for Storing Line Level Rendering Physicians/Practitioners National Provider Identifier (NPI) and Physician Specialty Code Information.”* This CR implemented the line level NPI being displayed and stored for combined billing of professional and institutional services on the CMS-1450 (UB-04) institutional claim form. In addition, CMS also issued CR 13900, *“Editing for Duplicate Processing for Practitioner Professional Services and Critical Access Hospital (CAH) Professional Services,”* where reason codes 31006 and 31007 were created to validate line level rendering provider/practitioner National Provider Identifier (NPI) and ensure that these professional providers were correctly reassigned for combined billing.

Medicare must be able to determine the line level rendering professional for each outpatient service on a combined billing claim submitted to Medicare and store this information in our databases for data analysis purposes. The primary rendering professional is also used to support standard claims processing, medical review, fraud detection, Health Insurance Portability and Accountability Act (HIPAA) compliance, identifying revoked practitioners, Office of Inspector General (OIG) audits/overpayments, supporting program planning and capturing potential practitioner-level incentives tied to the NPI.

As previously instructed, providers submitting a combined claim (that is, claims that include both facility and professional components) need to report the rendering professional at the line level if it differs from the rendering professional reported at the claim level. Affected Medicare providers are CAHs billing under Method II and Federally Qualified Health Centers/ Rural Health Clinics (FQHCs/RHCs).

Line level editing applies to Type of Bill (TOB) 085X, revenue codes 096X, 097X and 098X, using the following hierarchy:

- Line Level “Rendering Provider” field when populated, or
- Claim level “Rendering Provider” field where a line level “Rendering Provider” field is blank, or
- Claim level “Attending Provider” field if the claim level “Rendering Provider” field is blank.

NOTE: Blank NPI line level information indicates the claim level attending or rendering provider who performed the services. For the 5010 version of the 837I, the rendering provider/practitioner information on the line is located in loop 2420C.

B. Policy: There are no policy changes related to this instruction.

III. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
14482.1	The Contractor shall be aware of the manual updates to Publication 100-04, Chapter 4, Section 250.3.3.1 and 250.18 of the Internet Only Manual (IOM).	X								
14482.2	The Contractors shall ensure their CAH Method II providers are aware of the billing guidelines.	X								

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part A

V. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: 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 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.

ATTACHMENTS: 0

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

Table of Contents
(Rev. 13799; Issued: 05-28-2026)

250.18 – CAH Method II Line Level Rendering Provider Billing

250.3.3.1 - Payment for CRNA Pass-Through Services

(Rev.13799; Issued: 05-28-2026; Effective: 06-29-2026; Implementation: 06-29-2026)

Rural hospitals and Critical Access Hospitals (CAHs) or hospitals/CAHs reclassified to a rural area can qualify for reasonable cost reimbursement of anesthesia services performed in the hospital or CAH by a qualified non-physician anesthetist if they meet certain criteria and obtain approval for the CRNA/AA cost reimbursement. Non-physician anesthetists are defined as certified registered nurse anesthetists (CRNAs) and anesthesiologist assistants (AA).

CAHs are eligible to receive CRNA pass-through payments (“pass-through exemption”) for both inpatient and outpatient services if they meet criteria discussed at 42 CFR § 412.113(c) of the regulations. CRNA pass-through payments and the Method II election for outpatient CAH services are applied as described below. Note that for CAHs that have a CRNA pass-through exemption, all CRNA services provided to CAH swing-bed patients must be included on the CAH swing-bed bill. (See MCPM, Ch. 3, 60 and 100.2 for more information)

If a CAH meets the criteria for a pass-through exemption and is interested in selecting Method II for its physicians and/or other practitioners, it can choose Method II for all outpatient professionals except the CRNAs and still retain the approved CRNA pass-through exemption for both inpatient and outpatient CRNA professional services.

The hospital may elect the CRNA exemption under 42 CFR 412.113.

Facilities pursuing CRNA cost reimbursement for anesthesia services must submit copies of the following information with your request to their Medicare Administrative Contactor (MAC):

- Written, signed, and dated agreements with the CRNA/AAs under contract or employment for services to be rendered during the calendar year. Hospitals or CAH may employ or contract with more than one anesthetist, however, the total number of hours of service furnished by the anesthetists may not exceed 2,080 hours per year.*
- Current CRNA/AA license.*
- Surgical procedure logs (inpatient and outpatient) for the facility’s entire patient population demonstrating the number of surgical hours and number of surgeries requiring anesthesia services (include name of CRNA/AA and surgical hours utilized for each procedure) for the period January 1 – September 30 each calendar year. Annualized surgical procedures for this period should not exceed 800 surgeries.*
- Written, signed, and dated attestation agreements stating that the CRNA/AA has not and will not be billed on a reasonable charge basis for his or her patient care to Medicare beneficiaries in that hospital or CAH for the calendar year.*
- Documentation that the hospital or CAH is located in a rural area as defined for prospective payment system purposes or has been reclassified as rural under 42 CFR 412.103.*

Note: CRNA services where the provider has elected the cost reimbursement pass-through exception do not require that the CRNA perform a formal reassignment of benefits with an 855I

or the 855A.

Alternatively, a CAH, with an approved pass-through exemption, can choose to give up its pass-through exemption for both inpatient and outpatient CRNA professional services in order to include its CRNA outpatient professional services under Method II. By choosing to include the CRNA under Method II for outpatient services, the CAH 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 A/B MAC (B) for the CRNA inpatient professional services. All A/B MAC (A) payments for CRNA services are subject to cost settlement.

Provider Billing Requirements for CRNA Pass-Through

TOBs = 11X and 18X

Revenue Code 037X for CRNA technical

services Revenue Code 0964 for Professional

services

Reimbursement

Revenue Code 37X, CRNA technical service = Cost Reimbursement (101 percent of reasonable cost)

Revenue Code 0964, CRNA professional service = Cost Reimbursement (100 percent of reasonable cost) for both inpatient (including swing-bed) and outpatient

Deductible and coinsurance apply.

Provider Billing Requirements for CRNA Pass-Through

TOB = 85X

Revenue Code 037X for CRNA technical

services Revenue Code 0964 for Professional

services

Anesthesia HCPCS codes and for any HCPCS codes for services the CRNA is legally authorized to perform in the state in which the services are furnished. The appropriate HCPCS should be included when required for the applicable TOB and or revenue code.

Reimbursement

Revenue Code 37X, CRNA technical service = Cost Reimbursement (101 percent of reasonable cost)

Revenue Code 0964, CRNA professional service = Cost Reimbursement (100 percent of reasonable cost) for both inpatient (including swing-bed) 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.

250.18 – CAH Method II Line Level Rendering Provider Billing (Rev.13799; Issued: 05-28-2026; Effective: 06-29-2026; Implementation: 06-29-2026)

For Critical Access Hospital (CAH) billing under Method II (the optional payment method), CMS and the Medicare Administrative Contractors (MACs) require the rendering practitioner's National Provider Identifier (NPI) to be reported at the line level if it differs from the rendering NPI submitted at the claim level.

CMS implemented Change Request (CR) 7578, "Fiscal Intermediary Shared System (FISS) and Common Working File (CWF) System Enhancement for Storing Line Level Rendering Physicians/Practitioners National Provider Identifier (NPI) and Physician Specialty Code Information." This change enabled the display and storage of line-level NPIs for combined billing of professional and institutional services on the CMS-1450 (UB-04) institutional claim form and was implemented to support HIPAA-compliant processing. Medicare must be able to determine the line level rendering professional for each outpatient service on a combined billing claim submitted to Medicare and store this information in our databases for data analysis purposes. The primary rendering professional is also used to support standard claims processing, medical review, fraud detection, Health Insurance Portability and Accountability Act (HIPAA) compliance, identifying revoked practitioners, Office of Inspector General (OIG) audits/overpayments, supporting program planning and capturing potential practitioner-level incentives tied to the NPI.

As previously instructed, HIPAA requires that if the claim level rendering provider is different from the attending provider, that a claim level rendering provider be reported. HIPAA also requires that if the line level rendering provider is different than the claim level rendering provider for combined claims that contain both facility and professional charges, the line level rendering provider must be reported. Please ensure these guidelines are followed. Affected Medicare providers are CAHs billing under Method II and Federally Qualified Health Centers/ Rural Health Clinics (FQHCs/RHCs).

Prior to the implementation of the 5010 version of the 837I transaction, rendering provider information could only be captured at the claim level. However, since 2012, line-level rendering provider reporting has been required to ensure more accurate tracking.

Line-level rendering provider editing applies to Type of Bill (TOB) 085X and revenue codes 096X, 097X, and 098X, following the hierarchy below:

- Line Level "Rendering Physician" field when populated, or*
- Claim level "Rendering Physician" field where a line level "Rendering Provider" field is blank, or*
- Claim level "Attending Physician" field if the claim level "Rendering Provider" field is blank.*

NOTE: Blank NPI line level rendering provider information indicates the claim level rendering provider performed the professional services. Blank NPI claim level rendering provider information indicates the attending provider performed the professional services.

Please read the situational rule for Loop: 2420C — RENDERING PROVIDER NAME in the current version of the HIPAA 837I.

***Required** when Rendering Provider is different than the Attending Provider reported in the 2310A loop of this claim.*

AND

State or federal regulatory requirements call for a "combined claim," that is, a claim that includes both facility and professional components (for example, a Medicaid clinic bill or Critical Access Hospital Claim.)

AND

The Rendering Provider for this line is different than the Rendering Provider reported in Loop ID 2310D (claim level).

If not required by this implementation guide, do not send.

For information on the enrollment policy rules and how to reassign your benefits see IOM 100-08, Chapter 10.

For all these examples assume the NPI for the Professional service provider is **111111111**.

Example 1 – The Professional service revenue code provider has reassigned benefits to the CAH and is the claim level attending.

In this example if the professional service revenue code provider has not reassigned their benefits in PECOS with an effective date that is prior to the from date on the claim, the claim will receive reason code 31007.

Revenue Code	Line Level Rendering Provider NPI in paper FL 43 or electronic Loop 2420C	Claim level Attending Provider NPI in paper FL 76 or electronic Loop 2310A	Claim level Rendering Provider NPI in paper FL 78-79 or electronic Loop 2310D
		111111111	
096x			

Example 2 – The Professional service revenue code provider has reassigned benefits to the CAH but is not the claim level attending but is the claim level rendering provider.

In this example if the professional service revenue code provider has not reassigned their benefits in PECOS with an effective date that is prior to the from date on the claim, the claim will receive reason code 31006.

Revenue Code	Line Level Rendering Provider NPI in paper FL 43 or electronic Loop 2420C	Claim level Attending Provider NPI in paper FL 76 or electronic Loop 2310A	Claim level Rendering Provider NPI in paper FL 78-79 or electronic Loop 2310D
		222222222	111111111
096x			

Example 3 – Professional has reassigned benefits to the CAH but is not the claim level attending or rendering provider.

In this example if the professional service revenue code provider has not reassigned their benefits in PECOS with an effective date that is prior to the from date on the claim, the claim will receive reason code 31006.

Revenue Code	Line Level Rendering Provider NPI in paper FL 43 or electronic Loop 2420C	Claim level Attending Provider NPI in paper FL 76 or electronic Loop 2310A	Claim level Rendering Provider NPI in paper FL 78-79 or electronic Loop 2310D
		222222222	333333333
096x	111111111		