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PROGRAM MEMORANDUM CARRIERS

Department of Health and Human Services

Health Care Financing Administration

Transmittal No. **Date**

CHANGE REQUEST 1256

This Program Memoranda supersedes any and all carrier claims processing information previously published on consolidated billing (CB) for skilled nursing facilities (SNFs).

SUBJECT: Consolidated Billing for SNF Residents

Section I.

A. Background.--Section 4432(b) of the Balanced Budget Act (BBA) requires CB for SNFs. Under the CB requirement, the SNF must submit Medicare claims to the fiscal intermediary (FI) for all the Part A and Part B services that its residents receive, except for certain excluded services listed in section I-G. The CB requirement essentially confers on the SNF itself the Medicare billing responsibility for the entire package of care that its residents receive, except for a limited number of specifically excluded services.

For services and supplies furnished to either a SNF resident covered under the Part A benefit or to a resident not in a Part A covered stay (Part A benefits exhausted, post-hospital or level of care requirements not met), SNFs will no longer be able to unbundle services to an outside provider of services of supplies that can then submit a separate bill directly to the Medicare carrier. Instead, the SNF must furnish the services or supplies either directly or under an arrangement with an outside provider. The SNF, rather than the provider of the service or supplies, bills Medicare. Medicare does not pay amounts that are due a provider of the services or supplies to any other entity under assignment, power of attorney, or any other direct payment arrangement. (See 42 CFR 424.73.) As a result, the outside provider of the service or supplies must look to the SNF, rather than to the beneficiary or the Medicare carrier, for payment. The SNF may collect any applicable deductible or coinsurance from the beneficiary.

A SNF resident is defined as a beneficiary who is admitted to a Medicare-participating SNF, or to the nonparticipating portion of a nursing home that also includes a Medicare-participating SNF, regardless of whether Part A covers the stay.

All covered services and supplies billed by the SNF, including those furnished under arrangement with an outside provider, for a resident of a SNF in a covered Part A stay are included in the SNF's bill to the FI. If a resident is not in a covered Part A stay (Part A benefits exhausted, post-hospital or level of care requirements not met), the SNF still bills the FI for all the services and supplies not specifically covered or excluded.

Effective July 1, 1998, CB became effective for those services and items that were not specifically excluded by law that were furnished to residents of a SNF in a covered Part A stay. SNFs became subject to CB once they transitioned to the prospective payment system (PPS). By the end of 1998, all SNFs had completed transition and were subject to CB. Due to systems limitations, CB was not implemented at that time for residents not in a Part A covered stay (Part A benefits exhausted, post-hospital or level of care requirements not met). In addition, for either type of resident, the following requirements were also delayed: 1) that the physicians forward the technical portions of their services to the SNF to be billed to the FI for payment; and 2) the requirement that the physician enter the facility provider number of the SNF on the claim.

Effective July 1, 1998, through 42 CFR §411.15(p)(3))(iii) published on May 12, 1998, HCFA extended interpretation of the BBA to allow for a number of other services to be excluded from CB. In the outpatient hospital context, a small number of exceptionally intensive services that lay well beyond the scope of the care that SNFs would ordinarily furnish (and, thus beyond the scope of the plan of care), as well as emergency services (which by their nature can not be planned for in advance), were excluded from CB. These services will be billed by the hospital or outpatient department directly to the FI. HCPCS Codes for these services are included in section II, F.

Also excluded were hospice care and the ambulance trip that initially conveys an individual to the SNF to be admitted as a resident, or that conveys an individual from the SNF when discharged and no longer considered a resident..

Effective April 1, 2000, §103 of the Balanced Budget Refinement Act (BBRA) excluded additional services and drugs from CB that therefore had to be billed directly to the carrier or DMERC by the provider or supplier for payment. As opposed to whole categories of services being excluded, only certain specific services and drugs were excluded in each category. These exclusions included ambulance services furnished in conjunction with renal dialysis services, certain specific chemotherapy drugs and their administration services, certain specific radioisotope services and certain customized prosthetic devices. These specific services and drugs are listed by HCPCS codes in section II, E.

B. New Procedures.-- Effective April 01, 2001, CB will be implemented for services not specifically excluded by law that are provided to SNF residents not in a Part A covered stay (Part A benefits exhausted, post-hospital or level of care requirements not met). In addition, for those services and supplies that were not specifically excluded by law and are furnished to either a SNF resident covered under the Part A benefit or to a resident not in a Part A covered stay (Part A benefits exhausted, post-hospital or level of care requirements not met), the following requirements will be made effective:

o Physicians will be required to forward the technical portions of any services to the SNF to be billed by the SNF to the FI for payment; and

o Providers will be required to enter the facility provider number of the SNF on the claim.

C. Determining the End of a SNF Stay.--When a beneficiary leaves the SNF, their status as a SNF resident for CB purposes, along with the SNF's responsibility to furnish or make arrangements for needed services, ends when one of the following events occurs:

The beneficiary is admitted as an inpatient to a Medicare-participating hospital or critical access hospital (CAH), or as a resident to another SNF;

The beneficiary has been discharged from the SNF and receives services from a Medicare-participating home health agency under a plan of care;

The beneficiary receives emergency or certain outpatient services from a Medicare-participating hospital or CAH (These are relatively costly services which are beyond the general scope of SNF comprehensive care plans under 42 CFR • 483.20; or

The beneficiary is formally discharged or otherwise departs from the SNF. However, if the beneficiary is readmitted or returns to that or another SNF within 24 consecutive hours, the beneficiary will still be considered to be in a SNF stay.

NOTE: This instruction only applies to Medicare fee-for-service beneficiaries residing in a participating SNF or in the nonparticipating portion of a nursing home that also includes a participating distinct part SNF.

D. Types of Facilities Included in CB.--

o A participating SNF;

o Any part of a nursing home that includes a participating distinct part SNF. In this situation, place of service must always be coded as "SNF" even if the beneficiary was in a nursing facility (NF) for part of the time.

E. Types of Facilities Excluded from CB.--

o A nursing home that has no Medicare certification, such as a nursing home that does not participate at all in either the Medicare or Medicaid programs;

o A nursing home that exclusively participates only in the Medicaid program as a nursing facility.

F. Types of Services Included in CB.-- The CB requirement confers on the SNF the billing responsibility for the entire package of care that its residents receive, except for a limited number of specifically excluded services that are outlined below in section I, G. The list of services included here merely provides examples of services that are subject to consolidated billing. It is in no way finite or complete.

o The technical component (TC) of a diagnostic service (e.g. an X-ray)

o Physical, occupational, and speech-language therapy services, regardless of whether they are furnished by (or under the supervision of) a physician or other health care professional (see §1888(e)(2)(A)(ii) of the Social Security Act);

o Psychological services furnished by a clinical social worker; and

o Services furnished "incident to" the professional services of a physician or other excluded category of health care professional described below .

o Services provided offsite that are unrelated to the condition requiring SNF care as long as the beneficiary retains the status of a SNF resident.

G. Types of Services Excluded from Consolidated Billing.-- The following services and supplies provided by the following types of providers, are excluded from consolidated billing and are still billed separately to the Medicare carrier. If a service or supply does not appear on this list or fit in to one of these categories, then it is not excluded from CB and should be consolidated by the SNF to the FI for payment.

Effective July 1, 1998 per the BBA and by HCFA regulation:

o The professional component (PC) of physician's services furnished to SNF residents are not subject to the consolidated billing requirement except physical, occupational and speech-language therapy services and audio logic function tests. A physician is defined for Medicare purposes in §1861(r) of the Social Security Act.

o Physician assistants working under a physician's supervision;

o Nurse practitioners and clinical nurse specialists working in collaboration with a physician;

o Certified nurse-midwives;

o Qualified psychologists;

o Certified registered nurse anesthetists;

o Home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies;

o Erythropoietin (EPO) for certain dialysis patients, subject to methods and standards for its safe and effective use (see 42 CFR 405.2163(g) and (h));

o Emergency and certain exceptionally intensive outpatient services from a Medicare-participating hospital or CAH that lie well beyond the scope of the care that SNFs would ordinarily furnish. Those services are:

- cardiac catheterization;
- computerized axial tomography (CT) scans;
- magnetic resonance imaging (MRIs);
- ambulatory surgery involving the use of an operating room or comparable facilities such as a GI suite;
- radiation therapy;
- angiography; and
- lymphatic and venous procedures

The outpatient department or emergency room of a hospital will bill the FI for these services and will be reimbursed accordingly outside of the SNF PPS rate. Any related professional component of physician's services would be billed to the carrier.

o An ambulance trip for the purpose of receiving emergency or the defined intensive services at a CAH or hospital.

o Hospice care related to a beneficiary's terminal condition;

o An ambulance trip that transports a beneficiary to the SNF for the initial admission or from the SNF following a final discharge;

o **FOR 1998 ONLY** - The transportation costs of electrocardiogram equipment for electrocardiogram test services (HCPCS code R0076) furnished during 1998. This reflects §4559 of the BBA, which temporarily restored separate Part B payment for the transportation of portable electrocardiogram equipment used in furnishing tests during 1998.

Effective for services provided on or after April 01, 2000 per the BBRA, the categories for which a subset of HCPCS codes are excluded from CB are:

o Chemotherapy;
o Chemotherapy administration services;
o Radioisotope services; and
o Customized prosthetic devices.

In addition, the BBRA excluded:

o An ambulance trip for the purpose of receiving dialysis related services.

H. Risk Based HMO Beneficiaries.--Services to risk-based HMO enrollees are not included in consolidated billing. Managed care beneficiaries are identified on CWF with applicable Plan ID, entitlement and termination periods on the CWF GHOD screen. Claims received on or after the HMO enrollment effective date and prior to the HMO termination date are exempt from consolidated billing.

I. Clarification of Ambulance Services.-- CB includes those medically necessary ambulance trips that are furnished during the course of a covered Part A and Part B residential stay.

In most cases, ambulance trips are excluded from CB when resident status has ended. (See I-C. Determining the End of SNF Stay.) The ambulance service then must bill the carrier directly for payment. Listed below are a number of specific circumstances under which a beneficiary may receive ambulance services after residency has ended. These ambulance trips are covered by Medicare and are not subject to CB. These consist of:

o A medically necessary round trip to a Medicare participating hospital or CAH for the specific purpose of receiving emergency services or certain other intensive outpatient services that lie well beyond the scope of the care that SNFs would ordinarily furnish. **(See section I-G.)**

o Medically necessary ambulance trips after a formal discharge or other departure from the SNF, unless followed within 24 consecutive hours by a readmission to that or another SNF. A beneficiary's transfer from one SNF to another within 24 hours of departure from the first SNF is not excluded from CB. The first SNF is responsible for billing the services to the FI.

o An ambulance trip for the purpose of receiving dialysis related services is excluded from CB.

o A trip for an inpatient admission to a Medicare participating hospital or critical care access hospital (CAH);

o After a discharge from the SNF, a medically necessary trip to the beneficiary's home where the beneficiary will receive services from a Medicare participating home health agency under a plan of care.

Carriers are responsible for assuring that payment for ambulance services meet coverage criteria and determining when the services are included in CB and when the supplier may submit a separate bill.

J. Information for Providers and Suppliers on SNF Contracting with Outside Entities for Ancillary Services.--

Except for those services and supplies specifically excluded, under CB an outside provider or supplier can no longer submit a separate bill directly to Medicare for services furnished to a SNF resident. Instead, it must look to the SNF for its payment. This means that in making program payment for services furnished to SNF residents, Medicare deals exclusively with the SNF itself rather than with an outside provider or supplier that the SNF may elect to use.

The law is silent regarding specific terms of a SNF's payment to the outside provider or supplier and currently does not authorize the Medicare program to impose any requirements in this regard. Thus, the issue of the outside provider or supplier's payment by the SNF is a private, contractual matter that must be resolved through direct negotiations between the two parties themselves. The outside provider or supplier should ensure that the terms to which it agrees in such negotiations adequately address any concerns that it may have regarding the amount and timeliness of its payment by the SNF.

o Services provided under CB arrangements must be provided only by Medicare certified providers that are licensed to provide the service involved.

o Payment may not be made if the provider or supplier is subject to OIG sanctions that would prohibit Medicare payment for the service if the provider or supplier were billing independently.

o The law does not detail the specific terms of SNF payment to an provider or supplier of ancillary services and does not authorize the Medicare program to impose any requirements on payment amounts or other financial or administrative arrangements between the SNF and the provider or supplier. These are contractual matters that must be resolved through negotiations between the SNF and its suppliers.

Section II. CLAIMS PROCESSING INSTRUCTIONS & CARRIER EDITS

General Information.-- Effective April 01, 2001, for claims for a SNF resident covered under the Part A benefit with dates of service on or after April 01, 2001, both Common Working File (CWF) and standard system consolidated billing edits must be implemented. The SNF's must begin the consolidated billing procedures for residents not in a Part A covered stay, (Part A benefits exhausted, post-hospital or level of care requirements not met), effective for claims with dates of service on or after April1, 2001. For these residents, CWF and standard systems edits will be implemented for claims with dates of service on or after January 01, 2002.

A. Requirements for Entry of the SNF's Medicare Facility Provider Number.-- Per Section 4432(b)(4) of the BBA, when physicians provide services to a beneficiary residing in a SNF, the physician must include the Medicare facility provider number of the SNF on the claims form or electronic record. The Medicare provider facility number of the SNF is the number assigned to the SNF by the FI when they are certified as a Medicare facility

1) If the SNF is the location where the services were rendered (Place of Service Code 31), the SNF provider number must be entered in Item 32 of the Form HCFA-1500.

For electronic submissions, when the physician renders services in a SNF (Place of Service Code 31) to a beneficiary residing in a SNF, the Medicare facility provider number of the SNF should be reported in:

The National Standard Format: Record EA1, field EA1.04 (Facility/Lab ID); or

The ANSI X12N 837: Table 2, Position 250, segment/element NM109(Facility ID).

2) If the services were rendered to a SNF beneficiary outside of the SNF, the physician must enter the Medicare facility provider number of the SNF in Item 23 of the Form HCFA-1500.

For electronic submission, when the beneficiary resides in a SNF and a provider renders services to the beneficiary at another facility, the Medicare facility provider number of the SNF where the beneficiary resides must be reported in:

The National Standard Format: Record FB1, field 23, positions 280-294 (this is currently filler); or

The ANSI X12N 837: Line level loop, 2-500-NM1, with a value of "P0" (Patient Facility - facility where patient resides) in NM101, a value of "FA" (Facility ID) or "ZZ" (NPI - when implemented) in NM108, and the SNF ID in NM109;

For 1 & 2 above, verify that on physician bills for professional services furnished to SNF residents that the Medicare provider number of the SNF, which must be preceded by the prefix "SNF," has been entered in the appropriate block of the claims form or electronic record. If the Medicare provider number of the SNF is not on the claim form, reject the claim. Use the following Remittance Advice (RA):

Claim Adjustment Reason Code 16, Claim/service lacks information which is needed for adjudication; and

Claim Level Remark Code MA134, Missing/incomplete/invalid provider number of the facility where the patient resides.

3) In either situation, per MCM §2010, enter the name and address or Provider Identification Number of the facility where the service was performed in Item 32 of the Form HCFA-1500. For electronic submissions, the facility where services were rendered must be reported in:

The National Standard Format: Record EA1, field 04, (Facility ID/NPI); or

The ANSI X12N 837: Claim level loop, 2-250-NM1, with a value of "61" (Performed at the facility where work was performed) in NM101, a value of "FA" (Facility ID) or "ZZ" (NPI - when implemented) in NM108, and the facility ID in NM109.

Verify that the name and address of the facility where services are provided is entered in the appropriate block of the claims form or electronic record. If the information is not included, reject the claim. Use the following RA:

Claim Adjustment Reason Code 16, Claim/service lacks information which is needed for adjudication; and

Claim Level Remark Code MA114, Did not complete or enter accurately the name and address, or the carrier assigned PIN, of the entity where services were furnished. (Substitute NPI for PIN when effective.)

B. Use of the PC/TC Indicators to Identify Physician's Services.-- Codes for diagnostic tests may include both a technical portion, i.e., the test itself and a professional component, i.e., the physician's interpretation of the test. To identify the professional components of physician's services for SNF residents that are billable to the carrier, use the information in the Professional Component/Technical Component (PC/TC) indicator field of the Medicare Physician Fee Schedule (MPFS) for payment. For Medicare purposes, physicians and physician s services are defined per §1861(q) and (r) of the Social Security Act.

Pay the physician only for the professional component of physician services that have both technical and professional components or for those physician services that have only professional components. If technical components are billed, either separately or globally, reject that portion of the claim.

Below are examples of how claims should be processed based on the PC/TC indicator on the MPFSDB. In subsequent years, definitions of the indicators may change. Every year, it will be the responsibility of the carrier to review the current MPFSDB indicators and adjust reimbursement rules in claims processing logic as appropriate.

PC/TC Indicator	SNF Consolidated Billing/Payment Policy for MPFS Services
0	Physician Service Code: Codes with a 0 indicator are not considered to have a separately identifiable professional or technical component. They will never be seen with a TC or 26 modifier. Physicians submit these services to the carrier for processing and reimbursement.
1	Diagnostic Tests or Radiology Services: An indicator of 1 signifies a global code that when billed without a modifier includes both the PC and TC. The code can also be submitted using a 26 or TC modifier to bill just the PC or TC of that service (e.g., G0030, G03026 and G0030TC). If a global code is submitted, e.g., G0030, reject the claim. Notify the physician to resubmit only the PC. If just a TC is submitted, reject the service. Notify the physician that the TC must be billed by the SNF to the FI. Pay the service when submitted with the 26 modifier
2	Professional Component Only Codes: Codes with an indicator of 2 signify services that only have a PC. Physicians submit these services to the carrier for processing and reimbursement.
3	Technical Component Only Codes: Codes with an indicator of 3 signify services that only have a TC. Carriers must reject these services and notify the physicians to have the SNF bill to the FI through CB.
4	Global Test Only Codes: Codes with an indicator of 4 signify services that include both the PC and TC. The 26 and TC modifiers are not applicable. However, there are associated codes that describe only the technical and professional components of the service. If the physician submits the global code, reject the service (unless the code is an exception to consolidated billing and may be paid). Notify the physician to resubmit the service using the code that represents the PC only.
5	Incident To Codes: These codes are not considered physician services in the SNF setting. Reject the services and notify the physician that the SNF must bill the FI for payment.
6	Laboratory Physician Interpretation Codes: These codes are for the interpretation of clinical lab services. Physicians submit these services to the carrier for processing and reimbursement
7	Physician Therapy Services: Reject services for these codes. These services are only billable by the SNF to the FI. Notify the physician to have the SNF bill the FI for payment.
8	Physician Interpretation Codes: An indicator of 8 signifies codes that represent the professional component of a clinical lab code for which separate payment may be made. It only applies to codes 88141, 85060 and P3001-26. A TC indicator is not applicable. Physicians submit these services to the carrier for processing and reimbursement.
9	Concept of a Professional/Technical Component Does Not Apply: An indicator of 9 signifies a code that is not considered to be a physician service. Reject the service and notify the physician to have the SNF bill the FI for payment.

Verify that payment is not made for any technical components of claims based on the PC/TC indicators. To reject services, use the following RA messages:

Claim adjustment reason code 16, Claim/service lacks information which is needed for adjudication; and

Line level remark code M96, The technical component of a service furnished to an impatient may only be billed by that inpatient facility. You must contact the inpatient facility for your payment for the technical component. If not already billed, you should bill us for the professional component only.

C. HCPCS Codes to identify Physical, Occupational and Speech Language Therapy services and Audiologic function tests that are subject to CB.-- When coded with the following HCPCS codes with a POS code of 31, carriers must reject services on claims for SNF residents covered under the Part A benefit or residents not in a Part A covered stay (Part A benefits exhausted, post-hospital or level of care requirements not met).

Rehabilitation Services - Physical, Occupational and Speech Language Therapy

11040	29405	92598	97020	97250
11041	29445	95831	97022	97260
11042	29505	95832	97024	97261
11043	29515	95833	97026	97265
11044	29520	95834	97028	97504**
29065	29530	95851	97032	97520
29075	29540	95852	97033	97530
29085	29550	96105	97034	97535
29105	29580	96110	97035	97537
29125	29590	96111	97036	97542
29126	64550	96115	97039	97545
29130	90901	97001	97110	97546
29131	90911	97002	97112	97703
29200	92506	97003	97113	97750
29220	92507	97004	97770***	
29240	92508	97010	97116	
29260	92510	97012	97122	97799
29280	92525	97014	97124	V5362
29345	92526	97016	97139	V5363
29365	92597	97018	97150	V5364

** Code 97504 should not be reported with code 97116. Reject the services if both codes are reported on the same claim.

***This code is not considered to be an outpatient rehabilitation service when delivered by a clinical psychologist (specialty 68), psychiatrist (specialty 26), or clinical social worker (specialty 80) for the treatment of a psychiatric condition (ICD-9-CM code range 2900 through 319. Edit appropriately.

Audiologic Function Tests

92551	92552	92553	92555	92556	92557
92559	92560	92561	92562	92563	92564
92565	92567	92568	92569	92571	92572
92573	92575	92576	92577	92579	92582
92583	92584	92587	92588	92589	92590
92591	92593	92594	92595	92596	V5299

Reject the codes listed above for the therapy and audiologic services. Use the following RA and MSN/EOMB messages:

RA

Claim adjustment reason code 97, Payment is included in the allowance for the basic service/procedure; and

Claim level remark code MA101, A SNF is responsible for payment of outside providers who furnish these services/supplies to its residents.

MSN

Code 21.7, This service should be included on your inpatient bill.

EOMB

Code 16.8, Because you were an inpatient, the hospital should file a claim for Medicare benefits.

D. Ambulance Claims.--

1) Carriers must reject ambulance claims with HCPCS code A0225 through A0999 if both characters of the HCPCS modifier is N, origin and destination is SNF. These claims must be billed by the SNF to the FI.

Verify that claims with the ambulance HCPCS codes and modifier N are rejected. Use the following RA and MSN/EOMB messages:

RA

Claim adjustment reason code 97, Payment is included in the allowance for the basic service/procedure; and

Claim level remark code MA101, A SNF is responsible for payment of outside providers who furnish these services/supplies to its residents.

MSN

Beneficiary MSN code 21.7, This service should be included on your inpatient bill.

EOMB NEED TO GET A MESSAGE.**********

CLAIMS PROCESSING NOTE TO SECTIONS F, G, H, I AND J: The codes listed below in these sections are excluded from CB and may be paid by the carrier or DMERC. Implement necessary systems changes to allow services with these codes to be processed and paid for residents of a SNF.

E. Specific Drugs, Services and Supplies to be Excluded from CB.--Claims for services received using the following codes are excluded from CB and should be billed to and paid by the carrier or DMERC as appropriate. Any necessary systems changes should be implemented to allow these services to be paid for SNF residents.

Chemotherapy Drugs

J9000	J9065	J9095	J9150	J9206	J9270	J9350
J9015	J9070	J9096	J9151	J9208	J9280	J9360
J9020	J9080	J9097	J9170	J9211	J9290	J9370
J9040	J9090	J9100	J9181	J9230	J9291	J9375
J9045	J9091	J9110	J9182	J9245	J9293	J9380
J9050	J9092	J9120	J9185	J9265	J9310	J9390
J9060	J9093	J9130	J9200	J9266	J9320	J9600
J9062	J9094	J9140	J9201	J9268	J9340	

Chemotherapy Administration Services

36260	36530	36534	96405	96412	96423	96450
36261	36531	36535	96406	96414	96425	96520
36262	36532	36640	96408	96420	96440	96530
36489	36533	36823	96410	96422	96445	96542

Radioisotope Services

79030	79100	79200	79300	79400	79420	79440
79035						

Customized Prosthetic Devices

L5050	L5628	L5678	L5826	L6310	L6682	L6865
L5060	L5629	L5680	L5828	L6320	L6684	L6867
L5100	L5630	L5682	L5830	L6350	L6686	L6868
L5105	L5631	L5684	L5840	L6360	L6687	L6870
L5150	L5632	L5686	L5845	L6370	L6688	L6872
L5160	L5634	L5688	L5846	L6400	L6689	L6873
L5200	L5636	L5690	L5850	L6450	L6690	L6875
L5210	L5637	L5692	L5855	L6500	L6691	L6880
L5220	L5638	L5694	L5910	L6550	L6692	L6920
L5230	L5639	L5695	L5920	L6570	L6693	L6925
L5250	L5640	L5696	L5925	L6580	L6700	L6930
L5270	L5642	L5697	L5930	L6582	L6705	L6935
L5280	L5643	L5698	L5940	L6584	L6710	L6940
L5300	L5644	L5699	L5950	L6586	L6715	L6945
L5310	L5645	L5700	L5960	L6588	L6720	L6950
L5320	L5646	L5701	L5962	L6590	L6725	L6955
L5330	L5647	L5702	L5964	L6600	L6730	L6960
L5340	L5648	L5704	L5966	L6605	L6735	L6965
L5500	L5649	L5705	L5968	L6610	L6740	L6970
L5505	L5650	L5706	L5970	L6615	L6745	L6975
L5510	L5651	L5707	L5972	L6616	L6750	L7010
L5520	L5652	L5710	L5974	L6620	L6755	L7015
L5530	L5653	L5711	L5975	L6623	L6765	L7020
L5535	L5654	L5712	L5976	L6625	L6770	L7025
L5540	L5655	L5714	L5978	L6628	L6775	L7030
L5560	L5656	L5716	L5979	L6629	L6780	L7035
L5570	L5658	L5718	L5980	L6630	L6790	L7040
L5580	L5660	L5722	L5981	L6632	L6795	L7045
L5585	L5661	L5724	L5982	L6635	L6800	L7170

L5050	L5628	L5678	L5826	L6310	L6682	L6865
L5060	L5629	L5680	L5828	L6320	L6684	L6867
L5100	L5630	L5682	L5830	L6350	L6686	L6868
L5105	L5631	L5684	L5840	L6360	L6687	L6870
L5150	L5632	L5686	L5845	L6370	L6688	L6872
L5160	L5634	L5688	L5846	L6400	L6689	L6873
L5200	L5636	L5690	L5850	L6450	L6690	L6875
L5210	L5637	L5692	L5855	L6500	L6691	L6880
L5220	L5638	L5694	L5910	L6550	L6692	L6920
L5230	L5639	L5695	L5920	L6570	L6693	L6925
L5250	L5640	L5696	L5925	L6580	L6700	L6930
L5270	L5642	L5697	L5930	L6582	L6705	L6935
L5280	L5643	L5698	L5940	L6584	L6710	L6940
L5590	L5662	L5726	L5984	L6637	L6805	L7180
L5595	L5663	L5728	L5985	L6640	L6806	L7185
L5600	L5664	L5780	L5986	L6641	L6807	L7186
L5610	L5665	L5785	L5988	L6642	L6808	L7190
L5611	L5666	L5790	L6050	L6645	L6809	L7191
L5613	L5667	L5795	L6055	L6650	L6810	L7260
L5614	L5668	L5810	L6100	L6655	L6825	L7261
L5616	L5669	L5811	L6110	L6660	L6830	L7266
L5617	L5670	L5812	L6120	L6665	L6835	L7272
L5618	L5672	L5814	L6130	L6670	L6840	L7274
L5620	L5674	L5816	L6200	L6672	L6845	L7362
L5622	L5675	L5818	L6205	L6675	L6850	L7364
L5624	L5676	L5822	L6250	L6676	L6855	L7366
L5626	L5677	L5824	L6300	L6680	L6860	

F. Claims for Emergency Services Excluded from CB.-- The following services rendered in the hospital emergency room are excluded from CB and should be paid by the carrier or DMERC. These claims are identified with place of service code ‘23'.

CT Scans

70450	70487	71270	72131	73201	74170	76380
70460	70488	72125	72132	73202	Code Deleted	G0131
70470	70490	72126	72133	73700	76355	G0132
70480	70491	72127	72192	73701	76360	
70481	70492	72128	72193	73702	76365	
70482	71250	72129	72194	74150	76370	
70486	71260	72130	73200	74160	76375	

Cardiac Catheterization

93501	93511	93528	93533	93542	93556
93503	93514	93529	93536	93543	93561
93505	93524	93530	93539	93544	93562
93508	93526	93531	93540	93545	93571
93510	93527	93532	93541	93555	93572

MRI

70336	71550	72148	72196	73721	75554	76400
70540	71555	72149	72198	73725	75555	
70541	72141	72156	73220	74181	75556	
70551	72142	72157	73221	74185	76093	
70552	72146	72158	73225	75552	76094	
70553	72147	72159	73720	75553	76390	

Radiation Therapy

77261	77310	77336	77409	77430	77750	77784
77262	77315	77370	77411	77431	77761	77789
77263	77321	77399	77412	77432	77762	77790
77280	77326	77401	77413	77470	77763	77799
77285	77327	77402	77414	77499	77776	
77290	77328	77403	77416	77600	77777	
77295	77331	77404	77417	77605	77778	
77299	77332	77406	77419	77610	77781	
77300	77333	77407	77420	77615	77782	
77305	77334	77408	77425	77620	77783	

Angiography

75600	75676	75733	75805	75840	75893	75968
75605	75680	75736	75807	75842	75894	75970
75625	75685	75741	75809	75860	75898	75978
75630	75705	75743	75810	75870	75900	75980

75650	75710	75746	75820	75872	75940	75982
75658	75716	75756	75822	75880	75960	75992
75660	75722	75744	75825	75885	75961	75993
75662	75724	75790	75827	75887	75962	75994
75665	75726	75801	75831	75889	75964	75995
75671	75731	75803	75833	75891	75966	75996

Outpatient Surgery

EXCEPT for the following codes that are included in CB and should therefore be rejected by the carrier, codes ranging from 10040 through 69979 inclusive are excluded from CB.

10040	11950	17250	29355	30901	51797	63691
10060	11951	17340	29358	31720	53601	64550
10080	11952	17360	29365	31725	53660	65205
10120	11954	17380	29405	31730	53661	69000
11040	11975	17999	code deleted	36000	53670	69090
11041	11976	20000	29425	36140	53675	69200
11042	11977	20974	29435	36400	54150	69210
11043	15780	21084	29440	36405	54235	62368
11044	15781	21085	29445	36406	54240	
11055	15782	21497	29450	code deleted	54250	
11056	15783	26010	29505	36415	55870	
11057	15786	29058	29515	36430	57160	
11200	15787	29065	29540	36468	57170	
11300	15788	29075	29550	36469	58300	
11305	15789	29085	29580	36470	code deleted	
11400	15792	29105	29590	36471	58301	
11719	15793	29125	29700	36489	58321	
11720	15810	29126	29705	36600	58323	
11721	15811	29130	29710	36620	59020	
11740	16000	29131	29715	36680	59025	
11900	16020	29200	29720	44500	59425	
code deleted	17000	29220	29730	51772	59426	
11901	17003	29240	29740	51784	59430	
11920	17004	29260	29750	51785	62367	
11921	17110	29280	29799	51792	62368	
11922	17111	29345	30300	51795	63690	

Verify that the claims for services in this section that are excluded from CB have a POS 23. If the POS is not 23, reject the service.

Ensure that the outpatient surgery codes listed above that are included in CB are rejected when received.

Use the following RA and MSN/EOMB messages for either situation:

RA

Claim Adjustment Reason Code 97, Payment is included in the allowance for the basic service/procedure.

MSN

Code 21.7, This service should be included in your inpatient bill.

EOMB

Code 16.59, Medicare Part B does not pay for this item or service since our records show that you were in the hospital on this date.

G. Erythropoietin (EPO) Services.--These services are not included in the SNF Part A PPS rate and are excluded from CB. They must be billed to the carrier or DMERC for payment as they currently are per MCM §§2049.5B, 4273 and 5202.3. EPO services are identified by the following HCPCS codes:

Code Q9920 - Injection of EPO, per l,000 units, at patient HCT of 20 or less.

Codes Q9921 through Q9939 - Injection of EPO, per 1,000 units, at patient HCT of 2l through 39.

Code Q9940 - Injection of EPO, per l,000 units at patient HCT of 40 or above.

H. Dialysis.-- Home dialysis equipment, home dialysis support services, institutional dialysis services and supplies are excluded from CB and should be billed separately by the supplier to the DMERC or by the ESRD facility to the FI for payment. Claims for services for dialysis patients must have one of the following ICD-9-CM diagnosis codes:

403.01	404.02	584.5	584.8	586
403.11	404.12	584.6	584.9	788.5
403.91	404.92	584.7	585	958.5

Verify that for SNF residents, claims for home dialysis equipment and home dialysis support services and supplies have at least one of the above diagnosis codes on the claim. Claims submitted without the appropriate diagnosis code should be denied/rejected

The *implementation date* of this Program Memorandum (PM) is April 1, 2001.

The *effective date* of this PM is April 1, 2001.

Funding will be made available through the regular budget process for implementation.

This PM should be discarded after April 1, 2002.

Contractors should contact the appropriate regional office with any questions.