PROGRAM MEMORANDUM INTERMEDIARIES

Department of Health and Human Services

Health Care Financing Administration

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CHANGE REQUEST XXXX

SUBJECT: FEE SCHEDULE AND CONSOLIDATED BILLING FOR SNF SERVICES

I General

This PM contains instructions about:

- New CWF edit requirements relating to consolidated billing for SNF Part A services, and related contractor resolution procedures, effective April 1, 2001
- New CWF edit requirements to detect duplicate Part B claims billed by SNFs and other providers and suppliers, effective April 1, 2001
- Consolidated billing requirements for SNF inpatient Part B services effective for services provided January 1, 2002
- CWF edit requirements relating to consolidated billing for SNF inpatient Part B services, effective for services provided January 1, 2002
- Intermediary payment to SNFs under a fee schedule for SNF Part B services, effective for services provided April 1, 2001

It does not change intermediary claims processing requirements in PMs AB 98-18, AB 99-11, AB 98-45, AB 99-90, A 98-37, A 99-35, A 00-01, A 00-08, A 00-08A or AB 00-18.

There are no changes in program requirements not identified in this PM, such as SNF demand bills, spell of illness requirements, MSP requirements, and basic coverage rules.

SNF instructions are being issued in SNF Manual sections 529 - 544 and 595.

II Fee Schedule for SNF Part B Services

Section 1888(e)(9) of the Social Security Act as modified by the BBA of 1997 requires that the payment amount for Part B services furnished to a SNF resident shall be the amount prescribed in the otherwise applicable fee schedule. Thus, where a fee schedule exists for the type of service the fee amount (or charge if less than the applicable fee amount) will be paid.

This requirement will be implemented beginning with services provided on April 1, 2001. SNFs will continue to bill on Form UB 92 to intermediaries.

The fee schedule will be statewide, even where current fee schedules use localities.

A Application of Part B Deductible and Coinsurance

Where payment for SNF Part B services (bill type 22X and 23X) is made under a fee schedule any applicable beneficiary deductible and coinsurance are based on the approved amount. This includes situations where fee amounts for specific services are not included in the fee schedule but are determined on an individual basis.

Where payment is made on a cost basis, deductible and coinsurance continue to be based on SNF charges for the service.

Neither deductible nor coinsurance apply to clinical diagnostic lab services.

Neither deductible nor coinsurance apply to pneumococcal pneumonia vaccine (PPV), influenza vaccines or to the administration of either.

Deductible does not apply to screening mammography services.

B Services Not Covered by SNF Part B Fee Schedule

Fee schedules are not yet developed for the following. All other services on bill types 22X and 23X are to be paid via fee schedule.

Medical Supplies

A4570 A4212 A4580 A4590

Therapeutic Shoes

A5500 A5501 A5502 A5503 A5504 A5505 A5506 A5507

PEN Codes – See Medicare Intermediary Manual §3660.6 for Part B coverage. These services, if covered under Part B continue to be billed to the DMERC.

B4034 B4035 B4036 B4081 B4082 B4083 B4084 B4085 B4150 B4151 B4152 B4153 B4154
B4155 B4156 B4164 B4168 B4172 B4176 B4178 B4180 B4184 B4186 B4189 B4193 B4197
B4199 B4216 B4220 B4222 B4224 B5000 B5100 B5200 B9000 B9002 B9004 B9006 E0776XA

EMG Device

E0746

Salivation Device

E0755

Blood Products

P9010 P9011 P9012 P9013 P9016 P9017 P9018 P9019 P9020 P9021 P9022 P9023

Intraocular Lenses – These services must be billed by the SNF if the implant is performed in an ASC for a SNF resident.

V2630 V2631 V2632

Transfusion Medicine

86850 86860 86870 86880 86885 86886 86890 86891 86900 86901 86903 86904 86905
86906 86915 86920 86921 86922 86927 86930 86931 86932 86945 86950 86965 86970
86971 86972 86975 86976 86977 86978 86985 89250 89251 89252 89253 89254 89255
89256 89257 89258 89259 89260 89261 89264

All Drugs

Drug payment methodology is not changed.

C Publication of Fee Schedules

SNF fee schedule prices and related installation instructions will be provided to intermediaries through the Mainframe Telecommunications System in the same manner that other fee schedule information is provided.

Analysis is not yet completed on whether SNF fee schedule data for intermediaries will be included with other data or whether a separate file will be released.

There will be some differences from current fee schedules in that:

- SNFs bill only the technical or facility component for most services, except where they furnish the complete service or obtain the complete service under arrangements,
- Some service cannot be paid to SNFs; and
- Some services for SNF Part A residents, and beginning January 1, 2002 for Part B residents, cannot be paid to anyone else.

Modifiers will be needed to determine the correct payment amount unless the related HCPCS code definition sufficiently describes the physician/facility component.

Note that SNFs may not obtain physician services under arrangements except for services from physician therapists providing physical, occupational or speech language therapy services, which are required under consolidated billing. Services of physician employees of the SNF are not considered arranged for services, and related current Intermediary Manual and SNF Manual provisions about billing for provider based physician services on Form HCFA 1500 continue to apply.

In addition to Mainframe Telecommunications System data, HCFA will publish a public use file on the Internet in HTML or PDF format for SNF inquiry and/or downloading and use as reference material. Complete details for this file have not been finalized, but it will contain the following data elements.

- Fee schedule year;
- State;
- HCPCS code;
- Applicable modifiers;
- Narrative description;
- Medicare coverage status (whether or not the item is a Medicare covered service);
- Whether the code is billable by SNFs

For codes billable by SNFs:

- Whether to bill carrier or FI;
- Bundling requirements for billing if applicable;
- Price;
- Whether code for service considered technical (facility), professional or complete procedure;
- Whether included or excluded from Part B consolidated billing; and
- Whether included or excluded from Part A PPS

SNFs will be expected to access this file for basic information about each HCPCS code. Intermediaries may assist SNFs as appropriate. This file may also be used by intermediaries and carriers in resolving inquiries. Additional related instructions will be issued later.

D Special Payment Rules Relating to Fee Schedules for SNFs

1 Set Up Services in SNFs for Portable X-Ray Equipment

Where applicable, set up costs for portable X ray equipment in the SNF is billed using HCPCS code Q0092. Set up costs are not applicable for lab or EKG services.

X rays using portable equipment and related set up costs are included in consolidated billing and may be billed only by the SNF.

2 Specimen Collection

Specimen collection is allowed for SNF residents in circumstances such as drawing blood through venipuncture or collecting a urine sample by catheter. It does not matter whether the SNF staff or supplier staff performs the function. The SNF must bill for the service to be covered. Applicable HCPCS codes are:

G0001 Routine venipuncture for collection of specimen(s).
P9615 Catheterization for collection of specimen(s).

A separate specimen collection is not paid for throat cultures, routine capillary puncture for clotting or bleeding time, stool specimens.

Costs for related supplies and items such as gloves and slides are also not separately billed.

The current fee amount for specimen collection under the lab fee schedule is paid to the SNF.

Neither deductible nor coinsurance apply to specimen collection payments.

3 Travel Allowance

Travel allowance may be payable to the SNF where appropriate in connection with the following services:

- lab
- radiology
- EKG

Current HCFA rules for carriers for determining payment for travel/transportation will be used. These are described immediately below:

Where allocating miles or the flat rate between SNF patients and other supplier patients on a single trip is required, the supplier is expected to make all necessary calculations and bill the SNF only for the part of the travel allowed by Medicare. The SNF must bill only for the part of the travel allowed by Medicare.

a Travel Allowance to Collect Lab Specimen

In addition to a specimen collection fee, a travel allowance is payable to the SNF to cover the costs of related travel to the SNF where the lab separately charges the SNF for travel. The allowance covers the estimated travel costs of collecting a specimen and reflects the technician's salary and travel costs. The following HCPCS codes are used for travel allowances:

P9603 -- Travel allowance - one way, in connection with medically necessary laboratory specimen collection drawn from a SNF resident; prorated miles actually traveled (intermediary allowance on per mile basis); or

P9604 -- Travel allowance - one way, in connection with medically necessary laboratory specimen collection drawn from a SNF resident; prorated trip charge (intermediary allowance on flat fee basis).

Per Mile Travel Allowance (P9603) - There is a minimum of 75 cents a mile. The per mile travel allowance is to be used in situations where the distance from the lab to the SNF is longer than 20 miles round trip. It may be paid to the SNF where the lab bills travel expense to the SNF. Payment is the lower of the SNFs charge or the allowance. Actual miles must be shown on the claim in the units field.

The per mile allowance was computed using the Federal mileage rate of 31 cents a mile plus an additional 44 cents a mile to cover the technician's time and travel costs. Contractors have the option of establishing a higher per mile rate in excess of the minimum of 75 cents a mile if local

conditions warrant it. The minimum mileage rate will be reviewed and updated in conjunction with the clinical lab fee schedule as needed. At no time will the SNF be paid for more miles than are reasonable or for miles not actually traveled by the laboratory technician.

Example 1: A laboratory technician travels 60 miles round trip from a lab in a city to a SNF in a remote rural location, and back to the lab to draw a single Medicare patient's blood. The total reimbursement would be $45.00 (60 miles x .75 cents a mile), plus the specimen collection fee of $3.00.

Example 2: A laboratory technician travels 40 miles from the lab to a Medicare SNF to draw blood, then travels an additional 10 miles to a non-Medicare patient's home and then travels 30 miles to return to the lab. The total miles traveled would be 80 miles. The claim submitted would be for one half of the miles traveled or $30.00 (40 x .75), plus the specimen collection fee of $3.00.

Flat Rate (P9604) - There is a minimum of $7.50 one way. The flat rate travel allowance is to be used in areas where the distance from the lab to the SNF is less than 20 miles round trip. The flat rate travel fee is to be pro-rated for more than one blood specimen drawn at the same SNF, and for stops at a SNF and another location. The SNF must obtain a proration from the laboratory for submission on the claim based on the number of patients seen on that trip, in order to bill Medicare properly.

This rate was based on an assumption that a trip is an average of 15 minutes and up to 10 miles one way. It uses the Federal mileage rate of 31 cents a mile and a laboratory technician's time of $17.66 an hour, including overhead. Contractors have the option of establishing a flat rate in excess of the minimum of $7.50, if local conditions warrant it. The minimum national flat rate will be reviewed and updated in conjunction with the clinical laboratory fee schedule, as necessitated by adjustments in the Federal travel allowance and salaries.

Example 3: A laboratory technician travels from the laboratory to a single Medicare SNF and returns to the laboratory without making any other stops. The flat rate would be calculated as follows: 2 x $7.50 for a total trip reimbursement of $15.00, plus the $3.00 specimen collection fee.

Example 4: A laboratory technician travels from the laboratory to the homes of five patients to draw blood, four of the patients are Medicare patients and one is not. An additional flat rate would be charged to cover the 5 stops and the return trip to the lab (6 x $7.50 =$45.00). Each of the claims submitted would be for $9.00 ($45.00 /5 = $9.00). Since one of the patients is non-Medicare, four claims would be submitted for $9.00 each, plus the $3.00 specimen collection fee.

Example 5: A laboratory technician travels from a laboratory to a SNF and draws blood from 5 patients and returns to the laboratory. Four of the patients are on Medicare and one is not. The $7.50 flat rate is multiplied by two to cover the return trip to the laboratory (2 x $7.50 = $15.00) and then divided by five (1/5 of $15.00 = $3.00). Since one of the patients is non-Medicare, four claims would be submitted for $3.00 each, plus the $3.00 specimen collection fee.

HCFA has no requirement with respect to what the lab may bill the SNF or what the SNF may pay the lab. The requirements relates only to what the intermediary may pay the SNF.

b Travel Allowance for Radiology and EKG

Pay the SNF for non-lab travel expenses only in connection with furnishing covered portable X-ray and standard EKG services.

SNFs report travel related to portable X rays services with the following codes:

R0070 - For transportation of portable X ray equipment where only one patient seen
R0075 - For transportation of portable X ray equipment where more than one patient seen (this

code is billed for each patient)
R0076 - For transportation of portable EKG equipment (this code is billed for each patient)
99082 - Unusual travel

Intermediaries are now required to install an edit to allow payment for code R0070 or R0075 to SNFs only in connection with HCPCS codes 70000 through 79999.

Similarly, intermediaries must also edit to allow payment for code R0076 only in connection with the presence of one or more standard EKG procedures (CPT codes 93000 and 93005).

Pay the SNF separately for unusual travel (CPT code 99082) only when the SNF submits documentation to demonstrate that the travel was very unusual. CPT 99082 is paid on individual consideration only.

4 Questions on Special Payment Rules

Intermediaries should direct any questions about application of these special payment rules to your regional office.

III Consolidated Billing for SNF Part B Residents

Section 4432(b) of the BBA of 1997 requires consolidated billing for Skilled Nursing Facilities (SNFs). Under the consolidated billing requirement, the SNF must submit all Medicare claims for almost all services that its residents receive. Professional component of services other than rehabilitation therapy are excluded from consolidated billing. Also some specific services that are usually outside the scope of the SNF benefit are excluded. These are described later in this instruction.

A Implementation Schedule

Implementation will be in two phases.

The first phase begins with services furnished April 1, 2001. This phase includes implementation of CWF edits for SNF Part A and Part B claims.

Part A edits are designed to identify and deny services covered under the SNF Part A PPS rate that are billed separately. In addition duplicate edits will be expanded to identify Part B services that may be billed by either the SNF or a supplier or other provider, but that are billed by more than one entity.

These will be implemented April 1, 2001.

Phase two will be implemented beginning for services provided January 1, 2002.

Beginning with services furnished January 1, 2002, SNFs must bill for services to residents to whom Part A benefits are not payable (e.g., because of non entitlement to Part A or because benefits are exhausted). This includes surgical dressings, prosthetic and orthotic items covered for SNF residents, diagnostic services, and rehabilitation services. See Medicare Intermediary Manual section 3133.9 and 3110 - 3110.5 for a description of services covered for SNF Part B residents. Related SNF Manual instructions are in section 260. If the SNF does not bill the service, it is not covered except where described as an exception in section III.

SNFs may begin furnishing these services directly or under arrangements, and may bill for any of these services furnished at any time on or before January 1, 2002.

B Definition of SNF Resident

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. If the SNF has one or more Medicare

certified beds consolidated billing applies. This is applicable regardless of whether the beneficiary is in a certified or non certified bed. The beneficiary remains a resident until residency status ends as defined below.

1 Date Residency Begins.-- The beneficiary becomes a SNF resident for Part B consolidated billing purposes when :

(a) Part A benefits are exhausted and the beneficiary remains in the facility in a Medicare certified or non certified bed, or

(b) The beneficiary who can not receive benefits under Part A (e.g., Part B entitlement only, or Part A benefits exhausted) is admitted to the SNF in either a Medicare certified or non certified bed . This could be a first time admission or a readmission.

Services on and after this day are included in consolidated billing unless excluded as described in Section II, or unless otherwise non covered.

2 Date Residency Ends. -- Whenever a beneficiary leaves the facility, the beneficiary's status as a SNF resident for consolidated billing purposes (along with the SNF's responsibility to furnish or make arrangements for needed services) ends when one of the following events occurs:

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

Even if the beneficiary returns to the SNF by midnight of the same day, the beneficiary's residency ended upon admission to the hospital, and the admitting hospital or critical access hospital is responsible for billing. This is because these settings represent situations in which the admitting facility has assumed responsibility for the beneficiary's comprehensive health care needs.

The SNF should submit a discharge bill, and if the patient is readmitted to the SNF and has no Part A SNF benefits remaining, it should submit a new 221 type of bill.

(b) The beneficiary receives outpatient services from a Medicare participating hospital or critical access hospital, but only with respect to certain services identified in section IV. Other outpatient services furnished by the hospital or critical access hospital must be billed by the SNF.

The SNF need not submit a discharge bill where this situation applies. CWF edits allow hospitals and critical access hospitals to bill for these services identified in section IV C.5 for a SNF resident.
Receipt of outpatient services from another provider does not normally result in termination of SNF residency status. However, the rendering provider may submit a claim to the Medicare program where provided in section IV.

(c) The beneficiary receives services under a plan of care from a Medicare participating home health agency. Where the beneficiary receives services from a home health agency, the home health agency is responsible for billing. Home health services are not payable unless the patient is confined to his home, and under Medicare regulations, a SNF cannot qualify as a home.

(d) The beneficiary is formally discharged or otherwise departs for reasons other than described in paragraphs (a) through (c) above. However, if the beneficiary is readmitted or returns by midnight of the same day, his residency status is not considered interrupted and the SNF is responsible for billing for services during the period of absence, unless such services are otherwise excluded from consolidated billing or are excluded from Medicare coverage.

If a discharge bill has been processed when the beneficiary returns, the SNF should submit an adjustment bill (whether Part A or Part B) changing the patient status code and bill type, with the next scheduled billing submission. The adjustment should include any new charges for services after the patient's return.

C UB 92 Bill Types, Frequency of Billing, and Late Charges

Bill type 22x is to be used for all services to Part B residents, whether in a certified bed or otherwise, including services obtained from outside suppliers.

Bill type 23x is to be used for all Part B outpatient services furnished to those other than residents. The distinction between 22x and 23x is not related to receipt of skilled care but is determined solely on the basis of being a resident.

The current requirements for monthly billing continue to apply. The SNF is expected to make a reasonable effort to include all services on the bill. However there will be situations in which the SNF receives billing data from suppliers after the billing cut off, just as internal billing data can be received in the SNF system after the cut off.

These services are to be billed as late charge bills (bill type 225 or 235). CWF will apply duplicate edits using HCPCS code and date of service against other bills from the SNF and from suppliers to all late charge bills. Late charge bills for these services are used instead of adjustments because:

- Services are priced individually, unlike Part A services which are priced by RUG
- Late charge bills are simpler and less expensive to prepare by the SNF and less expensive to process by the intermediary than adjustment clams.
- Adequate duplicate edits will be installed to detect duplicate billings

The late charge bill must be completed in its entirety for the services billed on it, including diagnosis, HCPCS codes, dates of service, and all data elements required on an initial bill for the related service.

Adjustment bills remain necessary to delete charges.

An adjustment bill is necessary to increase the units for the same HCPCS code on the same day.

Late charge bills remain unacceptable for Part A SNF bills.

There are no other changes in requirements for reporting data elements on the UB 92 (HCFA 1450).

IV Exceptions to Consolidated Billing

A Facilities Excluded From Consolidated Billing

A nursing home that has no Medicare certification is not required to bill for Medicare Part B services furnished to residents by others.

Examples:

-- A nursing home that does not participate at all in either the Medicare or Medicaid programs; and;
-- A nursing home that exclusively participates only in the Medicaid program as a nursing facility.

B Physicians and Practitioners Excluded From Consolidated Billing

Services from the following may be billed by the rendering provider and paid separately by the carrier.

1. Physician's services other than physical, occupational and speech-language therapy

services furnished to SNF residents. Respiratory therapy services are not excluded from consolidated billing except for the physician's component.

Physician services are billed separately to the Part B carrier. Section 4432 (b)(4) of the BBA requires that physician bills for services to SNF residents include the SNF's Medicare provider number. Physician's service include the professional component of procedures that include professional and technical components, e.g., some radiology and some lab services. HCPCS codes may define whether the service is professional or technical, or it may be necessary to submit HCPCS modifiers with the code, depending upon the service and code. See section IIE15.

2. Physician assistants working under a physician's supervision;

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

4. Certified nurse-midwives;

5. Qualified psychologists;

6. Certified registered nurse anesthetists;

C Services Excluded From Consolidated Billing

The following services may be billed separately under Part B.

1. Home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies, including any related necessary ambulance services;

2. Erythropoietin (EPO) as described in section IVF12

3. Hospice care related to a beneficiary's terminal condition;

4. An ambulance trip (other than a trip to or from another SNF) that transports a beneficiary to the SNF for the initial admission or from the SNF following a final discharge; and ambulance services associated with a service exempted from consolidated billing.

5. The following services which are considered beyond the scope of SNF care when furnished in a Medicare participating hospital or critical access hospital. This exception does not apply if the service is furnished in an ASC. Specific HCPCS and/or revenue codes describing these services are described in the edit instructions that follow.

    - Cardiac catheterization
    - Computerized axial tomography (CT) scans
    - Magnetic resonance imaging (MRIs)
    - Angiography
    - Lymphatic and Venous Procedures
    - Ambulatory surgery involving the use of an operating room
    - Radiation therapy
    - Emergency services
    - Ambulance services when related to an excluded service (listed above)
    - Ambulance transportation related to dialysis services.

6. The following services when provided by any Medicare provider licensed to provide them. Specific HCPCS describing these services are in section IV.F items 1 though 4.

    - Some chemotherapy and chemotherapy administration services

- Radioisotope services
- Some customized prosthetic devices

7. For services furnished during 1998 only, the transportation costs of electrocardiogram equipment for electrocardiogram test services.

Section IV F below identifies revenue codes, HCPCS or diagnosis codes used to identify services excluded from consolidated billing.

D Beneficiaries Excluded From Consolidated Billing

These changes do not apply to a Medicare beneficiary enrolled in a Medicare Managed Care program. They apply only to Medicare fee-for service beneficiaries. Managed care beneficiaries are identified on CWF with applicable Plan ID, entitlement and termination periods on the GHOD screen. The Plan ID is a 4 position number preceded with "H". Claims received on or after the MCO effective date and prior to the MCO termination date are exempt from consolidated billing. In addition, Condition code "04" on the UB-92 identifies a risk-based MCO enrollee.

E Codes to Identify Services Included in Consolidated Billing

Services included or excluded from consolidated billing are identified with HCPCS codes, revenue codes and diagnosis codes in the following subsections. Standard systems as well as CWF will edit for services included and excluded from consolidated billing where history is available.

1. HCPCS Codes to Identify Physical, Occupational and Speech Language Therapy Services and Audiologic Function Tests Included in Consolidated Billing.-- The following codes identify rehabilitation services included in the Part A PPS rate and/or included in Part B consolidated billing. CWF will auto-cancel claims for such services where the dates of service overlap or are within SNF Part A or Part B admission periods on history.

The technical and professional component amounts for these services for SNF Part A and Part B residents are always billed by the SNF to the fiscal intermediary.

Revenue Codes

42X (physical therapy),
43X (occupational therapy), or
44X (speech therapy).

Rehabilitation (Therapy) Services

11040	11041	11042	11043	11044	29065	29075	29085	29105
29125	29126	29130	29131	29200	29220	29240	29260	29280
29345	29365	29405	29445	29505	29515	29520	29530	29540
29550	29580	29590	64550	90901	90911	92506	92507	92508
92510	92525	92526	92527	92598	95831	95832	95633	95834
95851	95852	96105	96110	96111	96115	97001	97002	97003
97004	97010*****		97012	97014	97016	97018	97020	97022
97024	97026	97028	97032	97033	97034	97035	97036	97039
97110	97112	97113	97116	97124	97139	97140	97150	97504**

97520	97530	97535	97537	97542	97545	97546	97703	97750
97770***		97799	G0169	V5362	V5363	V5364		

** Code 97504 should not be reported with code 97116 unless separate anatomic sites are involved. (CWF will reject the claim if both codes are reported on the same claim, unless modifier 59 is reported to indicate separate anatomic sites.)

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

*****Payment for code 97010 is bundled with other rehabilitation services It may be bundled with any therapy code.

Audiologic Function Tests

92552	92553	92555	92556	92557	92561	92562	92563	92564
92565	92567	92568	92569	92571	92572	92573	92575	92576
92577	92579	92582	92583	92584	92587	92588	92589	92596
V5299								

2. Ambulance Claims Included in Consolidated Billing.-- Intermediaries must reject ambulance claims (HCPCS code A0021 through A0999) if both characters of the HCPCS modifier are N (origin and destination is SNF).

F Applicable Codes To Identify Services Excluded From Consolidated Billing

The services may be paid separately for both Part A and Part B. Note that some of these services may not be covered in a SNF environment. See coverage instructions for a description of coverage rules. Consolidated billing does not change coverage rules except to make services listed above non-covered unless billed by the SNF.

1. Chemotherapy Items that May be Paid Separately if Covered.

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

2. Chemotherapy Administration Services that May Be Paid Separately

36260	36261	36262	36489	36530	36531	36532	36533	36534
36535	36640	36823	96405	96406	96408	96410	96412	96414

96420 96422 96423 96425 96440 96445 96450 96520 96530 96542

3. Radioisotope Services that May Be Paid Separately

79030 79035 79100 79200 79300 79400 79420 79440

4. Customized Prosthetic Devices That May Be Paid Separately

L5050 L5060 L5100 L5105 L5150 L5160 L5200 L5210 L5220
L5230 L5250 L5270 L5280 L5300 L5310 L5320 L5330 L5340
L5500 L5505 L5510 L5520 L5530 L5535 L5540 L5560 L5570
L5580 L5585 L5590 L5595 L5600 L5610 L5611 L5613 L5614
L5616 L5617 L5618 L5620 L5622 L5624 L5626 L5628 L5629
L5630 L5631 L5632 L5634 L5636 L5637 L5638 L5639 L5640
L5642 L5643 L5644 L5645 L5646 L5647 L5648 L5649 L5650
L5651 L5652 L5653 L5654 L5655 L5656 L5658 L5660 L5661
L5662 L5663 L5664 L5665 L5666 L5667 L5668 L5669 L5670
L5672 L5674 L5675 L5676 L5677 L5678 L5680 L5682 L5684
L5686 L5688 L5690 L5692 L5694 L5695 L5696 L5697 L5698
L5699 L5700 L5701 L5702 L5704 L5705 L5706 L5707 L5710
L5711 L5712 L5714 L5716 L5718 L5722 L5724 L5726 L5728
L5780 L5785 L5790 L5795 L5810 L5811 L5812 L5814 L5816
L5818 L5822 L5824 L5826 L5828 L5830 L5840 L5845 L5846
L5850 L5855 L5910 L5920 L5925 L5930 L5940 L5950 L5960
L5962 L5964 L5966 L5968 L5970 L5972 L5974 L5975 L5976
L5978 L5979 L5980 L5981 L5982 L5984 L5985 L5986 L5988
L6050 L6055 L6100 L6110 L6120 L6130 L6200 L6205 L6250
L6300 L6310 L6320 L6350 L6360 L6370 L6400 L6450 L6500
L6550 L6570 L6580 L6582 L6584 L6586 L6588 L6590 L6600
L6605 L6610 L6615 L6616 L6620 L6623 L6625 L6628 L6629
L6630 L6632 L6635 L6637 L6640 L6641 L6642 L6645 L6650
L6655 L6660 L6665 L6670 L6672 L6675 L6676 L6680 L6682
L6684 L6686 L6687 L6688 L6689 L6690 L6691 L6692 L6693
L6700 L6705 L6710 L6715 L6720 L6725 L6730 L6735 L6740
L6745 L6750 L6755 L6765 L6770 L6775 L6780 L6790 L6795

L6800	L6805	L6806	L6807	L6808	L6809	L6810	L6825	L6830
L6835	L6840	L6845	L6850	L6855	L6860	L6865	L6867	L6868
L6870	L6872	L6873	L6875	L6880	L6920	L6925	L6930	L6935
L6940	L6945	L6950	L6955	L6960	L6965	L6970	L6975	L7010
L7015	L7020	L7025	L7030	L7035	L7040	L7045	L7170	L7180
L7185	L7186	L7190	L7191	L7260	L7261	L7266	L7272	L7274
L7362	L7364	L7366						

5. Claims for Emergency Services that May Be Paid Separately.-- Services rendered in the hospital emergency room are excluded from consolidated billing and may be paid separately. Outpatient '13X', and Critical Access Hospital (CAH) '85X' claims that contain revenue code 45X (Emergency Room) may be paid. Other revenue codes on the same claim are also not included in consolidated billing. The hospital must bill these services.

6. CT Scans HCPCS Codes that May Be Paid Separately.--

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

7. Cardiac catheterization Codes that May Be Paid Separately

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

8. MRI Codes that May Be Paid Separately

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

9. Radiation Therapy Codes that May Be Paid Separately

77261	77262	77263	77280	77285	77290	77295	77299	77300
77305	77310	77315	77321	77326	77327	77328	77331	77332
77333	77334	77336	77370	77399	77401	77402	77403	77404
77406	77407	77408	77409	77411	77412	77413	77414	77416
77417	77427	77431	77432	77470	77499	77600	77605	77610
77615	77620	77750	77761	77762	77763	77776	77777	77778
77781	77782	77783	77784	77789	77790	77799		

10. Angiography Codes that May Be Paid Separately

75600	75605	75625	75630	75650	75658	75660	75662	75665	75671
75676	75680	75685	75705	75710	75716	75722	75724	75726	75731
75733	75736	75741	75743	75746	75756	75774	75790	75801	75803
75805	75807	75809	75810	75820	75822	75825	75827	75831	75833
75840	75842	75860	75870	75872	75880	75885	75887	75889	75891
75893	75894	75898	75900	75940	75960	75961	75962	75964	75966
75968	75970	75978	75980	75982	75992	75993	75994	75995	75996

11. Outpatient surgery codes ranging from 10040 - 69979 may be paid separately EXCEPT the following codes.

THESE CODES MAY NOT BE PAID SEPARATELY

10040	10060	10080	10120	11040	11041	11042	11043	11044
11055	11056	11057	11200	11300	11305	11400	11719	11720
11721	11740	11900	11901	11920	11921	11922	11950	11951
11952	11954	11975	11976	11977	15780	15781	15782	15783
15786	15787	15788	15789	15792	15793	15810	15811	16000
16020	17000	17003	17004	17110	17111	17250	17340	17360
17380	17999	20000	20974	21084	21085	21497	26010	29058
29065	29075	29085	29105	29125	29126	29130	29131	29200
29220	29240	29260	29280	29345	29355	29358	29365	29405
29425	29435	29440	29445	29450	29505	29515	29540	29550
29580	29590	29700	29705	29710	29715	29720	29730	29740
29750	29799	30300	30901	31720	31725	31730	36000	36140

36400	36405	36406	36415	36430	36468	36469	36470	36471
36489	36600	36620	36680	44500	51772	51784	51785	51792
51795	51797	53601	53660	53661	53670	53675	54150	54235
54240	54250	55870	57160	57170	58300	58301	58321	58323
59020	59025	59425	59426	59430	62367	62368	64550	65205
69000	69090	69200	69210	95970-95975				

12. EPO Services: EPO for dialysis patients is not included in the SNF Part A PPS rate and is excluded from Part B consolidated billing for dialysis patients. It may be billed by other providers and paid separately. EPO for dialysis patients is identified with the following revenue codes on the UB 92:

- Epoetin (EPO) - Administrations for an injection of less than 10,000 units of EPO was administered.
- Epoetin (EPO) - Administrations for an injection of 10,000 units or more of EPO was administered.

13. Codes to Identify Services for Dialysis Patients. Home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies are not included in the SNF Part A PPS rate and are excluded from Part B consolidated billing. These are billed to the Intermediary by the hospital or ESRD facility as appropriate and identified by type of bill 72X.

Some dialysis related services are billed by a hospital using type of bill 13X The following revenue codes accompanied by a dialysis related diagnosis code listed below identify those services:

Revenue Codes:

- 25X – Pharmacy
- 27X – Medical/Surgical Supplies
- 30X – Laboratory
- 31X – Laboratory Pathological
- 32X – Radiology – Diagnostic
- 38X – Blood
- 39X – Blood Storage and Processing
- 73X – EKG/ECG (Electrocardiogram)

Diagnosis Codes:

40301	40311	40391	40402	40412	40492	5845	5846
5847	5848	5849	585	586	7885	9585	

The consolidated billing exclusion is applicable to services within the composite rate and to services paid in addition to the composite rate.

Note that for Method 2 beneficiaries who receive services or supplies from a "provider" that normally bills the carrier, the carrier will continue to be billed.

14. Medicare Beneficiaries Enrolled in a Medicare Managed Care program are Excluded from Consolidated Billing. – SNF consolidated billing applies only to Medicare fee-for-service beneficiaries. Managed care beneficiaries are identified on CWF with an applicable Plan ID, entitlement and termination periods on the GHOD screen. The Plan ID is a 4 position number preceded with 'H'. Claims received on or after the MCO effective date and prior to the MCO termination date are exempt from consolidated billing. In addition, Condition code'04' on the UB-92 identifies a risk-based MCO enrollee.

15. Use of the PC/TC Indicators to Identify Technical and Professional Component. The PC/TC indicator in the Medicare Physician Fee Schedule (MPFS) will be used in the SNF fee schedule to identify the applicability of technical and/or physician component for the HCPCS codes. The following table describes intermediary processing for the PC/TC indicator.

In summary, intermediary standard system requirements are to:

- Pay if PC/TC code is 3, 5, 7, or 9.
- Pay if PC/TC 1 and modifier TC is present, otherwise reject.
- Reject if PC/TC indicator is 0, 2, 4, 6 or 8.
- Reject PC/TC code 4 unless the HCPCS code is listed as an exception in sections II F items 1 through 11 above, or the diagnosis is listed as an exception in II F item 13.

PC/TC Indicator	SNF Consolidated Billing/Payment Policy for Intermediaries for MPFS Services
0	Physician Service Code: Codes with a 0 indicator are not considered to have a separately identifiable professional or technical components. They will never be seen with a TC or 26 modifier. Intermediaries reject the service and notify the SNF to request the physician to bill the carrier. 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, G003026 and G0030TC). Intermediaries pay the service when submitted with the TC modifier If a global code is submitted, e.g., G0030 with no modifier, reject the service and notify the SNF to resubmit only the TC. If modifier 26 is submitted, reject the service and notify the SNF that the 26 must be billed by the physician to the carrier.
2	Professional Component Only Codes: Codes with an indicator of 2 signify services that only have a PC. Intermediaries reject these services and notify the SNF that the service must be billed to the carrier.
3	Technical Component Only Codes: Codes with an indicator of 3 signify services that have only a TC. Intermediaries pay these without a modifier. Carriers reject these services and notify the physicians to have the SNF bill to the intermediary.
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. Reject the service and notify the SNF to resubmit the service using the code that represents the TC only.

PC/TC Indicator	SNF Consolidated Billing/Payment Policy for Intermediaries for MPFS Services
5	Incident To Codes: These codes are not considered physician services in the SNF setting. These codes are paid by the intermediary. Carriers 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 physician services to interpret lab tests. Intermediaries do not pay for these services. Reject the service and notify the SNF that the services must be billed to the carrier. Considered a billable physician service and may be paid by the carrier.
7	Physician Therapy Services: These services are only billable by the SNF to the FI. Intermediaries pay. Carriers notify the physician to have the SNF bill the FI for payment. These codes are paid by the intermediary.
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. Intermediaries do not pay for these services. Reject the service and notify the SNF that the services must be billed to the carrier. Carriers reimburse the physician for these codes when submitted.
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. Intermediaries pay for these services. Carriers reject the service and notify the physician to have the SNF bill the FI for payment.

16 Ambulance Services Excluded from Consolidated Billing.-- The SNF PPS payment amount includes those ambulance trips, including covered services furnished during the ambulance trip, that are furnished during the course of a covered Part A stay to a beneficiary who is a Part A resident of the SNF. An ambulance trip, and related services, made in connection with certain specific circumstances (see below) that end a beneficiary's status as an SNF resident is excluded from the Part A PPS amount and also excluded from Part B consolidated billing. It may be billed separately by the SNF to the intermediary or by the supplier to the carrier providing medical necessity exists.

Those circumstances that end a beneficiary Part A or Part B resident status allowing separate ambulance billing to the intermediary or carrier are:

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

- After a discharge from the SNF, a trip to the beneficiary's home if medical necessity exists to receive services from a Medicare participating home health agency under a plan of care;

- A 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. The intensive outpatient services are listed below. HCPCS codes identifying these services are found in section II F items 5 through 11. A discharge bill and readmission bill are not appropriate in this circumstance.

  - Cardiac catheterization;
  - Computerized axial tomography (CT) scans;
  - Magnetic resonance imaging (MRI);
  - Ambulatory surgery involving the use of an operating room or comparable facilities such as a GI suite;
  - Radiation therapy;
  - Angiography ;
  - Lymphatic and venous procedures.

- A formal discharge or other departure from the SNF, unless followed by a readmission to that or another SNF by midnight of the same day.

Ambulance services in connection with a beneficiary's transfer from one SNF to another is not excluded from consolidated billing. The first SNF is responsible for billing the services where medical necessity exists.

In addition, the following ambulance services are excluded from consolidated billing and may be separately billed by the SNF or supplier.

- A trip that transports a beneficiary to the SNF for the initial admission or from the SNF following a final discharge;

- Ambulance transportation related to dialysis services.

Intermediaries are responsible for assuring that payment for ambulance services meet coverage criteria and determining when the services are included in consolidated billing and when the SNF or supplier may submit a separate bill. Until further edit guidelines are developed to make this determination, post payment audit procedures should include ambulance services.

Separate instructions are in development for determining payment for ambulance services, including development of an ambulance fee schedule. These will be released when developed.

V SNF Provider Agreements

A General Requirements

The SNF must exercise professional responsibility over the arranged-for services. The facility's professional supervision over arranged-for services requires application of many of the same quality controls as are applied to services furnished by salaried employees. The SNF must accept the patient for treatment in accordance with its admission policies; maintain a complete and timely clinical record of the patient which includes diagnosis, medical history, physician's orders, and progress notes relating to all services received; maintain liaison with the attending physician on the progress of the patient and the need for revised orders or, in the case of outpatient physical therapy, occupational therapy, or speech pathology services, to assure that the required plan of treatment is periodically reviewed by the physician; secure from the physician the required certifications and recertifications; and see to it that the medical necessity of such services is reviewed on a sample basis by its utilization review committee.

The SNF does not have to receive the supplier's bill before billing Medicare but it must know that the service has been performed.

The SNF must retain documentation of the service, including identification of the provider, service rendered, and results, for possible audit.

The SNF must have a written contract with its supplier if the annual cost of the service exceeds $10,000.00 per year.

B Verification of Supplier/Provider Medicare Status

Services subject to consolidated billing and provided under arrangements may be paid only if provided by Medicare certified providers that are authorized to provide the service involved. The SNF is responsible for ensuring that subcontractors/vendors meet Medicare requirements and all applicable State licensure requirements.

Also, payment may not be made to the SNF if the supplier is subject to OIG sanctions that would prohibit payment for the service if the supplier were billing independently. The SNF must also keep a copy of the agreement and a record of the credentials of its suppliers for audit by the intermediary or other entity.

The SNF may verify provider credentials by obtaining a copy of the provider's license and/or Medcare approval notice, and verifying with either the sanctioned provider bulletins distributed by intermediaries or by utilizing the OIG website at hhs.gov/progorg/oig/cumsan/index.htm.

The SNF must also keep a copy of the agreement, and record of the credentials of its suppliers for periodic audit by the intermediary. Instructions for intermediary audit will be issued later.

Instructions for intermediary monitoring of this area are not complete. They will be released in the Program Integrity Manual.

C Provisions of Agreements between SNFs and Suppliers

The law does not detail the specific terms of SNF payment to an outside supplier 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 supplier. These are contractual matters that must be resolved through negotiations between the SNF and its suppliers. However, the SNF is required to establish policies and controls to ensure medical necessity and quality of services provided. Examples of documentation requirements for each party are:

1. How the SNF orders services (who is authorized to order and by what methods).

2. What to do if the test is ordered in another manner or by another party, e.g., family physician.

3. Expected timeliness in performance of the service, completion of CMNs or other documentation and reporting methodology.

4. Timeliness of supplier notification of the results.

5. Billing and payment arrangements between the SNF and supplier.

6. Respective financial responsibilities if the service should be denied or if contract provisions are breached.

VI Edits for CWF and Contractors

A General

Effective for services beginning January 1, 2001, for Part A residents and January 1, 2002 for

Part B residents, CWF will reject outpatient bills received from intermediaries or carriers where a history record already exists for a SNF inpatient Part A or an inpatient Part B stay and the outpatient or carrier CWF record includes specified services.

- Services considered included in the SNF Part A PPS rate cannot be billed by other providers or suppliers. Such billing would be duplicate billing. Beginning January 1, 2002, in some cases services not included in the Part A PPS rate must be billed under Part B by the SNF (pneumococcal pneumonia, flu or hepatitis B vaccine) for the service to be covered. In other cases other providers may bill.

- Beginning January 1, 2002, most but not all services provided to SNF Part B residents are not covered by Medicare unless billed by the SNF.

- There are some services that SNFs are not required to provide but which they may provide under arrangements. Duplicate "crossover" edits to assure that payment is not made to each the SNF and a supplier are described in section B below.

Where an inpatient Part A or inpatient Part B bill is received and an outpatient or Part B history bill exists on CWF for specified services, CWF will process the inpatient SNF bill and send an unsolicited auto-cancel response to the carrier or intermediary for the Part B or outpatient bill. The carrier or intermediary must correct its records to agree with CWF, and must initiate overpayment procedures to retract the incorrect outpatient or Part B payment.

Also, HCPCS codes and dates on inpatient Part B records and will be compared to HCPCS codes and dates on outpatient records and carrier/DMERC records.

Contractor action (carrier, intermediary, or DMERC) on rejects will be to:

- Reject the pending claim where the services fall within dates of service on record and all services on the pending claim are non billable.

- Change or return to the provider to change claim data where the incoming claim has both billable and non billable services or where service dates overlap the history. (It will be the contractor's responsibility to decide where to adjust records and where to notify the provider to resubmit.)

- If the outpatient, carrier or DMERC Part B claim that would be rejected if the inpatient bill were received first is posted before the inpatient (21X effective January 1, 2001 and 22X effective January 1, 2002) claim is received by CWF, the contractor must accept the CWF auto-cancel response, recover the overpayment and update the action taken on their history.

B Intermediary Resolution of Edits

The following resolution procedures are to be used by intermediaries to complete processing of claims that reject due to consolidated billing edits. Applicable remittance reason codes and MSN codes are provided for rejected claims. The CWF edit code is shown in the left column**.** Contractors are responsible for determining appropriate notification procedures and any related coding requirements for providers for cases that are developed.

AB Crossover Coverage Edits (Error codes are to be assigned before release. The number in the left column now corresponds to internal HCFA documentation and will be replaced by the edit number when assigned)

Error code	EXPLANATION
To Be Assigned (1)	Outpatient Therapy Claim Within Inpatient Part A SNF Claim History An outpatient bill type (outpatient CWF record) is rejected because the

Error code	EXPLANATION
	services are physical, occupational, speech therapy or audiologic function tests for an inpatient SNF patient (inpatient CWF record). The dates of service are **within or equal** the inpatient stay. Purpose: To ensure that Part B therapy services for a SNF patient are not separately paid from the SNF bill. The provider is responsible for submitting the charges to and receiving payment from the SNF. The SNF must submit the charges on the inpatient SNF claim to the intermediary. Resolution: Reject the claim for the provider and the beneficiary if the Part B or outpatient services are within or equal the inpatient stay. Remittance codes: Use Claim Adjustment Reason Code 97: Payment is included in the allowance for the basic service/procedure. Use Group Code CO: Contractual Obligation Use Claim Level Remark Code MA101: A SNF is responsible for payment of outside providers who furnish these services/supplies to its residents. MSN codes: Use Beneficiary MSN Message 21.7 This service should be included on your inpatient bill.
To Be Assigned (1)	Outpatient Therapy Claim Overlaps Inpatient Part A SNF History An outpatient claim (outpatient CWF record) is rejected because the services are physical, occupational, speech therapy or audiologic function tests for an inpatient SNF patient. The dates of service **overlap** the inpatient stay (inpatient CWF record). The services within or equal to the SNF dates must be billed by the SNF. The outpatient services outside the SNF stay may be billed by the rendering provider. Purpose: To ensure that outpatient therapy services for a SNF patient are not separately paid from the SNF bill. The provider is responsible for submitting the charges to and receiving payment from the SNF. The SNF must submit the charges on the SNF claim. Resolution: Reject or return (develop) the claim to the provider if the dates of service overlap the SNF claim unless those services rendered within the SNF service dates can be identified. If they can be identified, reject the charges within the SNF service dates and continue processing remaining services outside the SNF service dates. Remittance codes: For Reject, use Claim Adjustment Reason Code 97: Payment is included in the allowance for the basic service/procedure.

Use Group Code CO: Contractual Obligation

To reject only the services within the inpatient service dates: Use Claim Level Remark Code MA101: A SNF is responsible for payment of outside providers who furnish these services/supplies to its residents.

To reject all services: Use Claim Level Remark Code MA 133: Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.

MSN codes:

Use Beneficiary MSN Message 17.11: This item or service cannot be paid as billed.

To Be Assigned (2)

Outpatient Claim (no therapy) Against Inpatient Part A SNF Claim History

An outpatient claim not containing therapy is rejected because the services rendered to a SNF Part A inpatient (inpatient record) (or SNF inpatient B claim effective for services on or after 1-1-2002) are **within or equal** the SNF dates of service. The outpatient services are not excluded from consolidated billing and must be billed by the SNF to the intermediary.

Purpose:

To ensure that services for a SNF patient that are not excluded from consolidated billing are not separately paid from the SNF bill. The provider is responsible for submitting the charges to and receiving payment from the SNF. The SNF must submit the charges on the SNF claim to the intermediary.

Resolution:

Reject the claim for the provider and the beneficiary if the Part B outpatient services are within or equal the inpatient stay.

Remittance codes:

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

Use Group Code CO: Contractual Obligation

Use Claim Level Remark Code MA101: A SNF is responsible for payment of outside providers who furnish these services/supplies to its residents.

MSN codes:
Use Beneficiary MSN Message 21.7: This service should be included on your inpatient bill.

To Be Assigned (2)

Outpatient Claim (no therapy) Against Inpatient Part A SNF Claim History

An outpatient claim is rejected because the services rendered to a SNF inpatient (or SNF inpatient B claim effective for services on or after 1-1-2002) **overlap** the SNF dates of service. The outpatient services are not excluded from consolidated billing and must be billed by the SNF.

Purpose:

To ensure that services for a SNF patient that are not excluded from consolidated billing are not separately paid from the SNF bill. The provider

is responsible for submitting the charges to and receiving payment from the SNF. The SNF must submit the charges on the SNF claim.

Resolution:

Reject or return (develop) the claim with the provider if the dates of service **overlap** the SNF claim unless those services rendered within the SNF service dates can be identified. If they can be identified, reject the charges within the SNF service dates and continue processing the remaining services outside the SNF service dates.

Remittance codes:

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

Use Group Code CO: Contractual Obligation

To reject only the services within the inpatient service dates: Use Claim Level Remark Code MA101: A SNF is responsible for payment of outside providers who furnish these services/supplies to its residents.

To reject all services: Use Claim Level Remark Code 133: Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.

MSN codes:

Use Beneficiary MSN Message 17.11: This item or service cannot be paid as billed.

To Be Assigned (5) Inpatient Part A SNF Claim (or effective for services 1-1-2002 SNF inpatient B) Within Outpatient Therapy Claim History

An inpatient Part A SNF claim (or effective for services 1-1-2002 SNF inpatient B) is received and the dates of service are **within or equal** to an outpatient therapy claim dates of service on history. The outpatient therapy history claim must be canceled. The services must be billed by the SNF.

Purpose:
To ensure that Part B therapy services for a SNF patient are not separately paid from the inpatient SNF bill. The provider is responsible for submitting the charges to and receiving payment from the SNF. The SNF must submit the charges on the SNF inpatient claim.

Resolution:

CWF will accept the inpatient '21X' claim (and effective 1-1-2002, '22X' type of bill) and send an unsolicited auto-cancel response to the intermediary for the outpatient therapy. The intermediary will continue processing the inpatient '21X' claim (and effective 1-1-2002,'22X' claim).

Cancel the outpatient therapy claim(s) on history so the inpatient claim can be processed when resubmitted.

Remittance code:

For Cancel/reject of Outpatient Therapy claim, use Claim Adjustment Reason Code 97: Payment is included in the allowance for the basic service/procedure.

Use Group Code CR: Correction

Use Claim Level Remark Code 101: A SNF is responsible for payment of outside providers who furnish these services/supplies to its residents.

MSN code:

Use Beneficiary MSN code 31.1 This is a correction to a previously processed claim and/or deductible record.

To Be Assigned (5) Inpatient Part A SNF Claim (or effective for services 1-1-2002 SNF inpatient B) Overlaps Outpatient Therapy Claim History

An inpatient Part A SNF claim (or effective for services 1-1-2002 SNF inpatient B) is received and the dates of service **overlap** an outpatient therapy claim dates of service on history. The services must be billed by the SNF.

Purpose:

To ensure that certain Part B services for a SNF patient are not separately paid from the SNF bill.

Resolution:

CWF will accept the inpatient '21X' claim (and effective 1-1-2002, '22X' type of bill) and send an unsolicited auto-cancel response to the intermediary for the outpatient therapy. The intermediary will continue processing the inpatient '21X' claim (and effective 1-1-2002,'22X' claim).

1) If the intermediary can determine which therapy services on the outpatient claim were rendered within the inpatient service dates, adjust the outpatient history claim to retract payment for the services within the SNF dates and pay the services outside the inpatient dates of service. 2). If the intermediary cannot determine the outpatient services that fall within the inpatient service dates, cancel the outpatient therapy claim on history and advise the provider to bill Medicare for therapy services that are rendered outside the inpatient SNF claim. Therapy services within the SNF inpatient stay should be billed to the SNF and included on the SNF inpatient claim.

Remittance codes:

1) If the intermediary **can** determine the services outside the inpatient stay use the following:

a. Retract the incorrect payment. Follow the remittance advice correction/ reversal requirements (group code CR). Offset the incorrect payment against other payments due the provider.

b. Reprocess the outpatient therapy claim. Deny outpatient therapy services furnished during the period of the inpatient stay with group code CO, reason code 97 (Payment is included in the allowance for the basic procedure) and claim remark code MA101 (A SNF is responsible for payment of outside providers who furnish these services/supplies to its residents.) Approve payment as warranted for the outpatient therapy services furnished while the patient was not an inpatient.

2) If the intermediary **cannot** determine which services were furnished outside the inpatient stay:

a. Retract the incorrect payment. Follow the remittance advice correction/

reversal requirements (group code CR). Include Claim Level Remark Code MA 133 (Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.) Offset the incorrect payment against other payments due the provider.

MSN codes:

Use Beneficiary MSN code 31.1 This is a correction to a previously processed claim and/or deductible record.

To Be Assigned (6) Inpatient Part A SNF Claim (or effective for services 1-1-2002 SNF inpatient B) Within Outpatient (no therapy) Claim History

An inpatient Part A SNF claim (and effective 1-1-2002, inpatient Part B claim) is received and the dates of service are **within or equal** to an outpatient claim dates of service on history and the outpatient claim is not for a service excluded from consolidated billing. The services must be billed by the SNF.

Purpose:

To ensure that outpatient services for a SNF inpatient are not separately paid from the SNF inpatient bill. The provider is responsible for submitting the charges to and receiving payment from the SNF. The SNF must submit the charges on the SNF inpatient claim.

Resolution:

CWF will accept the inpatient '21X' claim (and effective 1-1-2002, '22X' type of bill) and send an unsolicited auto-cancel response to the intermediary for the outpatient claim. The intermediary will continue processing the inpatient '21X' claim (and effective 1-1-2002,'22X' claim).

Cancel the outpatient claim(s) on history.

Remittance codes:

Retract the incorrect payment.

Follow the remittance advice correction/ reversal requirements (group code CR).

Include Claim Level Remark Code MA101 (A SNF is responsible for payment of outside providers who furnish these services/supplies to its residents.)

MSN codes:

Use Beneficiary MSN code 31.1 This is a correction to a previously processed claim and/or deductible record.

To Be Assigned (6) Inpatient Part A SNF Claim (or effective for services 1-1-2002 SNF inpatient B) Overlaps Outpatient Claim History

An inpatient Part A SNF claim (and effective 1-1-2002, inpatient Part B SNF claim) is received and the service dates **overlap** an outpatient claim dates of service on history and the outpatient claim is not for a service excluded from consolidated billing. The services within the inpatient dates of service must be billed by the SNF.

Purpose:

To ensure that outpatient services for a SNF inpatient are not separately paid from the SNF inpatient bill. The provider is responsible for submitting the charges to and receiving payment from the SNF. The SNF must submit the charges on the SNF inpatient claim.

Resolution:

1) CWF will accept the inpatient '21X' claim (and effective 1-1-2002, '22X' type of bill) and send an unsolicited auto-cancel response to the intermediary for the outpatient claim. The intermediary will continue processing the inpatient '21X' claim (and effective 1-1-2002,'22X' claim).

2) If the intermediary **can** determine which outpatient billed services were rendered within the inpatient services dates, adjust the outpatient history claim to retract payment for the services within the SNF dates and pay the services outside the inpatient dates of service.

3). If the intermediary **cannot** determine the outpatient services that fall within the inpatient service dates, cancel the outpatient claim on history. Advise the provider to bill Medicare for services that are outside the inpatient SNF dates of service. Services within the SNF inpatient stay that are not excluded from consolidated billing should be billed to the SNF and included on the SNF inpatient claim.

Remittance codes:

1) If the intermediary **can** determine the services outside the inpatient stay:

a. Retract the incorrect payment. Follow the remittance advice correction/ reversal requirements (group code CR).

b. Reprocess the outpatient claim. Deny outpatient services furnished during the period of the inpatient stay with group code CO, reason code 97 (Payment is included in the allowance for the basic procedure) and claim remark code MA101 (A SNF is responsible for payment of outside providers who furnish these services/supplies to its residents.) Approve payment as warranted for the outpatient services furnished while the patient was not an inpatient.

2) If the intermediary **cannot** determine which services were furnished outside the inpatient stay:

Retract the incorrect payment.

Follow the remittance advice correction/ reversal requirements (group code CR).

Include Claim Level Remark Code MA 133 (Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.)

MSN codes:

Use Beneficiary MSN code 31.1 This is a correction to a previously processed claim and/or deductible record.

To Be Assigned (7)

Inpatient Part A SNF Claim (or effective for services 1-1-2002 SNF inpatient B) Within Carrier Therapy Claim History

An inpatient Part A claim (and effective 1-1-2002, inpatient Part B SNF claim) is received and dates of service are **within or equal** to a Carrier Part

B therapy claim dates of service on history. The services must be billed by the SNF.

Purpose:

To ensure that Carrier Part B therapy services for a SNF patient are not separately paid from the SNF bill. The provider is responsible for submitting the charges to and receiving payment from the SNF. The SNF must submit the charges on the SNF inpatient claim.

Resolution:

CWF will accept the inpatient '21X' claim (and effective 1-1-2002, '22X' type of bill) and send an unsolicited auto-cancel response to the carrier. The Carrier must initiate overpayment procedures and reflect the action taken on the Carrier Part B claim(s) on their history.

The intermediary will process the claim.

Remittance codes:

No special processing applies for intermediary claims.

MSN codes:

No special processing applies for intermediary claims.

To Be Assigned (7) Inpatient Part A SNF Claim (or effective for services 1-1-2002 SNF inpatient B) Overlaps Carrier Therapy Claim History

An inpatient Part A SNF claim (and effective 1-1-2002, inpatient Part B claim) is received and the dates of service overlap the dates of service of a Carrier Part B therapy claim on history. The services must be billed by the SNF.

Purpose:

To ensure that certain Carrier Part B services for a SNF patient are not separately paid from the SNF bill.

Resolution:

CWF will accept the inpatient '21X' claim (and effective 1-1-2002, '22X' type of bill) and send an unsolicited auto-cancel response to the carrier. The Carrier must initiate overpayment procedures and reflect the action taken on the Carrier Part B claim(s) on history.

The intermediary will process the claim.

Remittance codes:

No special processing applies for intermediary claims.

MSN codes:

No special processing applies for intermediary claims.

To Be Assigned (8) Inpatient Part A SNF Claim (or effective for services 1-1-2002 SNF inpatient B) Within Carrier (No therapy) Claim History

An inpatient Part A or Part B SNF claim is received and the dates of service are **within or equal** to dates of service of a Carrier Part B claim on history

and the services are not excluded from consolidated billing. The services must be billed by the SNF.

Purpose:

To ensure that Carrier Part B services not excluded from consolidated billing for a SNF patient are not separately paid from the SNF bill. The provider is responsible for submitting the charges to and receiving payment from the SNF. The SNF must submit the charges on the SNF inpatient claim.

Resolution:

CWF will accept the inpatient '21X' claim (and effective 1-1-2002, '22X' type of bill) and send an unsolicited auto-cancel response to the carrier. The Carrier must initiate overpayment procedures and reflect the action taken on the Carrier Part B claim(s) on history.

The intermediary will process the inpatient claim.

Remittance codes:

No special processing applies for intermediary claims.

MSN codes:

No special processing applies for intermediary claims.

To Be Assigned (8) Inpatient Part A SNF Claim (or effective for services 1-1-2002 SNF inpatient B) Overlaps Outpatient (no therapy Claim History

An inpatient Part A SNF claim is received and the dates of service **overlap** the dates of service of a Carrier Part B claim on history. The services on the Carrier Part B claim are not excluded from consolidated billing. The services must be billed by the SNF.

Purpose:
To ensure that certain Carrier Part B services for a SNF patient are not separately paid from the SNF bill.

Resolution:

CWF will accept the inpatient '21X' claim (and effective 1-1-2002, '22X' type of bill) and send an unsolicited auto-cancel response to the carrier. The Carrier must initiate overpayment procedures and reflect the action taken on the Carrier Part B claim(s) on history.

The intermediary will process the inpatient claim.

Remittance codes:

No special processing applies for intermediary claims.

MSN codes:

No special processing applies for intermediary claims.

Duplicate Edit Resolution (Error codes are to be assigned; the memo reference refers to the PM section describing edit logic.)

Error code	EXPLANATION

Error code	EXPLANATION
To Be Assigned (10)	A SNF outpatient Part B claim (23X) for ambulance services is rejected if a Carrier Part B claim is already paid with ambulances services for the same date of service. Purpose: To ensure that a SNF outpatient Part B (23X) claim for ambulance service is not paid if a Carrier Part B claim for the same ambulance service on the same day is already paid. Resolution: Reject the SNF Outpatient claim. Remittance codes: Use adjustment reason code 18: Duplicate claim/service. Use line level remark code M86-Service denied because payment already made for similar procedure. MSN codes: Beneficiary MSN Message is 7.1: This is a duplicate of a charge already submitted.
To Be Assigned (11)	An Outpatient Part B claim is rejected if a SNF Inpatient Part B claim is already paid with the same HCPCS codes for the same date of service. Purpose: To ensure that SNF services are not paid in duplicate to a SNF, or a hospital. Resolution: Reject the Outpatient Hospital Part B claim. Remittance codes: Use adjustment reason code 18: Duplicate claim/service. Use line level remark code M86-Service denied because payment already made for similar procedure. MSN codes: Beneficiary MSN Message is 7.1: This is a duplicate of a charge already submitted.
To Be Assigned (12)	An Outpatient Hospital Part B claim or Inpatient Part B SNF claim is rejected if a Carrier/DMERC Part B claim is already paid with the same HCPCS codes for the same date of service. Purpose: To ensure that services are not paid in duplicate to a SNF, a hospital or a Carrier Part B provider. Resolution:

Reject the Outpatient Hospital Part B claim or the Inpatient Part B SNF claim.

Remittance codes:

Use adjustment reason code 18: Duplicate claim/service.

Use line level remark code M86-Service denied because payment already made for similar procedure.

MSN codes:

Beneficiary MSN Message is 7.1: This is a duplicate of a charge already submitted.

To Be Assigned (13)	An Inpatient Part B SNF claim is rejected if a Hospital Outpatient Part B claim is already paid with the same HCPCS codes for the same date of service.

Purpose:

To ensure that services are not paid in duplicate to a SNF, or a hospital.

Resolution:

Reject the Inpatient Part B SNF claim.

Remittance codes:

Use adjustment reason code 18: Duplicate claim/service.

Use line level remark code M86-Service denied because payment already made for similar procedure.

MSN codes:

Beneficiary MSN Message is 7.1: This is a duplicate of a charge already submitted.

Consistency Edit Resolution (Error codes are to be assigned.)

Error Code	EXPLANATION

For claims with dates of service on or after January 1, 2002, an outpatient or Carrier Part B claim is rejected if the service is for ambulance and the origin and destination are both SNF.

Purpose:

To ensure that ambulance services rendered to a SNF patient are included in consolidated billing and are not paid separately.

Resolution:

Reject the outpatient or Part B claim.

Remittance codes:

Use claim adjustment reason code 97 Payment is included in the allowance

Error Code	EXPLANATION
	for the basic service/procedure. Use group code CO . Use claim level remark code MA101: A SNF is responsible for payment of outside providers who furnish these services/supplies to its residents.

VII Contractor Reporting Requirements

Identification of contractor implementation reporting requirements is not complete. However contractors should plan on the following.

We have not identified any changes needed for continuing claims workload reporting. Requirements for reporting on medical review activities are being developed separately.

With respect to implementation reporting, intermediaries should plan now to be able to report the following as applicable. The format is not yet developed.

Preparation

- What information SNFs have been told in general and how (distribution of SNF manual revisions, Web sites, or intermediary bulletins, etc);
- What training is planned by intermediaries;
- What training has been completed on what subjects (HCPCS, coverage and billing rules for various service types, etc., and what SNFs attended and did not attend;
- With how many suppliers each SNF will have to develop agreements and the status of SNF development and intermediary verification of these agreements;
- What testing is planned and what has been done for CWF, standard systems, FIs and providers;
- What questions SNFs are asking intermediaries. HCFA plans to publish frequently asked questions (FAQs) on the Web page.

Implementation

- What edits occur with implementation and in what volume; and related efforts for correction.
- Volume of inquiries related to consolidated billing and the most frequently asked questions. HCFA will publish these FAQs on the Web page also.

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 January 1, 2002.

Contractors should contact the appropriate regional office with any questions.