
Medicare Skilled Nursing Facility Manual

Department of Health and
Human Services (DHHS)

Health Care Financing
Administration (HCFA)

Transmittal

Date Draft 8/08/00

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This transmittal contains instructions for implementation of provisions in the Balanced Budget Act of 1997 that require payment to SNFs for Part B services under a fee schedule. It also contains instructions about CWF edits to be implemented April 1, 2001 related to SNF Part A PPS, and effective January 1, 2002, related to consolidated SNF Part B consolidated billing.

HCPCS codes described in the draft version of this transmittal are based on codes in effect for 1999. They will be updated for 2001 before final publication.

**NEW/REVISED MATERIAL--EFFECTIVE DATE: April 1, 2001
IMPLEMENTATION DATE: April 1, 2001**

Beginning with services provided April 1, 2001 the intermediary will make payment for SNF Part B services under a fee schedule if there is a Medicare fee schedule established. This applies to 22X and 23X bill types. Related requirements are included in this transmittal. Services that are not paid under a fee schedule will be paid on a reasonable cost basis. The services listed below will not be paid under a fee schedule. Where covered they continue to be paid on a cost basis. Fee schedules will be established for these services in the future.

Edits will be implemented in CWF for services provided April 1, 2001 to SNF Part A residents. A description of these edits and instructions for contractor resolution are included.

**NEW/REVISED MATERIAL--EFFECTIVE DATE: January 1, 2002
IMPLEMENTATION DATE: January 1, 2002**

The Balance Budget Act of 1997 also requires that certain services provided under Part B to SNF

residents for whom Part A payment may not be made must be provided by the SNF and billed by the SNF in order to be covered by Medicare. SNFs will have until January 1 2002 to implement arrangements to comply with this provision. Related instructions are include in this transmittal.

Beginning with services furnished January 1, 2002, SNFs must bill for all services, including surgical dressings, any covered prosthetic and orthotic items, diagnostic services, rehabilitation services, etc, (with certain exceptions as described in this transmittal). If the SNF does not bill, the service is not paid. Exceptions are described in the individual manual sections.

A list of services not paid under the SNF fee schedule follows. This information is not included in the manual. It will be published on the HCFA web site and updated there as needed.

List of Services Not Paid Under Fee Schedule

Medical Supplies

A4570 A4212 A4580 A4590

Dialysis Supplies & Equipment

A4650 A4655 A4660 A4663 A4680 A4690 A4700 A4705 A4712 A4714 A4730 A4735
A4740 A4750 A4755 A4760 A4765 A4770 A4771 A4772 A4773 A4774 A4780 A4790
A4820 A4850 A4860 A4870 A4880 A4900 A4901 A4905 A4910 A4912 A4914 A4918
A4919 A4920 A4921 A4927

E1510 E1520 E1530 E1540 E1550 E1560 E1570 E1575 E1580 E1590 E1592 E1594 E1600
E1610 E1615 E1620 E1625 E1630 E1632 E1635 E1636 E1640

Therapeutic Shoes

A5500 A5501 A5502 A5503 A5504 A5505 A5506 A5507

PEN Codes -- PEN codes continue to be billed to the DMERC by either the supplier or the SNF until further notice.

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

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 Billed by the SNF on Bill Types 22X and 23X
All drugs continue to be paid under current rules..

Fee schedules are applicable for all other SNF inpatient B and outpatient services. If a fee amount has not been set for a particular service, the service will be priced under individual consideration and the payment will be considered a fee schedule payment.

SNFs continue to bill the intermediary for SNF services, bill the carrier for physician employee services; and if also approved as a DME supplier, SNFs bill the DMERC as a supplier of DME services.

In addition to changes described above, some sections have been updated to reflect changes in deductible, coinsurance and benefits that have been issued previously but not yet included in the SNF manual.

Specific changes are:

Section 155.2, Inpatient Hospital Services is updated for changes in application of coinsurance that were made January 1, 1982

Section 155.3, Post Hospital Home Health Services, has been changed to describe Home Health benefit coverage changes as a result of BBA-97.

Section 160.1, Benefits, a new paragraph 19 has been added to include material in section A 160.1 (1981 amendment supplement).

Section 160.3, Annual Part B Deductible and Coinsurance, is updated to include deductible changes after 1982.

Sections 206 - 206.2 Consolidated Billing and Under Arrangements, have been added to describe consolidated billing, exceptions, and related supplier agreements.

Section 230, Covered Extended Care Services, has been changed to include SNF Part A PPS

Section 270, Coverage of Outpatient Physical Therapy, Occupational Therapy, And Speech Pathology Services, has been updated to state that these services are not covered for SNF residents unless billed by the SNF.

Section 306, Time Limits For Requests and Claims For Payment for Services Reimbursed by PPS, Fee Schedule or a reasonable Cost Basis has been updated to include PPS and fee schedule payments.

Section 310.2, Part B Services, and Section 315, Time Limit for Filing Part B Claims , have been modified to manualize instructions previously issued about entries to make on the HCFA 1450 (UB 92) when filing claims after expiration of the normal time limit and to include claims paid under a fee schedule. Previous language limited application to reasonable cost and reasonable charge.

Section 415, Beneficiary Notification for Consolidated Billing, has been added to describe beneficiary notification requirements at admission for consolidated billing.

Section 502, Billing Medicare for the Professional Component of SNF-Based Physician's Services is updated to reflect Part A PPS and Part B fee schedules.

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Section 528 - 528.5, SNF PPS Billing have been added to include pertinent billing instructions for Part A SNF services from Program Memoranda issued to date.

Sections 529 - 544 (excluding section 531, Ambulance, which has not been changed) have been added to describe changes to the SNF Part B billing. This includes material in Program Memoranda issued to date and new instructions

Section 595, Consolidated Billing Edits and Resolution, is added to described CWF and standard system edits related to consolidated billing, and related resolution procedures.

In addition, some sections previously within 532 - 559 that do not relate exclusively to Part B billing have been relocated so that sections 532 - 559 can be used for Part B SNF billing inclusively. These are:

Old sections 542 - 544 have been moved to 565-565.1.

Old sections 545 - 559 have been moved to 566-566.1 .

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

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Hospital Insurance

155. HOSPITAL INSURANCE--A BRIEF DESCRIPTION

This is the basic part of the health insurance program. It is designed to help patients defray the expenses incurred by hospitalization and related care. In addition to inpatient hospital benefits, hospital insurance covers posthospital extended care in SNFs and posthospital care furnished by an HHA in the patient's home. In providing these additional benefits, recognition was given to the need for continued treatment after hospitalization and the need to encourage the appropriate use of more economical alternatives to inpatient hospital care. Program payment for services rendered to beneficiaries by providers (i.e., hospitals, SNFs and HHAs) are generally made to the provider based on the Prospective Payment System applicable to that type of provider.

155.1 Posthospital Extended Care Services.--Coverage of extended care services is provided under hospital insurance. The definition of the SNF, requirements for coverage, a description of extended care benefits, and the applicable coinsurance, limitations, and exclusions are fully treated in Chapter II.

155.2 Inpatient Hospital Services.--The items and services covered include: bed and board; nursing and other related services; use of hospital facilities and medical social services ordinarily furnished by the hospital for the care and treatment of inpatients; drugs, biologicals, supplies, appliances, and equipment for use in the hospital, which are ordinarily furnished by the hospital; diagnostic or other therapeutic items or services furnished by the hospital or by others under arrangements made by the hospital; services by interns or residents-in-training under approved teaching programs; and costs of blood after the first 3 pints in a benefit period and all costs of administering the blood including the provider's costs of administering the first 3 pints.

The patient is entitled to payment on his behalf for up to 90 days of inpatient hospital services in each benefit period. He is responsible for a deductible amount in each benefit period and a coinsurance amount equal to one-fourth of the inpatient hospital deductible for each day after the 60th day and through the 90th day of inpatient hospital services during a benefit period. In addition, a beneficiary has a 60-day lifetime reserve available for inpatient hospital services. Unless he elects not to use this reserve, he will be responsible for a coinsurance amount for each day used equal to one-half of the inpatient hospital deductible for the benefit period in which such reserve days are used. (See section 249 for chart reflecting the applicable deductible and coinsurance amounts.)

For services furnished before 1982, the year in which the benefit period begins determines not only the deductible amount to be applied during such benefit period, but also the coinsurance amounts for inpatient hospital services and extended care services furnished in the same spell of illness.

For services furnished on or after January 1, 1982, the coinsurance amounts are based on the inpatient hospital deductible applicable for the year in which the services are furnished.

Inpatient tuberculosis hospital services are covered if the services furnished to the individual are services which can reasonably be expected to improve his condition or render it noncommunicable. Inpatient psychiatric hospital services are covered if the services furnished to the patient are furnished when he is receiving intensive treatment, or are necessary for medically-related inpatient diagnostic study. Where an individual is in a qualified psychiatric hospital on the first day for which he is entitled to hospital insurance benefits, the days on which he was an inpatient of such a hospital in the 150-day period immediately before his first day of entitlement must be counted in determining the 150-day lifetime limitation of 190 covered inpatient psychiatric hospital days in a psychiatric hospital. A period spent in a psychiatric hospital prior to entitlement, however, does not count against the 190 days.

Payment may be made for emergency inpatient hospital services furnished by nonparticipating U.S. hospitals when the threat to life or health of the individual necessitates the use of the most accessible hospital. Payment may also be made for emergency inpatient hospital and certain related Part B services in Canada and Mexico where the foreign hospital is more accessible from the site of the emergency than the nearest participating U.S. hospital.

Inpatient hospital services and related Part B services provided to a United States resident in a hospital in Canada or Mexico which is closer or more accessible to his U.S. residence than the nearest participating U.S. hospital may be covered whether or not an emergency existed.

155.3 Posthospital Home Health Services. -- To qualify for Medicare coverage of home health care the beneficiary must be confined to the home, under the care of a physician, receiving services under a plan of care established and periodically reviewed by a physician, and be in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology, or have a continuing need for occupational therapy.

Home health benefits may be paid under Part A or under Part B depending upon:

- o Whether the beneficiary is entitled only under Part A, Part B, or both;
- o Whether the beneficiary has had a 3 consecutive day stay in a hospital or rural primary care hospital; and
- o If entitled under Part A whether home health services were initiated and the first covered home health visit is rendered within 14 days of discharge from a 3 consecutive day stay in a hospital or rural primary care hospital or within 14 days of discharge from a skilled nursing facility in which the individual was provided post-hospital extended care services. If the first home health visit is not initiated within 14 days of discharge, then home health services are financed under Part B.
- o After an individual exhausts 100 visits of Part A post-institutional home health services, Part B finances the balance of the home health spell of illness.

See the Medicare Home Health Agency Manual for a description of the home health benefit.

§271.4) Coverage of outpatient physical therapy also includes the services of a qualified physical therapist in independent practice when furnished in his/her office or the beneficiary's home; expenses incurred for such services in a calendar year may not exceed \$100 for services rendered prior to 1982 and \$500 for services rendered on and after January 1, 1982.

Pneumococcal vaccine and its administration; hepatitis B vaccine and its administration, and blood clotting factors for hemophiliac patients and their administration.

12. Certain medical supplies used in connection with home dialysis delivery systems;
13. ESRD composite rate for all outpatient maintenance dialysis items and services;
14. Antigens prepared by a physician;
15. Rural health clinic services;
16. Comprehensive outpatient rehabilitative services;
17. Ambulatory surgical facility services furnished in connection with certain surgical procedures;
18. Services furnished in a health maintenance organization by a clinical psychologist, a physician assistant, or nurse practitioner, and services and supplies furnished incident to such services.

Payment may not be made under Part B for services furnished an individual if he is entitled to have payment made for those services under Part A. An individual is considered entitled to have payment made under Part A if the expenses incurred were used to satisfy a Part A deductible or coinsurance amount, or if payment would be made under Part A except for the lack of request for payment or physician certification.

19 For services furnished after June 30, 1981 a dentist qualifies as a "physician" if he/she is a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he/she performs such function and who is acting within the scope of his license when he/she performs such functions. Such services include any otherwise covered service that may legally and alternatively be performed by doctors of medicine, osteopathy and dentistry, e.g., dental examinations to detect infections prior to certain surgical procedures, treatment of oral infections and interpretations of diagnostic X-ray examinations in connection with covered services. Because the general exclusion of payment for dental services has not been withdrawn, payment for the services of dentists is also limited to those procedures which are not primarily provided for the care, treatment, removal, or replacement of teeth or structures directly supporting teeth. (Section 280.12 also concerns this exclusion.) The coverage or exclusion of any given dental service is not affected by the professional designation of the "physician" rendering the service; i.e., an excluded dental service remains excluded and a covered dental service is still covered whether furnished by a dentist or a doctor of medicine or osteopathy.

160.2 Basis for Payment.--Payment for services covered by medical insurance and rendered by a participating hospital, skilled nursing facility, home health agency, or other provider of services, or under arrangements made by such providers, is based, depending upon the service, on a PPS system applicable to the provider, a fee schedule, or reasonable cost as defined by regulations and manuals.

160.3 Annual Part B Deductible and Coinsurance.--In each calendar year, a cash deductible must be satisfied before payment can be made under the supplementary medical insurance plan. (See §160.5 for exceptions.)

As of January 1, 1991, the deductible is \$100.

From January 1, 1982 through 1990, the deductible is \$75.

From 1973 through 1981, the deductible was \$60.

From 1966 through 1972, the deductible was \$50.

Expenses count toward the deductible on the basis of incurred, rather than paid expenses, and are based on the reasonable charge. Noncovered expenses do not count toward the deductible. Even though an individual is not entitled to Part B benefits for the entire calendar year, i.e., his insurance coverage begins after the first month of a year or he dies before the last month of the year, he is still subject to the full deductible for that year. Medical expenses incurred in the portion of the year preceding entitlement to medical insurance are not credited toward the deductible.

The date of service generally determines when expenses were incurred, but expenses are allocated to the deductible in the order in which the bills are received by the intermediary. Services which are not subject to the deductible cannot be used to satisfy the deductible.

After the deductible has been satisfied, providers will generally be paid the lesser of the reasonable costs or customary charges less 20 percent of the reasonable charge but no more than 80 percent of the reasonable costs, and physicians and other suppliers 80 percent of the reasonable charges, incurred during the balance of the calendar year. The patient is responsible for a coinsurance amount equal to 20 percent of the reasonable charges for the items and services. (See §160.5 for exceptions.)

160.4 Special Carryover Rule for Expenses Incurred Prior to 1981.--Expenses incurred in the last 3 months of a calendar year prior to 1981, which were applied toward the Part B deductible for the year in which they were incurred, may also be credited towards the deductible for the following year.

NOTE: This deductible carryover provision was repealed effective with expenses incurred on or after October 1, 1981.

160.5 Exceptions to Part B Deductible and Coinsurance.--

A. The 20 percent coinsurance does not have to be met with respect to the following:

1. Purchased used durable medical equipment (DME) including DME furnished as a home health benefit, if the charge does not exceed 75 percent of the reasonable charge of new equipment.

2. Preadmission Diagnostic Testing services furnished from December 5, 1980 through July 18, 1984.

Psychiatric hospitals that meet these requirements can qualify as emergency hospitals. A nonparticipating hospital within the United States may receive payment for covered emergency inpatient and outpatient hospital services if it meets at least these requirements. Coverage continues only as long as the emergency continues.

Stays in hospitals that meet these requirements also satisfy the 3 day hospital stay requirement for coverage of posthospital services.

Inpatient hospital services outside the United States can be covered under limited conditions.

205. PARTICIPATING PROVIDERS OF SERVICES

For purposes of §1866 of the Act, the term provider of services (or provider) means a hospital, skilled nursing facility, home health agency and, for the limited purpose of furnishing outpatient physical therapy, occupational therapy, or speech pathology services, a clinic, rehabilitation agency or public health agency which meets the applicable eligibility provisions of Title XVIII of the Act and regulations issued thereunder (i.e., the conditions of participation).

To be a participating provider under Medicare, a provider must be in compliance with the applicable provisions of title VI of the Civil Rights Act of 1964 and must enter into an agreement under §1866 of the Act which provides that it:

- o will not charge any individual or other person for items and services covered by the health insurance program other than allowable charges and deductibles and coinsurance amounts; and
- o will return any money incorrectly collected from the individual or other person on his behalf or make other disposition. (See §§318ff.)

206. CONSOLIDATED BILLING

With certain exceptions listed in section 206.1 below, effective with implementation of PPS for SNFs and no later than January 1, 1999, services for a SNF resident who is entitled to Part A benefits are not covered under Part B. These services (services not excepted in 206.1) are considered included in the SNF Part A PPS payment.

Effective with services provided January 1, 2002, services provided to SNF residents to whom Part A benefits are not payable (e.g., because of non entitlement to Part A or because benefits are exhausted), are not covered under Part B unless the SNF provides the service, either directly or under arrangements. Only the SNF may bill for the service unless specifically exempted in section 206.1

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 the SNF must bill for all Medicare services except those identified in section 206.1 below. This is applicable regardless of whether the beneficiary is in a certified or non certified bed.

Whenever such 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:

- 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 receives services from a Medicare-participating home health agency under a plan of care;
- The beneficiary receives outpatient services from a Medicare-participating hospital or CAH (but only with respect to those services that are listed as exceptions; or
- The beneficiary is formally discharged (or otherwise departs) from the SNF, unless the beneficiary is readmitted (or returns) to that or another SNF by midnight of the same day.

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.

206.1 Exceptions -

A 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 Services from the following may be billed by the rendering provider and paid separately, i.e., are not included in the PPS rate.

- Physician's services other than physical, occupational, and speech-language therapy services furnished to SNF residents . These services are billed separately to the Part B carrier. Respiratory therapy services are not excluded from consolidated billing except for physician's component. Section 4432 (b)(4) of the BBA requires bills for these particular services to include the SNF's Medicare provider number. Therefore the physician will need to know your Medicare provider number;
- Physician assistants, not employed by the SNF, working under a physician's supervision;
- Nurse practitioners and clinical nurse specialists, not employed by the SNF, working in collaboration with a physician;
- Certified nurse-midwives;
- Qualified psychologists;
- Certified registered nurse anesthetists;

C The following services may be billed separately under Part B (e.g. exempted under both Parts A and B), and may be paid in addition to the SNF's Part A PPS rate.

- Home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies, including any related necessary ambulance services;
- 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));
- Hospice care related to a beneficiary's terminal condition;
- An ambulance trip (other than a trip to or from another SNF) that transports a beneficiary to the SNF for the initial admission; from the SNF following a final discharge and ambulance services associated with a service exempted from consolidated billing.

- The following services are exempted from consolidated billing 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 revenues codes describing these services are in the billing chapter, section 531ff.
 - Cardiac catheterization
 - Computerized axial tomography (CT) scans
 - Magnetic resonance imaging (MRIs)
 - 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
- The following services when provided by any Medicare provider licensed to provide them. Specific HCPCS describing these services are in the billing chapter.
 - Some chemotherapy and chemotherapy administration services
 - Radioisotope services
 - Some customized prosthetic devices
- For services furnished during 1998 only, the transportation costs of electrocardiogram equipment for electrocardiogram test services.
- All services provided to risk based MCO beneficiaries. These beneficiaries may be identified with a label attached to their Medicare card and/or a separate health insurance card from an MCO indicating all services must be obtained or arranged through the MCO.

206.2 SNF Provider Agreements-- The SNF must exercise professional responsibility over the services provided under contract with a supplier. The facility's professional supervision over contracted services requires application 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 to assure that all ordered services are medically necessary.

Services subject to consolidated billing and provided under arrangements must be provided only by Medicare certified providers that are authorized to provide the service involved. The SNF is responsible for ensuring that subcontractors/vendors meet Medicare and all applicable State licensure requirements. Before a SNF selects a provider or contractor, it must, at a minimum verify that the provider is not sanctioned either from the sanctioned provider bulletins distributed by intermediaries or by utilizing the OIG website at [hhs.gov/progorg/oig/cumsan/index.htm](https://www.hhs.gov/progorg/oig/cumsan/index.htm). 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 must have a written contract with its supplier if the annual cost of the service exceeds \$10,000.00.

The law does not detail the specific terms of 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:

- How the SNF orders services (who is authorized to order and by what methods)
- What to do if the test is ordered in another manner or by another party, e.g., family physician
- Expected timeliness in performance of the service, completion of CMNs or other documentation and reporting methodology
- Timeliness of supplier notification of the results
- Billing and payment arrangements between the SNF and supplier
- Respective financial responsibilities if the service should be denied or if contract provisions are breached

The SNF does not have to receive the supplier's bill before billing Medicare but you 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 may determine the format of this documentation.

Requirements for Coverage of Extended
Care Services under Hospital Insurance

210. REQUIREMENTS--GENERAL

Posthospital extended care services furnished to inpatients of a skilled nursing facility are covered under the hospital insurance program. Patients with hospital insurance coverage are entitled to have payment made on their behalf for covered extended care services furnished by the facility, by others under arrangements with the facility, or by a hospital with which the facility has a transfer agreement. Effective with the start of the first cost reporting period on or after July 1, 1998, inpatient SNF services are reimbursed under a prospective payment system.

212. PRIOR HOSPITALIZATION AND TRANSFER REQUIREMENTS

In order to have payment made for posthospital extended care services, the individual must have been an inpatient of a hospital for a medically necessary stay of at least 3 consecutive calendar days. In addition, the individual must have been transferred to a participating skilled nursing facility within 30 days after discharge from the hospital, unless the exception in section 212.3B applies.

212.1 Three-Day Prior Hospitalization.--The hospital discharge must have occurred on or after the first day of the month in which the individual attains age 65 or becomes entitled to health insurance benefits under the disability or chronic renal disease provisions of the law. The 3 consecutive calendar days requirement can be met by stays totaling 3 consecutive days in one or more hospitals. In determining whether the requirement has been met, the day of admission, but not the day of discharge, is counted as a hospital inpatient day.

To be covered, the extended care services must be needed for a condition which was treated during the patient's qualifying hospital stay, or by a condition which arose while he was in the facility for treatment of a condition for which he was previously treated in the hospital. In addition, the qualifying hospital stay must have been medically necessary. The intermediary will determine whether this requirement is met; where the situation warrants it, by checking with the attending physician and the hospital.

obtained at the time of admission, or as soon thereafter as is reasonable and practicable. The routine admission procedure followed by a physician would not be sufficient certification of the necessity for posthospital extended care services for purposes of the program.

If ambulance service is furnished by an SNF, and additional certification is required, *it* may be furnished by any physician who has sufficient knowledge of the patient's case including the physician who requested the ambulance or the physician who examines the patient upon his arrival at the facility. The physician must certify that the ambulance service was medically required.

In addition, physician's certifications are required for the rental and purchase of durable medical equipment (see § 264) and outpatient physical therapy and outpatient speech pathology services. (See § 271.1.)

220.3 Recertification.--The recertification statement must meet the following standards as to its contents: it must contain an adequate written record of the reasons for continued need for extended care services, the estimated period of time the patient will need to remain in the facility, and any plans, where appropriate, for home care. The recertification statement made by the physician has to meet the content standards, unless, for example, all of the required information is in fact included in progress notes, in which case the physician's statement could indicate that the individual medical record contains the required information and that continued posthospital extended care services are medically necessary. A statement reciting only that continued extended care services are medically necessary is not, in and of itself, sufficient.

A certification may be mailed, faxed or completed when the physician is onsite. However, the physician cannot sign an initial certification and one or more recertifications at the same time.

If the circumstances require it, the first recertification must state that the continued need for a condition requiring such services which arose after the transfer from the hospital and while the patient was still in the facility for treatment of the condition(s) for which he had received inpatient hospital services.

Where the requirements for the second or subsequent recertification are satisfied by review of a stay of extended duration, pursuant to the utilization review (UR) plan, a separate recertification statement is not required. It is sufficient if the records of the UR committee show consideration was given to the recertification content standards. See § 251B for requirements regarding certification for presumed coverage cases.

220.4 Timing of Recertifications.--The first recertification must be made no later than as of the 14th day of inpatient extended care services. An SNF can, at its option, provide for the first recertification to be made earlier, or it can vary the timing of the first recertification within the 14-day period by diagnostic or clinical

categories. Subsequent recertifications must be made at intervals not exceeding 30 days. Such recertifications may be made at shorter intervals as established by the UR committee and the SNF.

At the option of the SNF, review of a stay of extended duration, pursuant to the facility's utilization review plan, may take the place of the second and any subsequent physician recertifications. The SNF should have available in its files a written description of the procedure it adopts with respect to the timing of recertifications. The procedure should specify the intervals at which recertifications are required, and whether review of long-stay cases by the UR committee serves as an alternative to recertification by a physician in the case of the second or subsequent recertifications.

220.5 Delayed Certifications and Recertifications.--Skilled nursing facilities are expected to obtain timely certification and recertification statements. However, delayed certifications and recertifications not more than 1 or 2 weeks late will be honored where, for example, there has been an oversight or lapse. Natural disasters or a demand bill filed late may be acceptable reasons for delayed certifications/recertifications exceeding 2 weeks.

In addition to complying with the content requirements, delayed certifications and recertifications must include an explanation for the delay and any medical or other evidence which the SNF considers relevant for purposes of explaining the delay. The facility will determine the format of delayed certification and recertification statements, and the method by which they are obtained. A delayed certification and recertification may appear in one statement; separate signed statements for each certification and recertification would not be required as they would if timely certification and recertification had been made.

220.6 Disposition of Certification and Recertification Statements.--Except for "presumed coverage" cases (see § 250), skilled nursing facilities do not have to transmit certification and recertification statements to the intermediary or the Health Care Financing Administration. Instead, the facility must certify on the admission and billing form that the required physician certification and recertification statements have been obtained and are on file.

Extended Care Services Covered under Hospital Insurance

230. COVERED EXTENDED CARE SERVICES

- A. Payment for Extended Care Services.--Patients covered under hospital insurance are entitled to have payment made on their behalf for covered extended care services furnished by the facility, by others under arrangements with the facility, or by a hospital with which the facility has a transfer agreement. Effective with the start of the first cost reporting period on or after July 1, 1998, inpatient SNF services are reimbursed under a prospective payment system. (see § 211) If the items or

EXAMPLE: Mrs. Jones, who had already met her deductible, purchased a wheelchair on February 1, which she used in her home until her admission to the SNF on April 15. She was discharged from the SNF to her home on June 15 and continued to need the wheelchair. The reasonable charge for the wheelchair was \$150 and the reasonable rental charge was \$15 per month. The intermediary scheduled 10 monthly payments of \$12 each (80 percent of \$15) and paid for February, March, and April. Since Mrs. Jones was institutionalized for the entire month of May, the fourth installment was suspended. This installment became the June payment, and payments continued through December rather than November, as originally scheduled.

D. Durable Medical Equipment Purchased Before Beneficiary's Coverage Begins.--The dates on which periodic payments for a covered purchased item are due and allocation of the installments for deductible purposes are determined under the rules in subsection B. However, in determining whether a purchased item is covered, the entire expense of the item is considered to have been incurred on the date the equipment was delivered. Accordingly, where a purchased item of durable medical equipment was delivered to an individual before his/her coverage period began, the entire expense of the item (whether it was paid for in its entirety at the time of purchase or on a deferred or installment basis), are excluded from coverage since payment cannot be made for any expense incurred before an individual's coverage period began.

Inpatient Part B and Outpatient Physical Therapy,
Occupational Therapy, and Speech Pathology Services
Covered under Medical Insurance

270. COVERAGE OF INPATIENT PART B AND OUTPATIENT PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH PATHOLOGY SERVICES

Under Part A, physical therapy, occupational therapy, and speech pathology services are included in the SNF PPS payment. For inpatient Part B residents and outpatient services, payment for such services is under a fee schedule. The SNF must bill for physical therapy, occupational therapy, or speech pathology services for Part A residents beginning with implementation of SNF PPS and for Part B residents beginning January 1, 2002. The SNF may furnish the services directly or under arrangements with another provider or supplier authorized to provide Medicare services. This includes approved clinics, rehabilitation agencies, and public health agencies as well as participating hospitals, SNFs, and HHAs. The patient is responsible only for applicable Part A coinsurance or the Part B deductible and coinsurance amounts.

NOTE: Part B dates of service for 2 calendar years may not be included on the same bill. Two separate Part B bills are required.

270.1 Services Furnished under Arrangements with Providers.--You may arrange with others to furnish covered outpatient physical therapy, occupational therapy, or speech pathology services. When such arrangements are made, receipt of payment by you for the arranged services (as with services provided directly) relieves the beneficiary or any other person of further liability to pay for them. (See §206.)

271. CONDITIONS FOR COVERAGE OF OUTPATIENT PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH PATHOLOGY SERVICES

To be covered under the Medicare program, outpatient physical therapy, occupational therapy, or speech pathology services that you furnish a patient must meet all of the conditions listed in §230.3 and the following requirements.

271.1 Physician's Certification and Recertification for Outpatient Physical Therapy, Occupational Therapy, and Speech Pathology Services.--

A. Content of Physician's Certification.--No payment is made for outpatient physical therapy, occupational therapy, or speech pathology services unless a physician certifies that:

o The services are or were furnished while the patient was under the care of a physician (see §271.2);

o A plan for furnishing such services is or was established by the physician, physical therapist, occupational therapist, or speech pathologist and periodically reviewed by the physician (see §271.3); and

o The services are or were required by the patient.

Since the certification is closely associated with the plan of treatment, the same physician who establishes or reviews the plan must certify to the necessity for the services. Obtain certification at the time the plan of treatment is established or as soon thereafter as possible. Physician means a doctor of medicine, osteopathy (including an osteopathic practitioner) or podiatric medicine legally authorized to practice by the State in which he/she performs these services. In addition, physician certifications by doctors of podiatric medicine must be consistent with the scope of the professional services provided by a doctor of podiatric medicine as authorized by applicable State law.

B. Recertification.--When outpatient physical therapy, occupational therapy, or speech pathology services are continued under the same plan of treatment for a period of time, the physician must recertify at intervals of at least once every 30 days that there is a continuing need for such services and estimate how long services will be needed. Obtain the recertification at the time the plan of treatment is reviewed since the same interval (at least once every 30 days) is required for the review of the plan. The physician who reviews the plan of treatment must sign the recertifications. The form and manner of obtaining timely recertification is up to you.

2. To incorporate, by stamp, or otherwise, information to the following effect on any bills sent to Medicare patients: "Do not use this bill for claiming Medicare benefits. A claim has been or will be submitted to Medicare on your behalf." This requirement is necessary to prevent patients from submitting duplicate claims.

The SNF also undertakes to make the patient signature files available for carrier and intermediary inspection on request.

302.3 has been deleted

302.4 Signature on the Request for Payment by Someone Other Than the Patient.--If at all practical, the patient should sign the request whether on the billing form or on the provider's record at the time of admission.

In certain circumstances, it would be impracticable for an individual to sign the request for payment himself because when he is submitted to a skilled nursing facility he is unconscious, incompetent, in great pain, or otherwise in such a condition that he should not be asked to transact business. In such a situation, his representative payee (i.e., a person designated by the Social Security Administration to receive monthly benefits on the patient's behalf, a relative, legal guardian, or a representative of an institution (other than the facility) usually responsible for his care, or a representative of a governmental entity providing welfare assistance, if present at time of admission, should be asked and permitted to sign on his behalf.

A. Provider Signs Request.--If, at the time of admission the patient cannot be asked to sign the request for payment and there is no person present exercising responsibility for him, an authorized official of the facility may sign the request. The skilled nursing facility should not routinely sign the request on behalf of any patient. If experience reveals an unusual frequency of such facility signed requests from a particular facility, the matter will be subject to review by the intermediary.

The SNF need not attempt to obtain the patient's signature where the physician sends a specimen (e.g., blood or urine sample) to a laboratory of a participating SNF for analysis, the patient does not go to the SNF, but the tests are billed on an assignment basis through it. The SNF may sign on behalf of the patient and should note in the space provided for the patient's signature in Item 12 on the Provider Billing for Medical and Other Health Services (HCFA-1483) and any accompanying Provider Billing for Patient Services by Physicians (HCFA-1554), "Patient not physically present for tests." This does not apply in cases in which the patient actually goes to the SNF laboratory for tests and the facility fails to obtain the patient's signature while he is there.

B. Patient Dies Before Signing Request for Payment.--If the patient dies before the request for payment is signed, it may be signed by the legal representative of his estate, or by any of the persons or institutions (including an authorized official of the facility) who could have signed it had he been alive and incompetent.

C. Need for Explanation of Signer's Relationship to Patient.--When someone other than the patient signs the request for payment, the signer will submit a brief statement explaining his relationship to the patient and the circumstances which make it impracticable for the patient to sign. The facility will forward this statement with its billing, or retain it in its files if the signature is obtained on the facility's own record.

302.5 Refusal by Patient to Request Payment Under the Program.--A patient on admission to a skilled nursing facility may refuse to request Medicare payment and agree to pay for his services out of his own funds or from other insurance. Such patients may have a philosophical objection to Medicare or may feel that they will receive better care if they pay for services themselves or they are paid for under some other insurance policy. The patient's impression that another insurer will pay

for the services may or may not be correct, as some contracts expressly disclaim liability for services covered under Medicare. Where the patient refuses to request Medicare payment, the provider should obtain his signed statement of refusal whenever possible. If the patient (or his representative) is unwilling to sign, the facility should record that the patient refused to file a request for payment but was unwilling to sign the statement of refusal.

In any event, there is no provision which requires a patient to have covered services he receives paid for under Medicare if he refuses to request payment. Therefore, a provider may bill an insured patient who positively and voluntarily declines to request Medicare payment. However, if such a person subsequently changes his mind (because he finds his other insurance will not pay or for another reason) and requests payment under the health insurance program within the prescribed time limit, the provider must bill the intermediary. The provider should then refund to the patient any amounts he paid in excess of the permissible charges.

Where a patient who has declined to request payment dies, his right to request payment may be exercised by the legal representative of his estate, by any of the persons or institutions mentioned in the second paragraph of § 302.4, by a person or institution which paid part or all of the bill, or in the event a request could not otherwise be obtained, by an authorized official of the facility. This permits payment to the facility for services which would not otherwise be paid for and allows a refund to the estate or to a person or institution which paid the bill on behalf of the deceased.

See §308 for effect on beneficiary and facility of refusal to file.

Time Limits--Cost Reimbursement

306. TIME LIMITS FOR REQUESTS AND CLAIMS FOR PAYMENT FOR SERVICES REIMBURSED BY PPS, FEE SCHEDULE OR ON A REASONABLE COST BASIS

Program payment may not be made under Part A or Part B for provider services unless the beneficiary or his representative has filed a timely request for payment, and the facility has filed a timely claim. (See §300.) The intermediary has the responsibility for determining a claim is timely filed.

306.1 Usual Time Limit.--Effective with claims filed after December 31, 1974, the beneficiary request and the provider claim must be filed on or before December 31 of the calendar year following the year in which the services were furnished. Services furnished in the last quarter of the year are considered furnished in the following year; i.e., the time limit is 2 years after the year in which such services were furnished.

EXAMPLE 1: A Medicare beneficiary received inpatient services at General SNF in September 1998. The beneficiary signed a request for Medicare payment at the time of admission. The SNF immediately submitted an admission notice and received a prompt reply. The facility billing for the services must be filed with the intermediary on or before December 31, 1999, the close of the year following the year in which the services were furnished.

EXAMPLE 2: A Medicare beneficiary received diagnostic tests at the outpatient department of General SNF in November 1998 but did not inform the SNF of his entitlement to Part B of Medicare at that time. His request for Medicare payment must be filed with the intermediary by December 31, 2000, the close of the following year the service "furnished." The services furnished in November 1998 are deemed to be furnished in 1999.

306.2 Extension of Time Limit Where Late Filing Is Due to Administrative Error.--Where HCFA error (i.e., misrepresentation, delay, mistake, or other action of HCFA or its intermediaries or carriers) causes the failure of the SNF to file a claim for payment within the time limit in §306.1, the time limit will be extended through the last day of the sixth calendar month following the month in which the error is rectified by notification to the SNF or beneficiary, but not beyond December 31 of the third calendar year after the year in which the services were furnished. (For services furnished during October -December of a year, the time limit may be extended no later than the end of the fourth year after that year.)

The administrative error which prevents timely filing of the claim may affect the SNF directly (or indirectly, i.e., by preventing the beneficiary or his representative from filing a timely request for payment.) Situations in which failure to file within the usual time limit in §306.1 will be considered to have been caused by administrative error include but are not limited to the following:

1. The failure resulted because the individual's entitlement to HI or SMI was not established until long after the month for which it was effective (e.g., a beneficiary is awarded 2 years of retroactive coverage).

2. The failure resulted from HCFA's failure to notify the individual that his entitlement to HI or SMI had been approved, or in giving him (or his representative or the SNF) cause to believe that he is not entitled to HI or SMI.

3. The failure resulted from misinformation from HCFA or the intermediary or carrier, e.g., that certain services were not covered under HI or SMI, although in fact they were covered.

4. The failure resulted from excessive delay by HCFA, the intermediary, or the carrier in furnishing information necessary for the filing of the claim.

5. The failure resulted from advice by HCFA or an authorized agent for HCFA that precluded the filing of a claim until the SNF receives certain information from the intermediary (e.g., an SNF following manual instructions does not file a billing for outpatient services where the services are expected to be paid for by worker's compensation; but the facility learns after the expiration of the time limit of the ultimate denial of workers' compensation liability).

The intermediary will submit to HCFA for advice any claim in which delay in establishing HI or SMI entitlement or notifying an individual of HI or SMI entitlement prevents the filing of a claim until more than 3 years after the year in which the services were furnished (4 years after the year, in the case of services furnished in the last quarter of the year).

EXAMPLE 1: Information submitted in connection with a claim for services during the period May 1998--September 1998, filing in March 2000, shows that the beneficiary's application for HI was initially denied. He was first notified on January 15, 2000, that he had HI effective May 1998. Under these circumstances, the intermediary may pay appropriate HI benefits for the services. Although the usual time limit expired December 31, 1999, the error in this case--delay in establishing HI entitlement--was not corrected until January 15, 2000, thus extending the time limit to July 31, 2000.

EXAMPLE 2: An individual requested enrollment in SMI in March 1998, the month before he attained age 65. He received covered outpatient services in July 1998, but did not request payment because he had not received notice of his SMI entitlement. Such notice was mailed to him on October 3, 1999. Although the regular time limit for the services in July 1998 expired on December 31, 1999, the claim will be considered promptly and timely filed if it is filed on or before April 30, 2000, (within the 6-month period following the month in which the notice was sent).

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308. EFFECT ON BENEFICIARY AND PROVIDER OF LATE FILING OR BENEFICIARY'S REFUSAL TO FILE

A. Skilled Nursing Facility Is Responsible for Not Filing Timely.--Where the beneficiary request was filed timely (or would have been filed timely had the SNF taken action to obtain a request from the patient whom the facility knew or had reason to believe might be a beneficiary) but the facility is responsible for not filing a timely claim, the SNF may not charge the beneficiary for the services except for such deductible and/or coinsurance amounts as would have been appropriate if Medicare payment had been made. The beneficiary is charged utilization days. (See § 528.)

B. Patient Refuses to Request Medicare Payment or SNF Is Unaware of His Eligibility.--The facility may charge the beneficiary for covered services where no timely request for payment is filed by or on behalf of the beneficiary because;

1. The beneficiary refused to file. (Utilization days will be charged, and if Part B services are rendered the Part B deductible will be credited to his SSA record.)

2. The patient failed to bring his entitlement or possible entitlement to the attention of the SNF and the SNF had no other reason to believe the patient had Medicare. If the patient later brings his entitlement to Part A or Part B (whichever is required for payment for the services) to the facility's attention after the time limit and the bill is not filed timely, utilization days will not be charged, and if Part B services are rendered the Part B deductible will not be credited.

310. FILING CLAIM WHERE USUAL TIME LIMIT HAS EXPIRED

Where it comes to the attention of a facility that health services which are or may be covered were furnished to a beneficiary but that the usual time limit in §306.1 on filing a claim for such services has expired, the facility should take the following action:

310.1 Part A Skilled Nursing Facility Services.-- Where the SNF accepts responsibility for late filing, it should file a no-payment bill. (See §§ 527ff.) Where the facility believes the beneficiary is responsible for a late filing, it should also file a no-payment bill and attach a statement explaining the circumstances which led to the late filing and giving the reasons for believing that the beneficiary (or other person acting for him) is responsible for the late filing and, if practicable, attach the statement of the beneficiary as to his view of these circumstances.

Where the SNF believes HCFA or its agents are responsible for the late filing, it should file a regular payment bill and attach a statement explaining its view of the circumstances which led to the late filing and, if practicable, the written explanation of the beneficiary as to such circumstances.

310.2 Part B Services (HCFA-1450 Billings).-- Where the facility accepts the responsibility for the late filing, it should submit an HCFA-1450 which contains the legend "late filed claim--provider fault" in the remarks section to differentiate it from a regular HCFA-1450. Provider liability is shown by using Occurrence Span Code 77. The intermediary will determine whether a span code 77 or 79 is appropriate.

Where the SNF believes the beneficiary is responsible for late filing, it should file a no-payment bill, attach a statement explaining the circumstances which led to late filing and setting forth reasons for belief that the beneficiary (or person acting for him) is responsible for the late filing and, if practicable, attach the statement of the beneficiary as to his view of the circumstances. Where the SNF believes HCFA or its agent is responsible for the late filing, it should proceed as in § 310.1.

310.3 Appeals.--Where the beneficiary does not agree with the determination that the claim was not filed timely or with the assignment to him of the responsibility for the late filing, the usual appeal rights are available to him, i.e., reconsideration, hearing (if the amount in controversy equals \$100 or more), etc. (See §383.) Where the provider is protesting the denial of payment or the assignment of responsibility for the late filing, no formal channels of appeal are available. However, the intermediary may, at the request of the provider, informally review its initial determination.

Time Limits--Part B Claims

315. TIME LIMIT FOR FILING PART B CLAIMS

For Medicare payment to be made for a claim for physician or other Part B services, the claim must be filed no later than the end of the calendar year following the year in which the service was furnished, except for services furnished in the last 3 months of a year, where the time limit is December 31 of the second year following the year in which the services were rendered. This time limit was effective with claims filed after March 1968. (See §§300.1 and 300.2 for effect of Federal nonworkdays and rules applicable to claims received in the mail.)

315.1 Extension of Item Limit Due to Administrative Error.-- Where administrative error (that is, misrepresentation, delays, mistake, or other action of HCFA or its intermediaries or carriers) causes the failure of a beneficiary or the provider, physician, or supplier to file a claim for payment within the time limit specified in § 315, the time limit will be extended through the close of the sixth calendar month following the month in which the error is rectified.

Consideration of possible extension of the time limit on Part B claims will be initiated by the intermediary only if there is a basis for belief that the claimant (the enrollee or his representative or assignee) has been prevented from timely filing by an administrative error; for example, he states that official misinformation caused the late filing, or the social security office calls to the contractor's attention a situation in which such error has caused late filing. (See § 306.3 for examples of administrative error.)

315.2 Time Limit Where a Skilled Nursing Facility Has Billed Improperly for Professional Component.--In some cases, an SNF may have incorrectly billed for a Part B professional component as a provider expense. For example, a physician's services were erroneously considered entirely administrative in nature and the error was not discovered until the final cost settlement. Where the claim which included the physician services was filed within the time limit, it establishes:

The date of discharge from the prior-stay hospital must have occurred on or after the first day of the month in which the beneficiary became entitled to Medicare.

Hospital days to which waiver of liability was applied cannot be used to satisfy the 3-day hospital stay requirement for SNF services.

The prior-stay hospital will usually send you a patient transfer form in accordance with your transfer agreement. When you have a transfer form on file showing the hospital's admission and discharge dates, or a written record of a telephone conversation with the transferring hospital containing this information, record these dates in Item 33 of the form HCFA-1450.

315.3 Responsibility When Claim Not Filed Timely.--When the time limit has expired on services payable on a reasonable charge basis, there is no requirement that a billing be filed. However, where a person (or organization) accepts assignment within the time limit but fails to submit a timely claim, he/she is barred by the terms of the assignment from collecting from the patient or others amounts in excess of the deductible and coinsurance for the services involved.

Special Provisions Related to Payment

317. RULES GOVERNING CHARGES TO BENEFICIARIES

A. General.--Under your provider agreement, you may charge a beneficiary only applicable deductible and coinsurance amounts and for noncovered services. Additional restrictions, implied by your provider agreement, on what you may collect or seek to collect from a beneficiary (or any party acting on the beneficiary's behalf) are set forth below. You must refund amounts incorrectly collected.

B. Requests and Requirements for Deposits and Other Payments.--You may not require, request, or accept a deposit or other payment from a Medicare beneficiary as a condition for admission, continued care, or other provision of services, except as follows:

o You may request and accept payment for a Part A deductible and coinsurance amount on or after the day to which it applies and payment for a Part B deductible and coinsurance amount at the time of or after the provision of the service to which it applies. You may not request or accept advance payment of Medicare deductible and coinsurance amounts.

o You may require, request, or accept a deposit or other payment for services if it is clear that the services are not covered by Medicare. See subsection C for the effect of a beneficiary request for submission of a demand bill. See subsection D for charges for personal comfort and convenience services.

C. Effect of Submission of Demand Bill by SNF.--If you believe that a beneficiary requires only a noncovered level of care beginning with admission or at some point thereafter, give the beneficiary proper notice to that effect. If the beneficiary disagrees and asks you to submit a demand bill to the intermediary, you may not require, request, or accept a deposit or other payment from the beneficiary for the services until the intermediary makes an initial determination that the services are not covered by Medicare.

EXCEPTION: You may request and accept payment for a potential Part A coinsurance amount no earlier than the day to which the coinsurance applies if the services are found to be covered.

If you believe that the services are noncovered for reasons other than the level of care required to be furnished (e.g., the 3-day prior hospitalization requirement is not met, the beneficiary is not admitted to the SNF within 30 days (or longer period, if appropriate) of discharge from the hospital, or SNF benefits are exhausted), you must still submit a demand bill upon request. You may require, request, and accept a deposit or other payment from the beneficiary while the intermediary determination is pending.

D. Charges for Personal Comfort and Convenience Services.--You may charge a beneficiary for noncovered personal comfort and convenience services (e.g., rental of a television set or the customary charge differential for a private room which is not medically necessary) if the beneficiary requests these services with knowledge of the charges. Also, you may require an advance deposit from the beneficiary for the noncovered services requested by the beneficiary if this is your practice

with non-Medicare patients. You may not, however, require a beneficiary to request such noncovered services as a condition for admission or continued care.

E. Other Restrictions and Requirements.--Medicare regulations include several other special limitations that are covered by or based on the provider agreement:

- o You may not evict or threaten to evict a beneficiary for inability to pay a deductible or coinsurance amount applying under Medicare;

- o You may not charge a beneficiary for your agreement to admit or readmit him/her as of some specified future date for inpatient services which are or may be covered under Medicare (as distinguished from charging a beneficiary for holding a bed for him/her at his/her request as is permissible); and

- o You may not charge a beneficiary who is receiving inpatient care which is or may be covered by Medicare for failure to remain in your facility for a certain period of time or for failure to give you advance notice of departure.

If you require the execution of an admission contract by the beneficiary (or by another person acting on behalf of the beneficiary), the terms of the contract must be consistent with this section.

F. Compliance.--Improper charges to beneficiaries under the above restrictions and requirements constitute violations of the provider agreement under §1866(a)(1) of the Act. Noncompliance with these restrictions and requirements may, depending on the nature and extent of the violations, subject you to termination of your provider agreement.

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The date of discharge from the prior-stay hospital must have occurred on or after the first day of the month in which the beneficiary became entitled to Medicare.

Hospital days to which waiver of liability was applied cannot be used to satisfy the 3-day hospital stay requirement for SNF services.

The prior-stay hospital will usually send you a patient transfer form in accordance with your transfer agreement. When you have a transfer form on file showing the hospital's admission and discharge dates, or a written record of a telephone conversation with the transferring hospital containing this information, record these dates in Item 33 of the form HCFA-1450.

415. BENEFICIARY NOTIFICATION FOR CONSOLIDATED BILLING

Notify the beneficiaries and the beneficiary's physician about the requirements for consolidated billing at the time the beneficiary is admitted to the SNF. Refer to section 206 for consolidated billing coverages and exclusions.

Inform them of the requirement that certain services are not covered unless the SNF bills for them, and also provide a listing of suppliers with which you have agreements, for the supplier types that furnish services that the beneficiary may need.

The interest period begins on the day after payment is due and ends on the day of payment.

EXAMPLES:	<u>Clean Paper Claim</u>	<u>Clean Electronic Claim</u>
Date Received	November 1, 1993	November 1, 1993
Payment Due	November 28, 1993	November 15, 1993
Payment Made	December 3, 1993	December 2, 1993
Interest Begins	December 2, 1993	December 2, 1993
Days for Which Interest Due	2	1
Amount of Payment	\$100	\$100
Interest Rate	5.625%	5.625%

Use the following formula:

o For the clean paper claim-- $\$100 \times .05625 \times 2$ divided by 365 = \$.0308 or \$.03 when rounded to the nearest penny.

o For the clean electronic claim-- $\$100 \times .05625 \times 1$ divided by 365 = \$.0154 or \$.02 when rounded to the nearest penny.

When interest payments are applicable, your intermediary indicates for the individual claim the amount of interest on their remittance record to you.

D. Definition of "Clean Claim"--A "clean" claim is one that does not require your intermediary to investigate or develop external to their Medicare operation on a prepayment basis.

Examples of clean claims are those that:

- o Pass all edits (intermediary and Common Working File (CWF)) and are processed electronically;
- o Do not require external development by your intermediary and are not approved for payment by CWF within 7 days of your intermediary's original claim submittal for reasons beyond your intermediary's or your control;
- o Are investigated within your intermediary's claims, medical review, or payment office without the need to contact you, the beneficiary, or other outside source;
- o Are subject to medical review but complete medical evidence is attached by you or forwarded simultaneously with EMC records in accordance with your intermediary's instructions. If medical evidence must be requested, see first item under subsection D; or
- o Are developed on a postpayment basis.

E. Other Claims--Claims that do not meet the definition of "clean" claims are considered "other" claims. Other claims require investigation or development external to your intermediary's Medicare operation on a prepayment basis. Other claims are those that are not approved by CWF which your intermediary identifies as requiring outside development. Examples are claims on which your intermediary:

- o Requests additional information from you or another external source. This includes routine data omitted from the bill, medical information, or information to resolve discrepancies;

- o Requests information or assistance from another contractor. This includes requests for charge data from the carrier or any other request for information from the carrier;
- o Develops MSP information;
- o Requests information necessary for a coverage determination;
- o Performs sequential processing when an earlier claim is in development; and
- o Performs outside development as result of a CWF edit.

For purposes of counting the 7 day period described above, all intermediaries (including CWF) start their count on the day after their original query or bill submittal.

502. BILLING MEDICARE FOR THE PROFESSIONAL COMPONENT OF SNF-BASED PHYSICIAN'S SERVICES

Section 275 defines "facility-based physicians," "professional component," and "facility component." The facility component for facility-based physician's services is always included in the customary charge structure (e.g., as part of the accommodations charge) and the facility receives payment under SNF PPS. (See Provider Reimbursement Manual, §§2108ff.)

Part B benefits for the professional component of physician or other nonprovider services are payable on a fee schedule basis. There are two methods of claiming these benefits:

- o The patient (or his representative) may request payment on the basis of an itemized bill (receipted or unpaid); or

- o The patient may assign his/her claim to the source of medical treatment or services. By accepting assignment, the physician (or facility authorized to bill and receive payment for physician services) can claim the payment. (See §§508-510.) The physician or facility accepting the assignment must agree to consider the reasonable charge determined by the carrier as the full charge for the service.

Use the HCFA-1500, Health Insurance Claim Form, to bill the carrier for physician services.

503. REDUCTION IN PAYMENT DUE TO P.L. 99-177

A. General.--Public Law 99-177, the Balanced Budget and Emergency Deficit Control Act of 1985 (Gramm-Rudman-Hollings), provides for an automatic deficit reduction procedure to be established for Federal FYs 1986 through 1991.

Each payment amount is reduced by a specified percentage which cannot exceed 1 percent for FY 1986 and 2 percent for each subsequent year in which sequestration takes place. The reduction percentages are proportionately decreased in any year in which the excess deficit is small enough to permit a smaller reduction.

The intermediary reduces all Medicare program payments after applying deductible, coinsurance, and any applicable MSP adjustment. It reduces each claim or interim payment (including PIP).

B. Definitions.--

Date of Service: The intermediary applies the reduction for all SNF services based upon the through date on the bill. You may bill earlier services separately to avoid the reduction.

Reduction Amount: The applicable reduction percentages by FY are:

- o Federal FY 1986 - 1 percent for all services (Part A and Part B) for the period March 1, 1986 through September 30, 1986.
- o Federal FY 1987 - There is no sequestration order for this period.
- o Federal FY 1988 - 2.324 percent as follows:
 - November 21, 1987 through March 31, 1988, for all Part A inpatient hospital services and all items and services (other than physicians' services) under Part B.
 - November 21, 1987 through December 31, 1987, all other Part A services.
- o Federal FY 1989 - There is no sequestration order for this period.
- o Federal FY 1990 -
 - 2.092 percent from October 17, 1989 through December 31, 1989, for items and services under Part A.
 - 2.092 percent from October 17, 1989 through March 31, 1990, for items and services under Part B.
 - 1.4 percent from April 1, 1990 through September 30, 1990, for items and services under Part B.
- o Federal FY 1991 -
 - There is no sequestration for Part A.
 - 2.00 percent from November 1, 1990 through December 31, 1990, for items and services under Part B.

The amount of the reduction is determined by October 15 for each year. You will be informed by your intermediary of the specific percentage by which bills are reduced after the final determination of the amount is made.

Submit a HCFA-1450 in the following situations where utilization is charged to the patient, even though no program payment can be made:

- o The patient or his representatives refuses to request that payment be made on his behalf. (See §302.5.);
- o The physician refuses to make an otherwise required certification for a reason other than lack of medical necessity. (See §220.);
- o The time limitation on filing for covered services expires before you file a claim for payment and you are responsible for the late filing. (See §§310ff.) A bill must be submitted to record utilization and applicable deductibles;
- o You fail to submit needed information ; and
- o The intermediary has notified you that a limitation of liability decision finds you at fault.

C. Changes Required in Bill Payment Procedures.--You may bill separately for all services prior to the effective date to avoid the reduction of the entire bill. Split any bills spanning the effective date of the reduction.

The intermediary reduces all bills with dates of service or through dates on or after the effective date. It will not develop bills which may contain earlier services, and will not accept adjustment bills to correct earlier bills spanning the effective date.

You can expect reduction on final payments and interim payments (cost-based interim payments), and PIP payments and PPS pass-through payments. When payment is for laboratory services, the intermediary makes the reduction after it decides whether the charge or fee schedule is lower.

The intermediary adjusts payment amounts, not payment rates. It applies the reduction to the amount that would have been paid before P.L. 99-177, i.e., after reduction for deductible, coinsurance and MSP. This provides a slightly higher payment to you than applying the percentage reduction before deductible, coinsurance and MSP.

You may not collect the reduction amount from beneficiaries.

In these cases, complete all items except the block set aside for intermediary use on the bill the same as on a payment bill.

If the patient or his representative refuses to sign a request for payment, submit a bill upon discharge or death so that utilization days will be charged. You may bill the patient for services.

If a physician refuses to sign a certification, even though he agrees that extended care services are required, no program payment can be made, but submit a bill upon discharge or death so that utilization days can be charged. However, the patient cannot be billed for any covered services, since your agreement with the Secretary precludes it. If the needed information is not submitted, or if an adverse limitation of liability decision was made, finding only you at fault under the limitation of liability provisions, submit a bill upon discharge or death so that utilization days may be charged. Do not bill the patient for Medicare services.

Billing Under SNF PPS

528. SNF PPS BILLING

Under SNF PPS, beneficiaries must meet the regular eligibility requirements for a SNF stay. That is, the beneficiary must have been an inpatient of a hospital for a medically necessary stay of at least 3 consecutive calendar days. In addition, the beneficiary must have been transferred to a participating SNF within 30 days after discharge from the hospital, unless the exception in §212.3B. To be covered, the extended care services must be needed for a condition which was treated during the patient's qualifying hospital stay, or for a condition which arose while in the provider for treatment of a condition for which the beneficiary was previously treated in a hospital.

528.1 Coverage and Patient Classification

Under SNF PPS, covered SNF services include posthospital SNF services for which benefits are provided under Part A (the hospital insurance program) and all items and services for which, prior to July 1, 1998 payment had been made under Part B (the supplementary medical insurance program) but furnished to SNF residents during a Part A covered stay *other than*

- physician's services,
- physician assistant services,
- nurse practitioner,
- clinical nurse specialist services,
- certified mid-wife services,
- qualified psychologist services,
- certified registered nurse anesthetist services,
- cardiac catheterization services,
- computerized axial tomography (CT scans),
- magnetic resonance imaging (MRIs),
- radiation therapy,
- ambulatory surgery involving the use of an operating room,
- emergency services,
- certain dialysis-related services including covered ambulance transportation to obtain the dialysis services,
- erythropoietin (EPO) for certain dialysis patients,
- hospice care related to a terminal condition,
- ambulance trips that convey a beneficiary to the SNF for admission or from the SNF following discharge,
- ambulance services that convey a beneficiary to a facility to receive any of the previously mentioned excluded services, and,
- for services furnished during 1998 only, the transportation costs of electrocardiogram equipment for electrocardiogram test services.

Coverage determinations (i.e., level of care determinations) are significantly simplified by adopting the system for classifying residents based on resource utilization known as Resource Utilization Groups, Version III (RUG-III). Facilities will utilize information from the Minimum Data Set (MDS) version 2.0, resident assessment instrument (RAI), to classify residents into the RUG-III groups. The MDS contains a core set of screening, clinical, and functional status elements, including common definitions and coding categories, that form the basis of a comprehensive assessment. The assessments are required by law and are to be performed based on a predetermined schedule for purposes of Medicare reimbursement (see Medicare Assessment Schedule chart below). The software programs used by providers to assign patients to appropriate RUG-III groups based on the MDS 2.0, called groupers, are available from many software vendors. The grouper can also be accessed directly by providers from HCFA's Internet web site at: <http://www.hcfa.gov/medicare/hsqb/mds20>.

For Medicare billing purposes, there is a payment code associated with each of the 44 RUG-III groups, and each assessment applies to specific days within a resident's SNF stay. SNFs that fail to perform assessments timely are paid a default payment for the days of a patient's care for which they are not in compliance with this schedule. Facilities will send each beneficiary's MDS assessment to the State and claims for Medicare payment to the intermediary on a 30-day cycle.

Beneficiaries that are classified to any of the highest 26 of the 44 RUG-III groups automatically meet the SNF level of care definition for purposes of coverage if the services are reasonable and necessary. For a beneficiary assigned to one of these upper 26 groups, the required initial certification and periodic recertifications essentially serve to verify the correctness of the beneficiary's assignment to that particular RUG-III group. RUG-III hierarchy categories that automatically confer Medicare coverage (assuming services provided are reasonable and necessary) include

1. Rehabilitation;
2. Extensive Care;
3. Special Care; or
4. Clinically Complex.

A beneficiary who is assigned to any of the lower 18 of the 44 RUG-III groups is not automatically classified as meeting or not meeting the SNF level of care definition. Instead, the beneficiary must receive an individual level of care determination using existing administrative criteria and procedures.

Once a SNF is included in PPS coverage may not be based solely on the basis of subcutaneous injections; hypodermoclysis; overall management and evaluation of care plan; observation and assessment of patient's changing condition; and patient education services. Also, external feedings are recognized as a skilled service only in those instances where the beneficiary receives at least 25 percent of daily caloric requirements and at least 501 milliliters of fluid per day through such feedings.

These changes in the existing administrative criteria become effective on the date the individual SNF enters SNF PPS, and not before, i.e, for the SNF's first cost reporting period beginning on or after July 1, 1998. Any beneficiary who, upon the date a SNF comes under SNF PPS, was currently in a covered SNF stay will not have his or her coverage terminated on the basis of the change in the method of making level of care determinations under the PPS for the duration of that covered stay.

MEDICARE ASSESSMENT SCHEDULE

Medicare MDS Assessment Type	Reason for Assessment (AA8b code)	Assessment Reference Date	Number of Days Authorized for Coverage and Payment **	Applicable Medicare Payment Days
5 day	1	Days 1 - 8*	14	1 through 14
14 day	7	Days 11 - 14	16	15 through 30
30 day	2	Days 21 - 29	30	31 through 60
60 day	3	Days 50 - 59	30	61 through 90
90 day	4	Days 80 - 89	10	91 through 100

*If a patient expires or transfers to another facility before day 8, the facility must still prepare an MDS as completely as possible for the RUG-III classification and Medicare payment purposes. Otherwise the days will be paid at the default rate.

**This column represents the maximum number of days until the next assessment. If the patient is discharged or recovers to the extent that a covered level of care no longer exists, coverage ends with the date of discharge or recovery if earlier.

528.2 Payment Provisions

Section 1888(e) of the BBA of 1997 provides the basis for the establishment of the per diem Federal payment rates applied under PPS to SNFs that received their first payment from Medicare on or after October 1, 1995. A transition period applied for those SNFs who first accepted payment under the Medicare program prior to October 1, 1995. The BBA sets forth the formula for establishing the rates as well as the data on which they are based. In addition, this section prescribes adjustments to such rates based on geographic variation and case-mix and the methodology for updating the rates in future years. For the initial period of the PPS beginning on July 1, 1998 and ending on September 30, 1999, all payment rates and associated rules were published in the Federal Register before May 1, 1998. For each succeeding fiscal year, the rates will be published in the Federal Register before August 1 of the year preceding the affected fiscal year.

Providers currently enrolled in the Multi-State Case Mix and Quality Demonstration could remain in the demonstration until the end of their current fiscal year. Providers with fiscal years that ended on June 30, 1998 converted to PPS payment on the first day of their fiscal year beginning with the cost reporting year July 1, 1998, with all providers having transitioned by June 30, 1999.

The PPS incorporates per diem Federal rates based on mean SNF costs in a base year updated for inflation to the first effective period of the system. The Federal payment rates were developed by HCFA using allowable costs from hospital-based and freestanding SNF cost reports from reporting periods beginning in fiscal year 1995. The data used in developing the Federal rates incorporate an estimate of the amount payable under Part B for covered SNF services furnished during fiscal year 1995 to individuals who were residents of the facility and receiving Part A covered services. Costs were updated to the first effective year of the PPS (15 month period beginning July 1, 1998) using a SNF market basket index and standardized for facility differences in case mix and for geographic variations in wages. Providers that received "new provider" exemptions were excluded from the data base used to compute the federal payment rates. In addition, costs related to "exceptions payments" were excluded from the data base used to compute the federal payment rates. In accordance with the formula prescribed in the BBA, the federal rates are set at a level equal to the weighted mean of freestanding costs plus 50 percent of the difference between the freestanding mean and the mean of all SNF costs (hospital-based and freestanding) combined. Payment rates were computed and applied separately for facilities located in urban and rural areas.

In addition, the portion of the Federal rate attributable to wage-related costs is adjusted by an appropriate wage index.

The Federal rate incorporates adjustments to account for facility case mix using Resource Utilization Groups (RUG-III) Version III, the patient classification system used under the national PPS. RUG-III, is a 44-group patient classification system that provides the basis for the case-mix payment indices (or relative payment weights) used both for standardization of the Federal rates and subsequently to establish case-mix adjustments to the rates for patients with different service use. A case-mix adjusted payment system measures the intensity of care (e.g., hours of nursing or therapy time needed per day) and services required (i.e., requirement of a ventilator) for each resident and then translates it into a specific payment level. Information from the Minimum Data Set version 2.0 (MDS), resident assessment instrument (RAI), is used by SNFs to classify residents into one of 44 RUGS-III groups. SNFs complete these assessments according to an assessment schedule specifically designed for Medicare payment, that is on the 5th, 14th, 30th, 60th, and 90th days after admission to the SNF. For Medicare billing purposes, there is a Health Insurance PPS rate code (HIPPS) associated with each of the 44 RUG-III groups, and each assessment applies to specific days within a resident's SNF stay. SNFs that fail to perform assessments timely are paid a default payment for the days of a patient's care for which they are not in compliance with this schedule.

The Federal per diem rates effective July 1, 1998, were effective through September 30, 1999. For fiscal years 2000 through 2002 the rates are increased by a factor equal to the SNF market basket index amount minus 1 percentage point. For subsequent fiscal years, the rate is increased by the applicable SNF market basket index amount. The initial Federal rates were published in the Federal Register in 1998, and are updated annually.

Section 1888(e)(8) of the BBA prohibits judicial or administrative review on matters relating to the establishment of the Federal rates. This includes, but is not limited to, the methodology used in the computation of the federal rates, the case mix methodology, and the development and application of the wage index.

Beginning with a provider's first cost reporting period beginning on or after July 1, 1998 there was a transition period covering 3 cost reporting periods. During this transition phase, SNFs receive a payment rate comprised of a blend between the Federal rate and a facility specific rate based on each facility's FY 1995 cost report. SNFs that received their first payment (interim or otherwise) from Medicare on or after October 1, 1995, under present or previous ownership, are excluded from the transition period and payment is made according to the Federal rate only.

For SNFs that qualify for the transition period, the composition of the blended rates vary depending on the year of the transition. For the first cost reporting period beginning on or after July 1, 1998 payment is based on 75 percent of the facility specific rate and 25 percent of the Federal rate. In the next cost reporting period, the rate is comprised of 50 percent of the facility specific rate and 50 percent of the Federal rate. In the following cost reporting period, the rate is 25 percent of the facility specific rate and 75 percent of the Federal rate. For all subsequent cost reporting periods, payment is based entirely on the Federal rate.

The facility specific payment rate utilized for the transition is computed using the allowable costs of SNF services for cost reporting periods beginning in fiscal year 1995 (cost reporting periods beginning on or after October 1, 1994, and before October 1, 1995). Included in the facility specific per diem rate is an estimate of the amount payable under Part B for covered SNF services furnished during fiscal year 1995 to individuals who were residents of the facility and receiving Part A covered services. In contrast to the Federal rate, the facility specific rate includes amounts paid for exceptions to the routine cost limits. "New Provider" exemptions from the routine cost limits are also taken into account but only to the extent that routine costs do not exceed 150 percent of the routine

cost limit. Part A Medicare cost associated with approved educational activities, as defined in §413.85, of the Act, are not included in the facility-specific per diem rate. A facility's actual reasonable cost of approved educational activities are separately identified and apportioned to the Medicare program for payment purposes on the Medicare cost report effective for cost reporting periods beginning on or after July 1, 1998.

For facilities participating in the Nursing Home Case-Mix and Quality Demonstration (RUG-III), the Part A Medicare costs used to compute the facility-specific per diem rate consists of the aggregate RUG-III payment received for services furnished in calendar year 1997 plus the routine capital costs and ancillary costs (other than occupational therapy, physical therapy, and speech pathology costs) as reported on the facility's Medicare cost report that begins in calendar year 1997.

For those low volume SNFs that received a prospectively determined payment rate for SNF routine services in the FY 95 cost reporting period, under §888(d) of the Act and part 413, subpart I, the facility-specific per diem rate is the applicable prospectively determined payment rate plus Medicare ancillary cost per diem.

The facility specific rate is updated for each cost reporting period after fiscal year 1995 until the cost reporting period beginning on or after July 1, 1998, by a factor equal to the SNF market basket percentage minus 1 percentage point. For the fiscal years 1998 and 1999, this rate will be updated by a factor equal to the SNF market basket amount minus 1 percentage point, and for each subsequent cost reporting period, it will be updated by the applicable SNF market basket index amount.

528.3 Billing SNF PPS Services

SNFs are required to report inpatient Part A PPS billing data as follows.

Separate bills are required for admissions that span update effective dates (October 1999, April 1, 2000, October 1, 2000).

Report revenue code, 0022, and a HIPPS Rate Code on the same line to identify the RUG-III group the beneficiary was classified into as of the assessment reference date. These data are required in addition to standard UB-92 data elements.

Use Type of Bill 21X. See electronic record formats for the UB-92 flat file and the Medicare A 837 Health Care Claim. These record formats require an assessment (service) date on the IP Ancillary Services Data record type for SNF Type of Bill 21X.

- Revenue Code, Form Locator (FL) 42, (Record Type (RT) 60, field 4), must contain revenue code 0022. This code indicates that this claim is being paid under the PPS. This revenue code can appear on a claim as often as necessary to indicate different HIPPS Rate Code(s) or assessment periods.
- HCPCS/Rates, FL44, (RT60, field 5), must contain a five digit "HIPPS Code" (AAA00-SSC54). The first three positions of the code contain the MDS RUG-III group and the last two positions of the code contain a two digit type of assessment code for payment purposes. See Tables 1 and 2 below for valid RUG codes and assessment codes.
- The Service Date, FL45, (RT60, field 12), must contain an assessment reference date when FL42 contains revenue code 0022 unless FL44 contains HIPPS Rate Code AAA00.

- Service Units, FL46, (RT60, field 8), must contain the number of covered days for each HIPPS rate code and, if applicable, the number of visits for each rehabilitation therapy code.
- Total Charges, FL47, (RT60, field 9), should contain zero total charges when the revenue code is 0022.
- For accommodation revenue codes (010x-021x), total charges must equal the rate times the units. The SNF PRICER will calculate and return the rate for each line item with revenue code 0022. The claims processing standard system will multiply the rate by the number of units to get the payment amount and then sum the payment amounts for all lines with revenue code 0022 and make the appropriate payment. Payments will not be made based on the total charges shown in Revenue Code 0001.
- When a HIPPS rate code of RUAxx, RUBxx and/or RUCxx is present, a minimum of two rehabilitation therapy ancillary codes are required (042x and/or, 043x and/or, 044x). When a HIPPS rate code of RHAxx, RHBxx, RHCxx, RLAxx, RLBxx, RMAxx, RMBxx, RMCxx, RVAxx, RVBxx and/or RVCxx is present, a minimum of one rehabilitation therapy ancillary revenue code is required (042x, 043x or 044x). Bills that are missing required rehabilitation therapy ancillary revenue codes are to be returned to the SNF for resubmission.
- The number of units (FL46) on lines with revenue codes 0022 must be equal to the number of covered days on the claim minus any leave of absence days billed with revenue code 018x.

TABLE 1 HIPPS RATE CODES

The HIPPS rate code consists of the RUG-III code obtained from the MDS Grouper and a two digit modifier (See Table 2) to indicate the assessment type attributable to the RUG-III code. Both components of the HIPPS rate code must be present for a claim to be paid. There are a total of 45 HIPPS rate codes and a total of 21 modifiers.

AAA (the default code)
 BA1, BA2, BB1, BB2
 CA1, CA2, CB1, CB2, CC1, CC2
 IA1, IA2, IB1, IB2
 PA1, PA2, PB1, PB2, PC1, PC2, PD1, PD2, PE1, PE2
 RHA, RHB, RHC, RLA, RLB, RMA, RMB, RMC, RUA, RUB, RUC, RVA, RVB, RVC
 SE1, SE2, SE3, SSA, SSB, SSC

TABLE 2 HIPPS ASSESSMENT INDICATOR CODES

Code	Definition
00	Default code
01	5-day Medicare-required assessment/not an initial admission assessment
02	30-day Medicare-required assessment
03	60-day Medicare-required assessment
04	90-day Medicare-required assessment

Code	Definition
05	Readmission/Return Medicare-required assessment
07	14-day Medicare-required assessment/not an initial admission assessment
08	Off-cycle Other Medicare-required assessment (OMRA)
11	5-day (or readmission/return) Medicare-required assessment AND initial admission assessment
17	14-day Medicare-required assessment AND initial admission assessment: This code is to facilitate the planned automated generation of all assessment indicator codes. Previously, code 07 was used for all 14-day Medicare assessments regardless of whether it is also a clinical initial admission assessment (i.e., an assessment mandated as part of the Medicare/Medicaid certification process).
18	OMRA replacing 5-day Medicare-required assessment
28	OMRA replacing 30-day Medicare-required assessment
30	Off-cycle significant change assessment (outside assessment window)
31	Significant change assessment replacing 5-day Medicare-required assessment
32	Significant change assessment replacing 30-day Medicare-required assessment
33	Significant change assessment replacing 60-day Medicare-required assessment
34	Significant change assessment replacing 90-day Medicare-required assessment
35	Significant change assessment replacing a readmission/return Medicare-required assessment
37	Significant change assessment replacing 14-day Medicare-required assessment
38	OMRA replacing 60-day Medicare-required assessment
40	Off-cycle significant correction assessment of a prior assessment (outside assessment window)
41	Significant correction of a prior assessment replacing a 5-day Medicare-required assessment
42	Significant correction of a prior assessment replacing 30-day Medicare-required assessment
43	Significant correction of a prior assessment replacing 60-day Medicare-required assessment
44	Significant correction of a prior assessment replacing 90-day Medicare-required assessment
45	Significant correction of a prior assessment replacing a readmission/return assessment
47	Significant correction of a prior assessment replacing 14-day Medicare-required assessment
48	OMRA replacing 90-day Medicare-required assessment
54	90-day Medicare assessment that is also a quarterly assessment
78	OMRA replacing 14-day Medicare-required assessment

- A Significant Change in Status Assessment is completed when triggered by the guidelines on pages 2-8 through 2-11 in the current version of the Resident Assessment Instrument, Minimum Data Set, Version 2.0.
- An Other Medicare Required Assessment is completed only when a beneficiary discontinues all occupational, physical, and/or speech therapy.

A Significant Correction Of Prior Full Assessment (i.e., the Medicare Required Assessment, an OMRA replacement or an SCSA replacement) is completed when the SNF identifies that it 1) made a factual error in Section(s) A, AA, AB, AC or AD of the MDS for a claim that has already been submitted for payment; or 2) submitted an incorrect HIPPS rate code based on an MDS that was either inaccurate or incomplete for a claim that has already been submitted for payment, within 30 days of the assessment reference date. If a different HIPPS rate code is identified, payment is

made for up to the number of days (units of service) between the SNF significant correction assessment reference date and the next Medicare required assessment or other off-cycle

- assessment, whichever comes first.
- When a Significant Change in Status or Other Medicare Required Assessment is performed during the assessment window of a Medicare required assessment (i.e., 5 day, 14 day, 30 day, 60 day or 90 day) it takes the places of (i.e., replaces) the 5 day, 14 day, 30 day, 60 day, or 90day Medicare Required Assessment.

System Edits .--Standard system edits verify the following situations:

- To insure that revenue code 0022 is not reported on any bill type other than 21X;
- To insure that a valid HIPPS rate code is always present on revenue code 0022;
- To insure that all revenue code 0022 lines have units > 0;
- To insure that revenue code total charges line 0001 must equal the sum of the individual total charges lines;
- To insure that the length of stay in the statement covers period, from and through dates equals the total days for accommodations revenue codes 010x-021x, including revenue code 018x (leave of absence); and
- To insure that the sum of revenue codes 010x-021x units minus revenue code 018x, leave of absence units is equal to the sum of PPS revenue code 0022 units.

Billing Ancillary Services Under SNF PPS.- When coding PPS bills for ancillary services associated with a Part A inpatient stay, the traditional revenue codes will continue to be shown in FL 42, e.g., 0250 - Pharmacy, 042x - Physical Therapy, in conjunction with the appropriate entries in Service Units, FL46 and Total Charges, FL47.

- SNFs are required to report the number of units in FL 46 based on the procedure or service. Specific instructions for reporting units are contained in the specific section for the procedure or service.
- SNFs are required to report the actual charge for each line item, in Total Charges, FL 47.
- The accommodation revenue code 018x, (RT 50, field 4) (leave of absence) will continue to be used in the current manner including the appropriate UB92 occurrence span code, 74 (RT 40, field 28-33) and date range.

Demand Bills.--Demand bills are submitted as usual, indicating the beneficiary requested the noncovered claim be submitted by the SNF to the intermediary for consideration and approval. The HIPPS Rate Codes and the 0022 revenue code for SNF PPS must be present on the demand bill.

528.4 Determining Part A Admission and Discharge Dates

Note that the following instructions apply to determining Part A admission and discharge dates for billing Medicare. Consult instructions for completing the assessment for rules related to that.

A Date of Admission.- The beneficiary becomes a SNF resident for Part A Consolidated Billing purposes when admitted to the SNF in a Medicare certified bed . This could be a first time admission or a readmission following events described in section B. Services on and after this day

are included in the PPS rate and cannot be billed by other providers and suppliers unless excluded as described in §§531.

B Date of Discharge.- The beneficiary is considered discharged from the SNF when any of the following occur.

(1) The beneficiary is admitted as an inpatient to a Medicare participating hospital or critical access hospital or admitted as resident to another SNF. Even if the beneficiary returns to the SNF by midnight of the same day, the beneficiary is considered discharged, 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 should submit a new bill type 211.

The beneficiary receives outpatient services from a Medicare participating hospital or critical access hospital, but only with respect to certain service identified in §§ 531. Other outpatient services furnished by the hospital or critical access hospital must be billed by the SNF.

Medicare systems are set up so that the SNF need not submit a discharge bill where this situation applies. Edits allow hospitals and critical access hospitals to bill for these services for a SNF resident. Receipt of outpatient services by another provider does not normally result in SNF discharge.

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.

If you should question whether the beneficiary is a SNF resident or confined to home, ask your intermediary.

The beneficiary is formally discharged or otherwise departs for reasons other than described in paragraphs (1) through (3) above. However, if the beneficiary is readmitted or returns by midnight of the same day, he is not considered discharged 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.

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

Billing for Medical and Other Health Services

529. BILLING FOR MEDICAL AND OTHER HEALTH SERVICES--GENERAL

Use Form HCFA-1450 (UB-92) to bill for the covered Part B services (see §260A) furnished to inpatients whose benefit days are exhausted, or who are not entitled to have payment made for these services under Part A (e.g., 3-day prior stay requirement is not met). Use it also to bill for covered Part B services rendered to outpatients (§260B) and for ambulance services. Bill under Part B, outpatient physical therapy, speech therapy, and, occupational therapy services furnished to inpatients where the beneficiary has exhausted his benefits under Part A or is otherwise not eligible for them.

When the intermediary denies a Part A bill because the stay is not a covered level of care and no Part A program payment is possible, some or all services may be medically necessary and can be covered as ancillary services under Part B. Normally bill the intermediary unless the service is an exception identified that must be submitted to the carrier or DMERC. Sections 529 through 544 provide specific billing instructions.

If accommodation services are not medically necessary and program payment is not possible under waiver, and if the ancillary services are determined to be not medically necessary, do not complete a bill since no payment can be made. In this situation, if the ancillary services are determined to be medically necessary, the intermediary will ask you to complete a Part B bill.

No bill is required when:

- o The patient is not enrolled under Part B;
- o It is obvious that only noncovered services have been furnished;
- o Payment was made or will be made by the Public Health Service, VA, or other governmental entity;
- o Workers' Compensation has paid or will pay the bill; or
- o Payment was made by liability, no-fault insurance, group health plan, or a large group health plan.

529.1 Determining How Much to Charge Before Billing Is Submitted.--You may be able to determine from your own records, from a transferring hospital, or from the patient the extent to which the Part B cash deductible is met. You may charge the patient for the unmet deductible and coinsurance. Submit a bill even if no payment can be made because the unmet Part B cash deductible exceeds the covered charges. In addition, a bill is required when you become aware that no bill has been submitted for covered services even though the time limitation for filing has expired.

529.2 Charges for Services Provided in Different Accounting Years.--Do not put charges for services provided in different accounting years on the same bill. At the end of your accounting year, submit a bill which contains the charges for all services furnished to the patient since the last bill through the end of the year. Include bills in which the deductible covers full charges. Put services furnished in the succeeding accounting year on a separate bill. Complete all items on the subsequent bill.

529.3 General Payment Rules and Application of Part B Deductible and Coinsurance.--Section 1888(e)(9) of the Social Security Act 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 will be paid. Where despite the fee schedule the particular service is priced based on individual consideration the fee amount will be determined by individual consideration. Some specific services continue to be paid on a cost basis. These are specifically identified in § 531. Where payment is made under a fee schedule the beneficiary's deductible and coinsurance are based on approved amount. Where payment is made on a cost basis deductible and coinsurance are based on charges for the service.

529.4 Definition of SNF Resident for Part B.--

A Start of Residency.- The beneficiary becomes a SNF resident for Part B Consolidated Billing purposes when :

1. Part A benefits are exhausted and the beneficiary remains in the facility in a Medicare certified or non certified bed, or
2. 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 following events described in section B, or.

3 If skilled level of care is not met, covered Part B services are included in consolidated billing unless excluded as described in §§531.

B End of Residency.- Residency is ended when the beneficiary is discharged from the SNF when any of the following occur.

1 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 is considered discharged, 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 should submit a new bill type 221.

2 The beneficiary receives outpatient services from a Medicare participating hospital or critical access hospital, but only with respect to certain service identified in § 531. Other outpatient services furnished by the hospital or critical access hospital must be billed by the SNF.

Medicare systems are set up so that the SNF need not submit a discharge bill where this situation applies. Edits allow hospitals and critical access hospitals to bill for these services for a SNF resident.

Receipt of outpatient services by another provider does not normally result in SNF discharge.

3 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. If you should question whether the beneficiary is a SNF resident or confined to home, ask your intermediary.

4 The beneficiary is formally discharged or otherwise departs for reasons other than described in paragraphs (1) through (3) above. However, if the beneficiary is readmitted or returns by midnight of the same day, he is not considered discharged 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.

529.5 Services Provided in SNF Wholly Owned or Operated by Hospital Within Three Days Before Hospital Admission.--Section 1886(a)(4) of the Act includes a preadmission "payment window" provision for hospitals under which certain Part B services furnished by a hospital or by an entity wholly owned or operated by the hospital within three days (or for non-PPS hospitals, within one day) before an inpatient admission to the hospital are included in the Medicare Part A payment to the hospital. In addition section 1833(d) of the Act prohibits payment under Part B for any service for which payment can be made under Part A.

A SNF is considered to be "wholly owned or operated" by the hospital if the hospital is the sole owner or operator. A hospital need not exercise administrative control over a SNF in order to operate it. A hospital is considered the sole operator of the SNF if the hospital has exclusive responsibility for implementing SNF policies (i.e., conducting or overseeing the SNF's routine operations), regardless of whether it also has the authority to make the policies.

The services to which this applies are diagnostic services and other services related to the hospital admission. These services should not be billed by the hospital-owned SNF for Part B residents or for outpatients if provided within three days of a PPS hospital admission or within one day of a non-PPS hospital admission. It is not applicable to Part A SNF PPS services.

A. Diagnostic Services.- For this provision, diagnostic services are defined by the following revenue and/or HCPCS codes:

- 254 - Drugs incident to other diagnostic services
- 255 - Drugs incident to radiology
- 30X - Laboratory
- 31X - Laboratory pathological
- 32X - Radiology diagnostic
- 341 - Nuclear medicine, diagnostic
- 35X - CT scan
- 40X - Other imaging services
- 46X - Pulmonary function
- 48X - Cardiology, with HCPCS codes 93015, 93307, 93308, 93320, 93501, 93503, 93505, 93510, 93526, 93541, 93542, 93543, 93544-93552, 93561, or 93562
- 53X - Osteopathic services
- 61X - MRI
- 62X - Medical/surgical supplies, incident to radiology or other diagnostic services
- 73X - EKG/ECG
- 74X - EEG
- 92X - Other diagnostic services

B. Other Preadmission Services.-- Preadmission services are related to the admission if they are furnished in connection with the principal diagnosis that necessitates the patient's admission as a hospital inpatient. This provision does not apply to ambulance services.

530 DESCRIPTION OF HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

HCPCS is required for reporting SNF services paid by Medicare fee schedules.

HCPCS is based upon the American Medical Association's (AMA) Physicians' Current Procedural Terminology, Fourth Edition (CPT-4). It includes three levels of codes and modifiers. HCFA monitors the system to ensure uniformity. Level I contains only the AMA's CPT-4 codes. This level consists of all numeric codes. The second level contains the codes for physician and nonphysician services which are not included in CPT-4, e.g., ambulance, DME, orthotics and prosthetics. These are alpha-numeric codes maintained jointly by HCFA, the Blue Cross and Blue Shield Association (BCBSA), and the Health Insurance Association of America (HIAA). Level III (local assignment) contains the codes for services needed by individual contractors or State agencies to process Medicare and Medicaid claims. They are used for services which are not contained in either other level. The local codes are also alpha-numeric, but are restricted to the series beginning with W, X, Y, and Z.

Level I (CPT-4) codes/modifiers can be purchased in hardcopy form or a tape/cartridge from:

American Medical Association
P.O. Box 7046
Dover, DE 19903-7046
Telephone 1-800-621-8335

Level II (non-CPT-4) codes/modifiers can be purchased in hardcopy form from:

Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954
Telephone (202) 512-1800
Fax: (202) 512-2250

Level II codes/modifiers are also available on computer tape from the National Technical Information Services (NTIS). Their address is:

National Technical Information Service
5285 Port Royal Road
Springfield, VA 22161
Sales Desk: (703) 487-4650,
Subscriptions: (703) 487-4630,
TDD (hearing impaired only): (703) 487-4639,
RUSH Service (available for an additional fee):
1-800-553-NTIS, Fax: (703) 321-8547,
and E-Mail: orders@ntis.fedworld.gov

HCPCS information is also published on the HCFA Web Page at <http://www.hcfa.gov>
Select the Plans and Providers page.

530.1 Use and Maintenance of CPT-4 in HCPCS.--The text contains over seven thousand service codes, plus titles and modifiers. The AMA entered into an agreement with HCFA which states:

- o The AMA permits HCFA, its agents, and other entities participating in programs administered by HCFA, and the health care field in general, to use CPT-4 codes and terminology in HCPCS;
- o HCFA shall adopt and use CPT-4 in connection with HCPCS for reporting services under Medicare and Medicaid;
- o HCFA agrees to include a statement in HCPCS that participants are authorized to use the copies of CPT-4 material in HCPCS only for purposes directly related to participating in HCFA programs and that permission for any other use must be obtained from the AMA;
- o HCPCS shall be prepared in format(s) approved in writing by the AMA which include(s) appropriate notice(s) to indicate that CPT-4 is copyrighted material of the AMA. You may publish, edit, and abridge CPT-4 terminology for Medicare use within your own hospital.

You are not allowed to publish, edit, or abridge versions of CPT-4 for distribution outside of your facility. This would violate copyright laws. You may print the codes and approved narrative descriptions for internal processing purposes in billing or in development requests relating to individual Medicare or Medicaid claims;

- o Both AMA and HCFA will encourage health insurance organizations to adopt CPT-4 for the reporting of services to achieve the widest possible acceptance of the system and the uniformity of services reporting consistent therewith;
- o The AMA recognizes that HCFA and other users of CPT-4 may not provide payment under their programs for certain procedures identified in CPT-4. Accordingly, HCFA and other health insurance organizations may independently establish policies and procedures governing the manner in which the codes are used within their operations; and

- o The AMA Editorial Panel has the sole responsibility to revise, update, or modify CPT-4 codes.

The AMA updates and republishes CPT-4 annually and provides HCFA with the updated data. HCFA updates the alpha-numeric (Level II) portion of HCPCS and incorporates the updated AMA material to create the HCPCS file. The file is duplicated and distributed to Medicare contractors and State agencies. Your intermediary furnishes you with Level II of the codes as appropriate, or you may purchase them or download them from HCFA Web pages.

530.2 Addition, Deletion, and Change of Local Codes.--There may be procedures for which you bill, but are unable to determine a code. Contact your intermediary for advice. Furnish the intermediary with a full narrative description of the procedure, its projected volume, and the charge.

HCPCS is updated annually to reflect changes in the practice of medicine and provision of health care. HCFA provides a file containing the updated HCPCS codes to contractors and Medicaid State agencies 90 days in advance of the implementation of the annual update.

530.3 Considerations in Use of HCPCS for Medicare Billing.--Use the CPT-4 portion of HCPCS and/or level II as directed by the manual sections applicable to the service that you are billing.

In cases where there are separate codes for the technical component, professional component, and/or complete procedure, use the code that describes the procedure you provided.

There may be specific rules for use of HCPCS codes for specific types of services (e.g., SNF's must bill global services for therapies). These will be described in the manual sections for the applicable service.

530.4. All-inclusive Rate or No-Charge Structure SNF Billing Procedures for Part B Inpatient Ancillary Services

Prior to January 1, 2001, the following rules applied.

The charges to be billed for Part B ancillary services furnished to inpatients when Part A benefits are not payable is dependent upon the cost reimbursement method you use to apportion allowable costs between Medicare beneficiaries and other patients. Bill these inpatient ancillary services under Part B when the level of care becomes noncovered under Part A, when Part B benefits become exhausted, or are otherwise not payable under Part A.

Part B ancillary services for inpatients are listed in §260A.

When billing for Part B inpatient ancillary services where Part A benefits are not payable, an all-inclusive rate or no-charge structure SNF follows the appropriate cost reimbursement method of billing instructions listed below.

A. SNFs Using Method A (Use of Statistical Data).--Using the cost report for the immediately preceding cost reporting period:

- o Find the ratio of the total allowable costs of the Part B inpatient ancillary services to the total allowable costs of all inpatient services (including routine);

- o Apply the ratio to your current all-inclusive billing rate. The result represents the inclusive billing rate applicable to the Part B ancillary services when Part A benefits are not available; and,

- o Enter the charge amount obtained by this computation using revenue code 24X,

All Inclusive Ancillary.

B. SNFs Using Method D (Use of Comparable Skilled Nursing Facility Data).--The inclusive charge for the Part B inpatient ancillary services is determined by applying a fixed percentage (see below) to your average inpatient ancillary charge. The average inpatient ancillary charge is determined from your prior year cost report by applying to your all-inclusive rate a percentage based upon your total inpatient ancillary costs divided by total costs for all inpatient services (including routine). An inclusive billing rate applicable to the ancillary services covered for Part B inpatients is 65 percent. Enter the amount derived by multiplying the average inpatient ancillary service charge by the indicated percentage figure using Revenue Code 24X, All Inclusive Ancillary.

C. SNFs Using Method E (Percentage of Per Diem).--The inclusive charge for Part B inpatient ancillary services is computed by applying 2.5 percent to your all-inclusive rate for the cost reporting period.

Enter the amount derived by multiplying the total charge for inpatient services (ancillary and routine) by the percentage figure using Revenue Code 24X, All Inclusive Ancillary.

Beginning with services provided January 1, 2001, all-inclusive rate providers must report HCPCS codes and charges for all Part B services. You will be paid the lower of the fee schedule or charge reported for the HCPCS service. All consolidated billing rules apply.

531 SERVICES INCLUDED AND EXCLUDED FROM CONSOLIDATED BILLING-GENERAL

Certain services are not included in the Part A PPS rate. These are described in § 206.1 and in the following sections.

Generally services excluded (from PPS), are also excluded from consolidated billing. There are a small number of services specifically identified as being separately billable under Part B and included in consolidated billing. Pneumococcal pneumonia vaccine, influenza vaccine and hepatitis vaccine are covered under Part B in addition to the PPS rate. However beginning with services provided January 1, 2002, the SNF must bill for these. They are not covered if billed by another provider for a SNF resident. See § 536 for related billing instructions.

For most other services that are not included in the Part A PPS rate, the SNF is not required to bill under Part B because the services are included in the lists of services excluded in §§ 531.1 through 531.4

Where the following sections do not require the SNF to bill, the SNF may obtain the service under arrangements or may let the beneficiary and/or his physician make separate arrangements for the service.

531.1 Therapy Services.- Part A therapy services are included in the PPS rate. If payment cannot be made under Part A but can be made under Part B, beginning with services provided January 1, 2002, therapy services must be billed by the SNF.

Therapy services include revenue codes 42X (physical therapy) 43X (occupational therapy) or 44X (speech therapy) and/or the following HCPCS codes, regardless of the revenue code reported.

Audiological services are considered therapy services for this rule. HCPCS codes are to be reported when billing for audiological services under revenue code 470.

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	92597	92598	95831	95832	95833	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.

*** Code 97770 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.

*****Code 97010 should be bundled. It may be bundled with any therapy code.

Audiologic function test

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								

531.2 Physician's Services and Other Professional Services Excluded.- Except for the therapy services to Part B residents after December 31, 2001, professional component of physician services and the services of certain non-physician providers listed below are excluded from both the SNF Part A PPS rate and consolidated billing and may be billed separately by the physician.

For this purpose "physicians service" means the professional component of the service. The technical component if any must still be billed by the SNF. It is paid at the fee schedule rate for the technical component for the service. The carrier will pay only the professional component to the physician.

Providers with the following specialty codes assigned by HCFA upon enrollment with Medicare are considered physicians for this purpose. Some limitations are imposed by §1861 (q) and (r) of the Social Security Act..

Physician Codes

01	General Practice	37	Pediatric Medicine
02	General Surgery	38	Geriatric Medicine
03	Allergy/Immunology	39	Nephrology
04	Otolaryngology	40	Hand Surgery
05	Anesthesiology	41	Optometry
06	Cardiology	44	Infectious Disease
07	Dermatology	46	Endocrinology
08	Family Practice	48	Podiatry
10	Gastroenterology	66	Rheumatology
11	Internal Medicine	70	Multi specialty Clinic or Group Practice
12	Osteopathic Manipulative Therapy	76	Peripheral Vascular Disease
13	Neurology	77	Vascular Surgery
14	Neurosurgery	78	Cardiac Surgery
16	Obstetrics Gynecology	79	Addiction Medicine
18	Ophthalmology	81	Critical Care (Intensivists)
19	Oral Surgery (Dentists only)	82	Hematology
20	Orthopedic Surgery	83	Hematology/Oncology
22	Pathology	84	Preventive Medicine
24	Plastic and Reconstructive Surgery	85	Maxillofacial Surgery
25	Physical Medicine and Rehabilitation	86	Neuropsychiatry
26	Psychiatry	90	Medical Oncology
28	Colorectal Surgery (formerly Proctology)	91	Surgical Oncology
29	Pulmonary Disease	92	Radiation Oncology
30	Diagnostic Radiology	93	Emergency Medicine
33	Thoracic Surgery	94	Interventional Radiology
34	Urology	98	Gynecological/Oncology
35	Chiropractic	99	Unknown Physician Specialty
36	Nuclear Medicine		

Non - Physician Provider Specialty Codes.--These non physician providers may bill separately.

42	Certified Nurse Midwife	68	Clinical Psychologist
43	Certified Registered Nurse Anesthetist	89	Certified Clinical Nurse Specialist
Anesthesia Assistants (effective 1/1/89)			
50	Nurse Practitioner	97	Physician Assistant
62	Clinical Psychologist (billing		

Note that some HCPCS codes are defined as all professional component in the fee schedule. Fee schedule definitions apply for this purpose.

To identify "physician's services" for SNF residents and rules for billing, a HCPCS file specifically for SNFs is available on the HCFA internet web site. The address is:
<http://www.hcfa.gov/stats/pufiles.htm>

(If your Internet browser is open and you are reading this on a computer screen click on the address for access and browse to the SNF fee schedule.)

531.3 Ambulance Services.- Ambulance transportation and related ambulance services are not included in the PPS rate and are excluded from consolidated billing in only the following situations.

- The ambulance trip is to the SNF for admission (the second character (destination) of any

ambulance HCPCS modifier is N (SNF) other than modifier QN, and the date of service is the same as the SNF 21X admission date.)

- The ambulance trip is from the SNF to home (the first character (origin) of any HCPCS ambulance modifier is N (SNF)) and date of ambulance service is the same date as the SNF through date and the SNF patient status (FL 22) is other than 30.)
- The ambulance trip is to a hospital based or non hospital based ESRD facility (either one of any HCPCS ambulance modifier codes is G (Hospital based dialysis facility) or J (Non-hospital based dialysis facility) .
- Ambulance associated with emergency room, outpatient surgery and other consolidated billing exclusions.

The provider who furnishes the ambulance may bill or the SNF may bill under arrangements. Payment is under the ambulance fee schedule in either event.

531.4 Outpatient/Emergency Services in a Medicare Participating Hospital or Critical Access Hospital (CAH).- Under the regulations at 42 CFR §483.20, the beneficiary's status as a SNF resident ends when the beneficiary receives outpatient services from a Medicare-participating hospital or CAH. In the outpatient hospital context, this exclusion applies to a small number of exceptionally intensive services that lie well beyond the scope of the care that SNFs would ordinarily furnish and also to emergency services (which, by their nature, cannot be anticipated and planned for in advance). Under the regulations at 42 CFR §424.101, outpatient hospital emergency services are defined as services that are necessary to prevent death or serious impairment of health and, because of the danger to life or health, require use of the most accessible hospital available and equipped to furnish those services.

The following services are excluded from consolidated billing:

- cardiac catheterization,
- computerized axial tomography (CT) scans,
- magnetic resonance imaging (MRIs),
- radiation therapy,
- angiography,
- lymphatic and venous procedures,
- ambulatory surgery involving the use of an operating room,
- emergency services,
- ambulance related to the above exclusions
- ambulance transportation related to dialysis services.

These are relatively costly services which are beyond the scope of care in SNFs. Even though it may be medically appropriate for a beneficiary to be cared for in a SNF while receiving radiation therapy, the SNF is not responsible for paying for radiation therapy that a beneficiary receives. Similarly, angiography codes and codes for lymphatic and venous procedures are considered beyond the scope of services delivered by SNFs.

The hospital or Critical Access Hospital should bill the intermediary for the services. Emergency room services are defined by the presence of revenue code 45X on the claim.

Other services are defined by the following HCPCS codes. Any other services (defined by other HCPCS codes) must be bundled back to the SNF and the hospital must look to the SNF for payment.

Outpatient CT scans:

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	

Outpatient cardiac catheterization:

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						

Outpatient MRI:

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

Outpatient radiation therapy :

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		

Outpatient angiography:

75600	75605	75625	75630	75650	75658	75660	75662	75665
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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		

Outpatient surgery

All codes from 10040 - 69979 with the following exceptions. Codes that are within the list of exceptions may not be billed by the hospital as they fall within the range of minor procedures that the SNF may provide. These exceptions are:

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
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	36406	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	62368	95970-95975	G0001	

531.5 Chemotherapy, Chemotherapy Administration, and Radioisotope Services.--The following chemotherapy and radioisotope items are not included in the Part A PPS rate and are excluded from consolidated billing:

Chemotherapy

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								

Chemotherapy Administration Services that May Be Paid

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	96450	96530
96542								

Radioisotope Services that May Be Paid

79030	79035	79100	79200	79300	79400	79420	79440
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531.6 Certain Customized Prosthetic Devices.- The following customized prosthetic devices are not considered included in the Part A PPS rate and are excluded from consolidated billing.

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	L7975
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
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	

531.7 ESRD Services.- 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.

531.8 Other Services Paid on a Cost Basis

Access the HCFA Web site for an up to date list of items paid on a cost basis. A list effective with the date of this manual revision is included with the transmittal cover sheet.

532 BILLING THERAPY SERVICES

Part B payments for therapy services for which SNFs bill are based on a fee schedule.

The SNF must report revenue codes and HCPCS codes as described below.

The appropriate bill types are 22x or 23x, depending upon whether the patient is a Part B resident or an outpatient. Use 22x for residents, and 23x for beneficiaries that live outside the facility.

It is not necessary to match HCPCS codes to revenue codes because many therapy services physical therapy modalities or therapy procedures as described by HCPCS codes, may be delivered by both physical and occupational therapists. Other services may be delivered by either occupational therapists or speech-language pathologists. Therefore, providers report outpatient rehabilitation HCPCS in conjunction with the appropriate outpatient rehabilitation revenue code based on the type of therapist who delivered the service, or, if the service is not delivered by a therapist, then the type of therapy under the Plan of Care for which the service is delivered.

Applicable Revenue Codes

The applicable revenue codes for reporting outpatient rehabilitation services are 420, 430, and 440.

Applicable HCPCS Codes

The applicable HCPCS codes for reporting outpatient rehabilitation services are as follows:

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	92597	92598	95831	95832	95833	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.

*** Code 97770 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.

*****Code 97010 should be bundled. It may be bundled with any therapy code.

The above list of codes contains commonly utilized codes for outpatient rehabilitation services. Intermediaries may consider other codes for payment as outpatient rehabilitation services to the

extent that such codes are determined to be medically reasonable and necessary and those that could be performed within the scope of practice of the therapist or provider providing the service.

In addition, the following HCPCS codes are to be reported when billing for audiological services:

Revenue Code	Description	HCPCS Codes
470	Audiologic function test	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, V5299

Reporting of Service Units

SNF's are required to report the number of units in FL 46 "Service Units" based on the procedure or service, e.g., based on the HCPCS codes reported instead of the revenue code. Units are reported based on the number of times the procedure, as described in the HCPCS code definition, is performed. When reporting service units for HCPCS codes where the procedure is not defined by a specific time frame report "1" in FL 46. Visits are not reported as units. Since providers may perform a number of procedures or services during a single visit, the number of units may exceed the number of visits.

EXAMPLE: A beneficiary received occupational therapy (HCPCS code 97530 which is defined in 15 minute intervals) for a total of 60 minutes. The provider would report revenue code 43X in FL 42, HCPCS code 97530 in FL 44, "four" units in FL 46.

Providers report in FLs 39-41 value code 50, 51, or 52 as appropriate the total number of physical therapy, occupational therapy, or speech therapy visits provided from start of care through the billing period. This item is visits; not service units.

Line Item Date of Service Reporting

SNFs are required to report line item dates of service per revenue code line for Part B rehabilitation services. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. Line item dates of service are reported in FL 45 "Service Date" (MMDDYY). See example below of reporting line item dates of service. This example is for physical therapy services provided twice during a billing period.

For the UB-92 flat file, report as follows:

Record Type	Revenue Code	HCPCS	Dates of Service	Units	Total Charges
61	420	97001	20010505	1	\$60.90
61	420	97110	20010529	2	\$44.02

For the hard copy UB-92 (HCFA-1450), report as follows:

FL 42	FL 44	FL 45	FL 46	FL 47
420	97001	05-05-01	1	\$60.90
420	97110	05-29-01	2	\$44.02

Intermediaries will return bills that span two or more dates if a line item date of service is not entered for each HCPCS reported.

Edit Requirements

Intermediaries edit to assure the presence of a HCPCS code when revenue codes 420, 430, 440 or 470 are reported. They do not edit the matching of revenue codes to HCPCS codes or edit to limit provider reporting to only those HCPCS codes listed in this instruction.

533. BILLING PART B RADIOLOGY SERVICES AND OTHER DIAGNOSTIC PROCEDURES

Acceptable HCPCS codes for radiology and other diagnostic services are taken primarily from the CPT-4 portion of HCPCS. Payment is under the Medicare physician fee schedule. Revenue codes, dates of service, and applicable HCPCS modifiers are required. Use the revenue code that maps to your charge master. Charges must be reported by HCPCS code. If the same revenue code applies to two or more HCPCS codes, repeat the revenue code and show the charges for the related HCPCS code on the HCPCS line. Deductible and coinsurance apply, and coinsurance applies on allowed amount.

There are some services, described in the following sections, for which the related ICD-9-CM diagnosis code is required to support the need for the service.

533.1 Special Billing Instructions.--

- a. Aborted Procedure.--When a procedure is not completed, bill an unlisted code showing the actual charges for radiology services and for other diagnostic procedures.
- b. Combined Procedures (Radiology).--There are no separate codes covering certain combined procedures, e.g., a hand and forearm included in a single X-ray. Use the code with the higher fee schedule amount.
- c. Treatment Management Delivery.--Do not bill weekly treatment management services (codes 77419, 77420, 77425, 77430, and 77431). Instead, bill for radiation treatment delivery (codes 77401 - 77404, 77406 - 77409, 77411 - 77414, and 77416). Also, bill for therapeutic radiology port film (code 77417) which was previously a part of the weekly services. Enter the number of services in the units field.
- d. "On Call" Charges.--These are not billed separately. The appropriate code for the performed procedures must be reported. Costs related to on call personnel may be included on the cost report and may be spread across individual charges related to the personnel.
- e. Portable Equipment (C-Arm, Swing Arm, etc.).--When procedures are performed using portable equipment, bill using the appropriate code for the procedure. Additional set up charges for the use of portable equipment may be submitted where applicable. Use HCPCS code Q0092.
- f. Payment for Contrast Material Other Than Low Osmolar Contrast Material (LOCM) (Radiology).--When you provide a radiology procedure with contrast material, bill using the CPT-4

code that indicates "with" contrast material. If the coding does not distinguish between "with" and "without" contrast material, use the available code.

Contrast material other than LOCM may be billed separately in addition to the radiology procedure, or it may be billed as part of the amount for the radiology procedure. If you bill separately for the contrast material and your charge for the procedure includes a charge for contrast material, you must adjust the charge for the procedure to exclude any amount for the contrast material. Regardless of the billing method used, charges are subject to the radiology fee schedule.

When billing separately for this contrast material, use revenue code 255 (drugs incident to radiology and subject to the payment limit) and report the charges on the same bill as the radiology procedure. Your intermediary will not accept late charge bills for this service.

g. Payment for Low Osmolar Contrast Material (LOCM) (Radiology).--LOCM is paid on a reasonable cost basis (in addition to payment for the radiology procedure) when it is used in the following situations:

(1) In all intrathecal injections. The applicable HCPCS codes for such injections are:

70010 70015 72240 72255 72265 72270 72285 72295; or

(2) In intravenous and intra-arterial injections only when certain medical conditions are present in an outpatient. You must verify the existence of at least one of the following medical conditions, and report the applicable ICD-9-CM code(s) in item 67 (principal diagnosis code) or items 68 through 75 (other diagnosis codes) of the HCFA-1450:

o A history of previous adverse reaction to contrast material. The applicable ICD-9-CM codes are V14.8 and V14.9. The conditions which should not be considered adverse reactions are a sensation of heat, flushing, or a single episode of nausea or vomiting. If the adverse reaction occurs on that visit with the induction of contrast material, codes describing hives, urticaria, etc. should also be present, as well as a code describing the external cause of injury and poisoning, E947.8;

o A history or condition of asthma or allergy. The applicable ICD-9-CM codes are V07.1, V14.0 through V14.9, V15.0, 493.00, 493.01, 493.10, 493.11, 493.20, 493.21, 493.90, 493.91, 495.0, 495.1, 495.2, 495.3, 495.4, 495.5, 495.6, 495.7, 495.8, 495.9, 995.0, 995.1, 995.2, and 995.3;

o Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension. The applicable ICD-9-CM codes are:

402.00, 402.01, 402.10, 402.11, 402.90, 402.91;

404.00, 404.01, 404.02, 404.03;

404.10, 404.11, 404.12, 404.13;

404.90, 404.91, 404.92, 404.93;

410.00, 410.01, 410.02, 410.10, 410.11, 410.12;

410.20, 410.21, 410.22, 410.30, 410.31, 410.32

410.40, 410.41, 410.42, 410.50, 410.51, 410.52;
 410.60, 410.61, 410.62, 410.70, 410.71, 410.72;
 410.80, 410.81, 410.82, 410.90, 410.91, 410.92;
 411.1, 415.0, 416.0, 416.1, 416.8, 416.9;
 420.0, 420.90, 420.91, 420.99, 424.90, 424.91;
 424.99, 427.0, 427.1, 427.2, 427.31, 427.32;
 427.41, 427.42, 427.5, 427.60, 427.61, 427.69;
 427.81, 427.89, 427.9, 428.0, 428.1, 428.9, 429.0;
 429.1, 429.2, 429.3, 429.4, 429.5, 429.6, 429.71;
 429.79, 429.81, 429.82, 429.89, 429.9, 785.50, 785.51, and 785.59;

o Generalized severe debilitation. The applicable ICD-9-CM codes are 203.00, 203.01, all codes for diabetes mellitus, 518.81, 585, 586, 799.3, 799.4, and V46.1; or

o Sickle Cell disease. The applicable ICD-9-CM codes are 282.4, 282.60, 282.61, 282.62, 282.63, and 282.69.

HCPCS codes are required when billing for LOCM. If one of the above conditions for payment is met, use one of the following HCPCS codes as appropriate:

<u>1/1/92 through 12/31/93</u>	<u>1/1/94 on</u>	
0105	A4644	Supply of low osmolar contrast material (100-199 mgs of iodine);
Q0106	A4645	Supply of low osmolar contrast material (200-299 mgs of iodine); or
Q0107	A4646	Supply of low osmolar contrast material (300-399 mgs of iodine).

When billing for LOCM, use revenue code 636. If your charge for the radiology procedure includes a charge for contrast material, you must adjust the charge for the procedure to exclude any amount for the contrast material.

NOTE: LOCM is never billed with revenue code 255 or as part of the radiology procedure.

Your intermediary will edit for the intrathecal procedure codes and the above ICD-9-CM codes to determine if payment for LOCM is to be made. If an intrathecal procedure code is not present, or one of the ICD-9-CM codes is not present to indicate that a required medical condition is met, your intermediary will deny payment for LOCM. In these instances, LOCM is **not** covered and should not be billed to Medicare.

Noncovered charges may be billed to the Medicare beneficiary only if the beneficiary received written notice of noncoverage prior to the service being provided.

h. Payment for Radiopharmaceuticals.--Radiopharmaceuticals are not subject to the radiology fee schedule, but are paid based on reasonable cost. HCPCS codes are required for billing. Report HCPCS codes 79900, A4641, A4642, A9500, A9503, and A9505, as appropriate, with revenue codes 333, 34x, or 636.

NOTE: Do not report HCPCS code 78990. This code is not valid for Medicare purposes and has been replaced with code A4641.

EXCEPTION: HCPCS codes 77781, 77782, 77783, and 77784 include payment for the radiopharmaceutical in the technical component. When these procedures are performed, do not report radiopharmaceutical codes 79900, A4641, A4642, A9500, A9503, and A9505. Your intermediary will reject codes 79900, A4641, A4642, A9500, A9503, and A9505 when they are billed for supplies used in conjunction with procedure codes 77781, 77782, 77783, and 77784.

i. Payment for IV Persantine.--The drug IV Persantine is paid based on the drug pricing methodology when used in conjunction with nuclear medicine and cardiovascular stress testing procedures furnished to SNF outpatients. Separate drug pricing methodology payments for IV Persantine will be made in addition to payments made for the procedure. When billing for IV Persantine, HCPCS coding is required. Report HCPCS code J1245 (Injection, Dipyridamole, per 10 mg.) with revenue code 636.

j. Transportation of Equipment.--When you transport portable X-ray equipment to a site by van or other vehicle, bill for the transportation costs using one of the following HCPCS codes along with the appropriate revenue code:

R0070 - Transportation of Portable X-ray Equipment and Personnel to Home or Nursing Home, Per Trip to Facility or Location, One Patient Seen.

R0075 - Transportation of Portable X-ray Equipment and Personnel to Home or Nursing Home, Per Trip to Facility or Location, More than One Patient Seen, Per Patient.

These HCPCS codes are subject to the fee schedule.

533.2 Positron Emission Tomography (PET) Scans.--Positron emission tomography (PET), also known as positron emission transverse tomography (PETT), is a noninvasive imaging procedure that assesses perfusion and the level of metabolic activity in various organ systems of the human body. A positron camera (tomograph) is used to produce cross-sectional tomographic images by detecting radioactivity from a radioactive tracer substance (radiopharmaceutical) that is injected into the patient.

For dates of service on and after March 14, 1995, Medicare covers one use of PET scans, i.e., imaging of the perfusion of the heart using Rubidium 82 (Rb 82), provided that the following conditions are met:

o The PET is done at a PET imaging center with a PET scanner that has been approved by the FDA;

o The PET scan is a rest alone or rest with pharmacologic stress PET scan, used for noninvasive imaging of the perfusion of the heart for the diagnosis and management of patients with known or suspected coronary artery disease, using Rb 82; and

o Either the PET scan is used in place of, but not in addition to, a single photon emission computed tomography (SPECT) or the PET scan is used following a SPECT that was found inconclusive.

See Coverage Issues Manual, §50-36 for additional coverage instructions for PET scans.

Use the HCPCS "G" codes listed below to indicate the conditions under which a PET scan was done. These codes represent the technical component. Bill these codes under Revenue Code 404 (Positron Emission Tomography).

- G0030 PET myocardial perfusion imaging, (following previous PET, G0030-G0047); single study, rest or stress (exercise and/or pharmacologic)
- G0031 PET myocardial perfusion imaging, (following previous PET, G0030-G0047); multiple studies, rest or stress (exercise and/or pharmacologic)
- G0032 PET myocardial perfusion imaging, (following rest SPECT, 78464); single study, rest or stress (exercise and/or pharmacologic)
- G0033 PET myocardial perfusion imaging, (following rest SPECT, 78464); multiple studies, rest or stress (exercise and/or pharmacologic)
- G0034 PET myocardial perfusion imaging, (following stress SPECT, 78465); single study, rest or stress (exercise and/or pharmacologic)
- G0035 PET myocardial perfusion imaging, (following stress SPECT, 78465); multiple studies, rest or stress (exercise and/or pharmacologic)
- G0036 PET myocardial perfusion imaging, (following coronary angiography, 93510-93529); single study, rest or stress (exercise and/or pharmacologic)
- G0037 PET myocardial perfusion imaging, (following coronary angiography, 93510-93529); multiple studies, rest or stress (exercise and/or pharmacologic)
- G0038 PET myocardial perfusion imaging, (following stress planar myocardial perfusion, 78460; single study, rest or stress (exercise and/or pharmacologic)
- G0039 PET myocardial perfusion imaging, (following stress planar myocardial perfusion, 78460; multiple studies, rest or stress (exercise and/or pharmacologic)
- G0040 PET myocardial perfusion imaging, (following stress echocardiogram, 93350); single study, rest or stress (exercise and/or pharmacologic)
- G0041 PET myocardial perfusion imaging, (following stress echocardiogram, 93350); multiple studies, rest or stress (exercise and/or pharmacologic)
- G0042 PET myocardial perfusion imaging, (following stress nuclear ventriculogram, 78481 or 78483); single study, rest or stress (exercise and/or pharmacologic)
- G0043 PET myocardial perfusion imaging, (following stress nuclear ventriculogram 78481 or 78483); multiple studies, rest or stress (exercise and/or pharmacologic)
- G0044 PET myocardial perfusion imaging, (following rest ECG, 93000); single study, rest or stress (exercise and/or pharmacologic)
- G0045 PET myocardial perfusion imaging, (following rest ECG, 93000); multiple studies, rest or stress (exercise and/or pharmacologic)

- G0046 PET myocardial perfusion imaging, (following stress ECG, 93015); single study, rest or stress (exercise and/or pharmacologic)
- G0047 PET myocardial perfusion imaging, (following stress ECG, 93015); multiple studies, rest or stress (exercise and/or pharmacologic)

Effective July 1, 1999, Medicare expanded coverage of PET scans to include the evaluation of recurrent colorectal cancer in patients with rising levels of carinoembryonic antigen (CEA), for the staging of lymphoma (both Hodgkins and non-Hodgkins) when the PET scan substitutes for a gallium scan or lymphangiogram, and for the staging of recurrent melanoma prior to surgery, provided certain conditions are met. All three indications are covered only when using the radiopharmaceutical FDA (2-[flourine-18]-fluoro-2-deoxy-D-glucose), and are further predicated on the legal availability of FDG for use in such scans.

Three new HCPCS codes for PET scans when performed on or after July 1, 1999 are listed below.

- o G0163--Positron Emission Tomography (PET), whole body, for recurrence of colorectal or colorectal metastatic cancer.

- o G0164--Positron Emission Tomography (PET), whole body, for staging and characterization of lymphoma.

- o G0165-- Positron Emission Tomography (PET), whole body, for recurrence of melanoma or melanoma tastatic cancer.

These codes represent the technical component costs associated with these procedures and are payable on a fee schedule basis. They are reported with revenue code 404 (Positron Emission Tomography). SNFs can bill for the above PET scans performed on or after July 1, 1999, provided all the terms and conditions set forth in the coverage guidelines for PET are met.

Postpayment Review

As with any claim, but particularly in view of the limitations on this coverage, Medicare may decide to conduct post-payment reviews to determine that the use of PET scans is consistent with coverage instructions. SNFs must keep patient record information on file for each Medicare patient for whom a PET scan claim is made. These medical records will be used in any post-payment reviews and must include the information necessary to substantiate the need for the PET scan. These records must include standard information (e.g., age, sex, and height) along with sufficient patient histories to allow determination that the steps required in the coverage instructions were followed. Such information must include, but is not limited to, the date, place and results of previous diagnostic tests (e.g., cytopathology and surgical pathology reports, CT, etc.), as well as the results and reports of the PET scan(s) performed at the center. If available, such records should include the prognosis derived from the PET scan, together with information regarding the physician or institution to which the patient proceeded following the scan for treatment or evaluation. The ordering physician is responsible for forwarding appropriate clinical data to the PET scan facility.

533.3. Payment for Adenosine.--The drug adenosine is paid based on the drug payment methodology when used as a pharmacologic stressor for other diagnostic testing. Separate based payment for adenosine will be made in addition to payments made for the procedure. When billing for adenosine, HCPCS coding is required. Report HCPCS code J0150 (Injection, adenosine, 6 mg.) with revenue code 636.

533.4 Radiology or Other Diagnostic Unlisted Service or Procedure.--You may find radiology and other diagnostic services for which a corresponding code in HCPCS may not be found. This is

because these are typically services that are rarely provided, unusual, or new. Assign the appropriate "unlisted procedure" code to any such service. The following list contains the "unlisted procedure" codes along with the suggested revenue code for billing. These services are paid on a fee schedule if one exists or individual consideration if a fee has not been established. However before billing any of these codes you are to furnish a complete description of the radiology procedure to your intermediary for review and analysis. Include a narrative definition of the procedure and a description of the nature, extent and need for the procedure and the time, effort, and equipment necessary. Your intermediary will determine if you have correctly identified the procedure as "unlisted." If the procedure is not identified correctly, your intermediary will inform you of the correct HCPCS code to assign to the procedure. If there is no fee schedule amount established these services are paid based on individual consideration.

For Radiology

<u>Revenue Code</u>	<u>HCPCS</u>	<u>Definition</u>
32X	76499	Unlisted diagnostic radiologic procedure
402	76999	Unlisted ultrasound procedure
333	77299	Unlisted procedure, therapeutic radiology clinical treatment planning
333	77399	Unlisted procedure, medical radiation physics, dosimetry and treatment devices
333	77499	Unlisted procedure, therapeutic radiology clinical treatment management
333	77799	Unlisted procedure, clinical brachytherapy
34X	78099	Unlisted endocrine procedure, diagnostic nuclear medicine
34X	78199	Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine
34X	78299	Unlisted gastrointestinal procedure, diagnostic nuclear medicine
34X	78399	Unlisted musculoskeletal procedure, diagnostic nuclear medicine
34X	78499	Unlisted cardiovascular procedure, diagnostic nuclear medicine
34X	78599	Unlisted respiratory procedure, diagnostic nuclear medicine
34X	78699	Unlisted nervous system procedure, diagnostic nuclear medicine
34X	78799	Unlisted genitourinary procedure, diagnostic nuclear medicine
34X	78999	Unlisted miscellaneous procedure, diagnostic nuclear medicine
34X	79999	Unlisted radiopharmaceutical therapeutic procedure

For Other Diagnostic Procedures

<u>Revenue Code</u>	<u>HCPCS</u>	<u>Definition</u>
75X	91299	Unlisted diagnostic gastroenterology procedure
47X	92599	Unlisted otorhinolaryngological service or procedure
48X	93799	Unlisted cardiovascular service or procedure
73X	93799	Unlisted cardiovascular service or procedure
921	93799	Unlisted cardiovascular service or procedure
46X	94799	Unlisted pulmonary service or procedure
74X	95999	Unlisted neurological or neuromuscular diagnostic procedure
922	95999	Unlisted neurological or neuromuscular diagnostic procedure

E. EMC Formats--

Use record type 61 (Addendum A) on the UB-92 and the SV2 segment on the ANSI format to report Part B radiology services. Record type, sequence number, patient control number (if used), revenue code, HCPCS code, units and charges are required. Modifiers and dates of service are needed. The "from" and "through" dates of the bill are included in another record in the EMC format.

533.5 Bone Mass Measurements--

Sections 1861(s)(15) and (rr)(1) of the Social Security Act (as added by §4106 of the Balanced Budget Act (BBA) of 1997) standardize Medicare coverage of medically necessary bone mass measurements by providing for uniform coverage under Medicare Part B. This standardized coverage is effective for claims with dates of service furnished on or after July 1, 1998.

Conditions of Coverage--Medicare pays for a bone mass measurement that meets all of the following criteria:

- (1) Is a radiologic or radioisotopic procedure or other procedure which
 - o Is performed with a bone densitometer (other than dual photon absorptiometry (DPA)) or a bone sonometer (i.e., ultrasound) device approved or cleared for marketing by the Food and Drug Administration (FDA);
 - o Is performed for the purpose of identifying bone mass or detecting bone loss or determining bone quality; and
 - o Includes a physician's interpretation of the results of the procedure.
- (2) Is performed on a qualified individual. The term "qualified individual" means a Medicare beneficiary who meets the medical indications for at least one of the five categories listed below:
 - o A woman who has been determined by the physician or a qualified nonphysician practitioner treating her to be estrogen-deficient and at clinical risk for osteoporosis, based on her medical history and other findings;
 - o An individual with vertebral abnormalities as demonstrated by an x-ray to be indicative of osteoporosis, osteopenia (low bone mass), or vertebral fracture;
 - o An individual receiving (or expecting to receive) glucocorticoid (steroid) therapy equivalent to 7.5 mg of prednisone, or greater, per day, for more than 3 months;
 - o An individual with primary hyperparathyroidism; or
 - o An individual being monitored to assess the response to or efficacy of an FDA-approved osteoporosis drug therapy.

(3) Is ordered by the individual's physician or qualified nonphysician practitioner who is treating the beneficiary following an evaluation of the need for a measurement, including a determination as to the medically appropriate measurement to be used for the individual

A physician or qualified nonphysician practitioner treating the beneficiary for purposes of this provision is one who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the patient. For the purposes of the bone mass measurement benefit, qualified nonphysician practitioners include physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives.

(4) Is furnished by a qualified supplier or provider of such services under the appropriate level of supervision of a physician.

(5) Is reasonable and necessary for diagnosing, treating, or monitoring the condition of a “qualified individual” as that term is defined above.

(6) Is performed at a frequency that conforms to the requirements described below.

NOTE: Since not every woman who has been prescribed estrogen replacement therapy (ERT) may be receiving an “adequate” dose of the therapy, the fact that a woman is receiving ERT should not preclude her treating physician or other qualified treating nonphysician practitioner from ordering a bone mass measurement for her. If a bone mass measurement is ordered for a woman following a careful evaluation of her medical need, however, it is expected that the ordering treating physician (or other qualified treating nonphysician practitioner) will document in her medical record why he or she believes that the woman is estrogen-deficient and at clinical risk for osteoporosis.

Frequency Standard.--Medicare pays for a bone mass measurement meeting the criteria as stated above once every 2 years (at least 23 months have passed since the month the last bone mass measurement was performed). However, if it is medically necessary, Medicare may pay for a bone mass measurement for a beneficiary more frequently than every 2 years. Examples of situations where more frequent bone mass measurement procedures may be medically necessary include, but are not limited to, the following medical circumstances:

- o Monitoring beneficiaries on long-term glucocorticoid (steroid) therapy of more than 3 months; and

- o Allowing for a confirmatory baseline bone mass measurement (either central or peripheral) to permit monitoring of beneficiaries in the future if the initial test was performed with a technique that is different from the proposed monitoring method (for example, if the initial test was performed using bone sonometry and monitoring is anticipated using bone densitometry, cover the baseline measurement using bone densitometry).

HCPCS Coding.--The following HCPCS codes should be used when billing for bone mass measurements:

- o 76075 - Dual energy x-ray absorptiometry (DEXA), bone density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine);

- o 76076 - Dual energy x-ray absorptiometry (DEXA), bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel);

- o 76078 - Radiographic absorptiometry (photo densitometry), one or more sites; and

- o 78350 - Bone density (bone mineral content) study, one or more sites, single photon absorptiometry; and

- o 76977 - Ultrasound bone density measurement and interpretation, peripheral site(s), any method.

NOTE: For claims with dates of service on or after January 1, 1999, code 76977 replaces HCPCS code G0133. Code G0133 is discontinued December 31, 1998.

- o G0130 - Single energy x-ray absorptiometry (SEXA) bone density study, one or more sites, appendicular skeleton (peripheral) (e.g., radius, wrist, heel) (Short descriptor: SINGLE ENERGY X-RAY STUDY);

o G0131 - Computerized tomography bone mineral density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine) (Short descriptor: CT SCAN, BONE DENSITY STUDY);

o G0132 - Computerized tomography bone mineral density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)

(Short descriptor: CT SCAN, BONE DENSITY STUDY); and

o G0133 - Ultra-sound bone mineral density study, one or more sites, appendicular skeleton (peripheral) (e.g., radius, wrist, heel) (Short descriptor: ECHO EXAM, BONE DENSITY STUDY).

All of the aforementioned codes are bone densitometry measurements except codes G0133 and 76977 which qualify as bone sonometry measurements. Any of the above codes, as appropriate, should be used when billing for bone mass measurements.

Follow the general bill review instructions in §560. Bill on Form HCFA-1450 or its electronic equivalent.

Applicable Bill Types.--The appropriate bill types are 22X and 23X. If you utilize the UB-92 flat file to bill use record type 40 to report bill type. Record type (Field No. 1), sequence number (Field No. 2), patient control number (Field No. 3), and type of bill (Field No. 4) are required.

If you utilize the hard copy UB-92 (HCFA-1450) report the applicable bill type in Form Locator (FL) 4 "Type of Bill".

Coding Requirements.--You must report HCPCS codes for bone mass measurements under revenue code 320. In addition, report the number of units, and line item dates of service per revenue code line for each bone mass measurement reported. Line item date of service reporting is effective for claims with dates of service on or after October 1, 1998. If you utilize the UB-92 flat file to bill use record type 61 to report the bone mass procedure. Record type (Field No. 1), sequence number (Field No. 2), patient control number (Field No. 3), revenue code 320 (Field No. 4), HCPCS code, as appropriate (Field No. 5), units of service (Field No. 8), date of service (Field No. 12, Field No. 9 may be utilized in version 4.1 until September 30, 1998) and outpatient total charges (Field No. 10) are required.

If you utilize the hard copy UB-92 (HCFA Form 1450) report the appropriate HCPCS code in FL 44 "HCPCS/Rates," and revenue code 320 in FL 42 "Revenue Code." The date of service is reported in FL 45 "Service Date" (MMDDYYYY) and the number of service units in FL 46 "Service Units."

Payment Methodology.--Part B deductible and coinsurance apply. Bone mass measurements are paid under the current payment methodology for radiology services.

534. BILLING FOR DURABLE MEDICAL EQUIPMENT (DME), ORTHOTIC/PROSTHETIC DEVICES, AND SURGICAL DRESSINGS

Section 4062 of P.L. 100-203, the Omnibus Budget Reconciliation Act of 1987 (OBRA), requires that payment for DMEPOS furnished under the Part A home health benefit and Part B DMEPOS, prosthetic and orthotic devices be made on the basis of a fee schedule for items provided January 1, 1989 and later with the exception of oxygen and oxygen equipment which are paid on the basis of a fee schedule for items provided June 1, 1989 and later. For inpatients with no entitlement to Part A, the fee schedule applies for payment that may be made under Part B. HCPCS coding is required. Deductible and coinsurance apply. In general, SNFs can bill for the following DME supplies:

- Surgical Dressings, and Splints, Casts, and Other Devices Used for Reduction of Fractures and Dislocations.
- Prosthetic Devices.
- Leg, Arm, Back, and Neck Braces, Trusses, and Artificial Legs, Arms, and Eyes.

The items are categorized into one of the following payment classes:

- Prosthetic and orthotic devices;
- Inexpensive or other routinely purchased DME;
- Items requiring frequent and substantial servicing;
- Certain customized items;
- Capped rental items; or
- Oxygen and oxygen equipment.

NOTE: When an inpatient is not entitled to Part A, payment may not be made under Part B for DME or oxygen provided in your facility. The definition of DME in §1861(n) of the Act provides that DME is covered by Part B only when intended for use in the home, which explicitly does not include a SNF. (See §264.C.) Payment may be made to you under Part B on a fee schedule basis only for outpatients taking the DME or oxygen system home.

Payment for supplies, other than drugs, that are necessary for the effective use of DME is made on the basis of a fee schedule.

The SNF or the supplier must bill DME on Form HCFA-1500 to the DMERC. If you do not have a supplier billing number from the National Supplier Clearinghouse (NSC), contact the NSC to secure one. If your local carrier has issued you a provider number for billing physician services, you cannot use the same number when billing for DME. Bill your intermediary for prosthetic/orthotic devices and surgical dressings on Form HCFA-1450. Follow requirements for submission of Form HCFA-1450 in §560.

For inpatient services, DME is included in the inpatient SNF PPS payment amount and no separate billing is allowed. For outpatient services (i.e., not a resident of the SNF) DME may be billed to the DMERC if the SNF is acting as a supplier. If this is true, it should refer to the DMERC manual for billing instructions and rules.

The following customized prosthetic devices are not considered included in the Part A PPS rate and are excluded from consolidated billing. These codes are:

L5050-L5340

L6050-L6370

L5500-L5611

L6400-L6880

L5613-L5986

L6920-L7274

L5988

L7362-L7366

If the SNF is also a supplier, the SNF must enroll with National Supplier Clearinghouse . The supplier must bill the DMEPOS on Form HCFA-1500. If these services are billed separately by the supplier, payment will be made directly to the supplier. If these services are billed by the SNF, no additional payment will be made.

535 BILLING FOR SURGICAL DRESSINGS

Bill for surgical dressing under bill type 22X or 23X, as applicable. Use revenue code 623. HCPCS codes for reporting surgical dressing are normally found in the Level II HCPCS codes in the A 6000 series.

Bill your intermediary.

Your intermediary makes payment based on the surgical dressing fee schedule. Where fee amounts have not been established the intermediary determines the fee in consultation with the DMERC. Updated fee amounts are published on the HCFA Web site.

536 BILLING FOR DRUGS

536.1 Self-Administered Drugs and Biologicals--

Drugs and biologicals furnished to outpatients for therapeutic purposes that are self-administered are not covered by Medicare unless those drugs and biologicals must be put directly into an item of durable medical equipment or a prosthetic device. The statute provides for such coverage (including blood clotting factors, drugs used in immunosuppressive therapy, erythropoietin (EPO), certain oral anti-cancer drugs and their associated anti-emetics), or the ordinarily non-covered, self-administered drug insulin is administered in an emergency situation to a patient in a diabetic coma.

Where covered under Part B, bill self-administered drugs with bill type 22X for SNF residents and bill type 23X for non residents (see section 529.4 for a definition of resident).

Self-Administered Drug Administered In An Emergency Situation.--Medicare pays for the ordinarily non-covered, self-administered drug insulin administered in an emergency situation to a patient in a diabetic coma. Bill for the aforementioned drug on Form HCFA-1450 or its electronic equivalent with bill type 22X or 23X, as appropriate. Enter value code A4 and its related dollar amount (the amount included in covered charges for the ordinarily non-covered, self-administered drug insulin administered to the patient in an emergency situation) in FLs 39-41 under revenue code 637 (self-administerable drugs not requiring detailed coding) in FL 42. Complete the remaining items in accordance with regular billing instructions.

NOTE: Do not utilize revenue code 637 (self-administerable drugs not requiring detailed coding) for the reporting of those self-administerable drugs and biologicals that are statutorily covered. Follow the existing reporting requirements for those self-administered drugs and biologicals.

Self-Administered Oral Cancer Drugs.--Section 13553 of OBRA 1993 provides coverage for self-administered oral versions of covered injectable cancer drugs prescribed as an anti-cancer chemotherapeutic on or after January 1, 1994. To be covered, an oral cancer drug must:

- o Be prescribed by a physician or practitioner as an anti-cancer chemotherapeutic agent;
- o Be a drug or biological approved by the Food and Drug Administration (FDA);
- o Have the same active ingredients as a non-self-administerable anti-cancer chemotherapeutic drug or biological that is covered when furnished incident to a physician's service. The oral anti-cancer drug and the non-self-administerable drug must have the same chemical/generic name as indicated by the FDA's Approved Drug and Products (Orange Book), Physician's Desk Reference (PDR), or an authoritative drug compendium; or

-- Effective January 1, 1999 be a FDA-approved oral anti-cancer Prodrug, an oral drug ingested into the body that metabolizes into the same active ingredient that is found in the non-self-administerable form of the drug;

- o Be used for the same indications (including off-label uses) as the non-self-administerable version of the drug; and

- o Be reasonable and necessary for the individual patient.

<u>Generic/Chemical Name</u>	<u>How Supplied</u>	<u>HCPCS</u>	
Busulfan	2 mg/ORAL	J8510	
Capecitabine	150 mg/ORAL	J8520	
Capecitabine	500 mg/ORAL	J8521	
Cyclophosphamide	25 mg/ORAL 50 mg/ORAL	J8530 J8530	(Treat 50 mg. as 2 units)
Etoposide	50 mg/ORAL	J8560	
Methotrexate	2.5 mg/ORAL	J8610	
Melphalan	2 mg/ORAL	J8600	
Prescription Drug, Chemotherapeutic,	ORAL NOS	J8999	

Part B of Medicare pays 80 percent of the reasonable cost of oral cancer drugs furnished by a provider. Deductible and coinsurance apply. Bill for these drugs on the HCFA-1450 or its electronic equivalent with bill type 22X or 23X, as appropriate. Enter revenue code 636 in FL 42 of the HCFA-1450, the name and HCPCS of the oral drug in FLs 43 and 44 on the HCFA-1450, and the number of tablets or capsules in FL 46 of the HCFA-1450. Each tablet or capsule is equal to one unit, except for 50 mg/ORAL of cyclophosphamide (J8530), which is shown as 2 units. Report oral anti-cancer Prodrugs under revenue code 636 in FL 42 and HCPCS code J8999 in FL 44. Complete the remaining items in accordance with regular billing instructions. A cancer diagnosis must be entered in FLs 67-75 of Form HCFA-1450 for coverage of an oral cancer drug or an oral cancer Prodrug.

Self-Administered Antiemetic Drugs.--Effective with dates of service on or after January 24, 1996, Medicare pays for self-administerable oral or rectal versions of self-administered antiemetic drugs when they are necessary for the administration and absorption of primary Medicare covered oral anti-cancer chemotherapeutic agents when a high likelihood of vomiting exists. The self-administered antiemetic drug is covered as a necessary means for the administration of the oral anti-

cancer drug (similar to a syringe and needle necessary for injectable administration). Self-administered antiemetics which are prescribed for use to permit the patient to tolerate the primary anti-cancer drug in high doses for longer periods are not covered. In addition, self-administered antiemetics used to reduce the side effects of nausea and vomiting brought on by the primary drug are not included beyond the administration necessary to achieve drug absorption. (See §230.4.)

Part B of Medicare pays 80 percent of the reasonable cost of self-administered antiemetic drugs furnished by a provider. Deductible and coinsurance apply. Bill for these drugs on Form HCFA-1450 or its electronic equivalent with bill type 22X or 23X, as appropriate. Enter revenue code 636 in FL 42. For claims with dates of service on or after January 24, 1996 through March 31, 1996, enter HCPCS code J3490 in FL 44. For dates of service on or after April 1, 1996, enter one of the following HCPCS codes in FL 44, as appropriate:

K0415 Prescription anti-emetic drug, oral, per 1 mg, for use in conjunction with oral anti-cancer drug, not otherwise specified; or

K0416 Prescription anti-emetic drug, rectal, per 1 mg, for use in conjunction with oral anti-cancer drug, not otherwise specified.

Enter the name of the self-administered antiemetic drug in FL 43 and the number of units in FL 46. Each milligram of the tablet, capsule, or rectal suppository is equal to one unit. Complete the remaining items in accordance with regular billing instructions.

Claims are edited to assure that the beneficiary is receiving the self-administered antiemetic drug in conjunction with a Medicare covered oral anti-cancer drug.

Oral Anti-Nausea Drugs as Full Therapeutic Replacements for Intravenous Dosage Forms As Part of a Cancer Chemotherapeutic Regimen.--Section 4557 of the Balanced Budget Act of 1997 provides coverage for claims with dates of service on or after January 1, 1998 for oral anti-emetic drugs as full therapeutic replacements for intravenous dosage forms as part of a chemotherapeutic regimen provided that the drug(s) be administered or prescribed by a physician for use immediately before, at, or within 48 hours after the time of administration of the chemotherapeutic agent.

For purposes of this provision, the allowable period of covered therapy is defined to include day one, the date of service of the chemotherapy drug (beginning with the time of treatment), plus a period not to exceed 2 additional calendar days, or a maximum period up to 48 hours. The oral anti-emetic drug(s) should only be prescribed on a per chemotherapy treatment basis. For example, only enough of the oral anti-emetic(s) for one 24 or 48-hour dosage regimen (depending upon the drug) should be prescribed/supplied for each incidence of chemotherapy treatment at a time. The beneficiary's medical record must be documented to reflect that the beneficiary is receiving the oral anti-emetic drug(s) as full therapeutic replacement for an intravenous anti-emetic drug as part of a cancer chemotherapeutic regimen. This will indicate that the Q codes listed in §422.4A are being reported when billing for the oral anti-emetic(s). The use of the appropriate Q code(s) on the claim will serve as affirmation of the correct use of the benefit. A cancer diagnosis must be entered in FLs 67-75 of Form HCFA-1450 for coverage of these drugs.

Payment for these drugs is made under Part B. Medicare pays 80 percent of the reasonable cost of these drugs furnished by a provider. Deductible and coinsurance apply.

Bill for these drugs on Form HCFA-1450 or its electronic equivalent with bill type 22X or 23X, as appropriate.

A. Revenue Code and HCPCS Reporting.--Report the oral anti-emetic drug(s) under revenue code 636 in FL 42 "Revenue Code." For claims with dates of service on or after January 1, 1998

through March 31, 1998, report the HCPCS code J3490 in FL 44 "HCPCS/Rates." For dates of service on or after April 1, 1998 report the following HCPCS code(s), as appropriate, in FL 44:

- Q0163 DIPHENHYDRAMINE HYDROCHLORIDE, 50 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at time of chemotherapy treatment not to exceed a 48 hour dosage regimen.
- Q0164 PROCHLORPERAZINE MALEATE, 5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.
- Q0165 PROCHLORPERAZINE MALEATE, 10 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.
- Q0166 GRANISETRON HYDROCHLORIDE, 1 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 24 hour dosage regimen.
- Q0167 DRONABINOL, 2.5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.
- Q0168 DRONABINOL, 5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.
- Q0169 PROMETHAZINE HYDROCHLORIDE, 12.5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.
- Q0170 PROMETHAZINE HYDROCHLORIDE, 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.
- Q0171 CHLORPROMAZINE HYDROCHLORIDE, 10 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.
- Q0172 CHLORPROMAZINE HYDROCHLORIDE, 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.
- Q0173 TRIMETHOBENZAMIDE HYDROCHLORIDE, 250 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.
- Q0174 THIETHYLPERAZINE MALEATE, 10 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.
- Q0175 PERPHENAZINE, 4 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

- Q0176 PERPHENAZINE, 8 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hours dosage regimen.
- Q0177 HYDROXYZINE PAMOATE, 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.
- Q0178 HYDROXYZINE PAMOATE, 50 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.
- Q0179 ONDANSETRON HYDROCHLORIDE, 8 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.
- Q0180 DOLASETRON MESYLATE, 100 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 24 hour dosage regimen.
- Q0181 UNSPECIFIED ORAL DOSAGE FORM, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for a IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

NOTE: The 24 hour maximum drug supply limitation on dispensing, for HCPCS codes Q0166 and Q0180, has been established to bring the Medicare benefit as it applies to these two therapeutic entities in conformance with the “Indications and Usage” section of currently Food and Drug Administration approved product labeling for each affected drug product. In addition, when billing for chemotherapy drugs (which includes oral cancer and IV chemotherapy drugs), you must report the HCPCS code of the chemotherapy drug in FL 44 under revenue code 636 in FL 42.

NOTE: When billing for an oral anti-emetic drug(s) on the hard copy UB-92 (Form HCFA-1450), report the name of the oral anti-emetic drug(s) in FL 43 “Description” on the appropriate revenue lines.

B. Line Item Dates of Service Reporting.--When billing for an oral anti-emetic drug(s) used as full replacement for intravenous forms, you are required to report line item dates of service for the oral anti-emetic(s). Line item dates of service are reported in FL 45 “Service Date” (MMDDYYYY). (See example below.)

C. Service Unit Reporting.--Report the number of units of the oral anti-emetic drug(s) in FL 46 “Service Units” for each drug reported. Each HCPCS code descriptor is equal to one service unit. Complete the remaining items in accordance with regular billing instructions.

536.2 -- Special Billing Instructions for Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines

Part B of Medicare pays 100 percent for pneumococcal pneumonia vaccines (PPV) and influenza virus vaccines and their administration. Payment is based on a cost basis. Deductible and coinsurance do not apply. Part B of Medicare also covers the hepatitis B vaccine and its administration. Deductible and coinsurance apply.

A. Coverage Requirements.--Effective for services furnished on or after July 1, 2000, Medicare does not require for coverage purposes, that the PPV vaccine and its administration be ordered by a doctor of medicine or osteopathy. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

Effective for services furnished on or after September 1, 1984, hepatitis B vaccine and its administration is covered if it is ordered by a doctor of medicine or osteopathy and is available to Medicare beneficiaries who are at high or intermediate risk of contracting hepatitis B.

Effective for services furnished on or after May 1, 1993, influenza virus vaccine and its administration is covered when furnished in compliance with any applicable State law. Typically, this vaccine is administered once a year in the fall or winter. Medicare does not require for coverage purposes that the vaccine must be ordered by a doctor of medicine or osteopathy. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

B. General Billing Requirements.--Follow the general billing instructions in §560. You must file your claim on a HCFA-1450, using bill types 22X and 23X. For these bills, you must complete Item 44 (HCPCS) on the HCFA-1450. (See §560.) Bill for the vaccines and their administration on the same claim. There is no requirement for a separate bill for the vaccines and their administration.

C. HCPCS Coding.--Bill for the vaccines using the following HCPCS codes listed below:

- 90657 Influenza virus vaccine, split virus, 6-35 months dosage, for intramuscular or jet injection use;
- 90658 Influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use;
- 90659 Influenza virus vaccine, whole virus, for intramuscular or jet injection use;
- 90732 Pneumococcal polysaccharide vaccine, 23-valent, adult dosage, for subcutaneous or intramuscular use;
- 90744 Hepatitis B vaccine, pediatric or pediatric/adolescent dosage, for intramuscular use;
- 90745 Hepatitis B vaccine, adolescent/high risk infant dosage, for intramuscular use;
- 90746 Hepatitis B vaccine, adult dosage, for intramuscular use;
- 90747 Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, for intramuscular use;
- 90748 Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use.

These codes are for reporting of the vaccines only. Bill for the administration of the vaccines using HCPCS code G0008 for the influenza virus vaccine, G0009 for the PPV vaccine, and G0010 for the hepatitis B vaccine.

D. Applicable Revenue Codes.--Bill for the vaccines using revenue code 636. Bill for the administration of the vaccines using revenue code 771.

E. Other Coding Requirements.--You must report a diagnosis code for each vaccine if the sole purpose for the visit is to receive a vaccine or if a vaccine is the only service billed on a claim. Report code V04.8 for the influenza virus vaccine, code V03.82 for PPV, and code V05.3 for the hepatitis B vaccine. In addition, for the influenza virus vaccine, report UPIN code SLF000 if the vaccine is not ordered by a doctor of medicine or osteopathy.

F. Simplified Billing of Influenza Virus Vaccine by Mass Immunizers.--Some potential "mass immunizers" have expressed concern about the complexity of billing for the influenza virus vaccine and its administration. Consequently, to increase the number of beneficiaries who obtain needed

preventive immunizations, simplified (roster) billing procedures are available to mass immunizers. A mass immunizer is defined as any entity that gives the influenza virus vaccine to a group of beneficiaries, e.g., at Public Health Clinics, shopping malls, grocery stores, senior citizen homes, and health fairs. To qualify for roster billing, immunizations of at least five beneficiaries on the same date is required.

The simplified process involves use of the HCFA-1450 with preprinted standardized information relative to you and the benefit. When conducting mass immunizations, attach a standard roster to a single pre-printed HCFA-1450 that contains the variable claims information regarding the service provider and individual beneficiaries. The roster must contain, at a minimum, the following information:

- o Provider name and number;
- o Date of service;
- o Patient name and address;
- o Patient date of birth;
- o Patient sex;
- o Patient health insurance claim number; and
- o Beneficiary signature or stamped "signature on file".

NOTE: A stamped "signature on file" can be used in place of the beneficiary's actual signature provided you have a signed authorization on file to bill Medicare for services rendered. In this situation, you are not required to obtain the patient signature on the roster. However, you have the option of reporting "signature on file" in lieu of obtaining the patient's actual signature.

The modified HCFA-1450 shows the following preprinted information in specific FLs:

- o The words "See Attached Roster" in FL 12, (Patient Name);
- o Patient Status code 01 in FL 22 (Patient Status);
- o Condition code M1 in FLs 24-30 (Condition Code) (See NOTE: below);
- o Condition code A6 in FLs 24-30 (Condition Code);
- o Revenue code 636 in FL 42 (Revenue Code), along with the appropriate HCPCS code in FL 44 (HCPCS Code);
- o Revenue code 771 in FL 42 (Revenue Code), along with HCPCS code G0008 FL 44 (HCPCS Code);
- o "Medicare" on line A of FL 50 (Payer);
- o The words "See Attached Roster" on line A of FL 51 (Provider Number);
- o UPIN SLF000 in FL 82; and
- o Diagnosis code V04.8 in FL 67 (Principal Diagnosis Code).

When conducting mass immunizations, you are required to complete the following FLs on the preprinted HCFA-1450:

- o FL 4 (Type of Bill);
- o FL 47 (Total Charges);
- o FL 85 (Provider Representative); and
- o FL 86 (Date).

NOTE: Medicare Secondary Payer (MSP) utilization editing is by-passed in CWF for all mass immunizer roster bills. However, if the provider knows that a particular group health plan covers the influenza virus vaccine and all other MSP requirements for the Medicare beneficiary are met, the primary payer must be billed.

If you do not mass immunize, continue to bill for the influenza virus vaccine using normal billing procedures; i.e., submission of a HCFA-1450 or electronic billing for each beneficiary.

G. Simplified Billing of Pneumococcal Pneumonia Vaccine (PPV) by Mass Immunizers.-- The simplified (roster) claims filing procedure has been expanded for PPV. A mass immunizer is defined as any entity that gives the PPV to a group of beneficiaries, e.g., at Public Health Clinics, shopping malls, grocery stores, senior citizen homes, and health fairs. To qualify for roster billing, immunizations of at least five beneficiaries on the same date is required. The simplified process involves use of the HCFA-1450 with preprinted standardized information relative to the provider and the benefit. Mass immunizers attach a standard roster to a single pre-printed HCFA-1450 which will contain the variable claims information regarding the service provider and individual beneficiaries.

The roster must contain, at a minimum, the following information:

- o Provider name and number;
- o Date of service;
- o Patient name and address;
- o Patient date of birth;
- o Patient sex;
- o Patient health insurance claim number; and
- o Beneficiary signature or stamped "signature on file".

NOTE: A stamped "signature on file" can be used in place of the beneficiary's actual signature provided you have a signed authorization on file to bill Medicare for services rendered. In this situation, you are not required to obtain the patient signature on the roster. However, you have the option of reporting "signature on file" in lieu of obtaining the patient's actual signature.

The roster should contain the following language to be used by you as a precaution to alert beneficiaries prior to administering the PPV.

WARNING: The beneficiary's vaccination status must be verified before administering the PPV. It is acceptable to rely on the patient's memory to determine prior vaccination status. If the patient is uncertain whether they have been vaccinated within the past 5 years, administer the vaccine. If patients are certain that they have been vaccinated

within the past 5 years, do not revaccinate.

The modified HCFA-1450 shows the following preprinted information in the specific form locators (FLs):

- o The words "See Attached Roster" in FL 12, (Patient Name);
- o Patient Status code 01 in FL 22 (Patient Status);
- o Condition code M1 in FLs 24-30 (Condition Code);
- o Condition code A6 in FLs 24-30 (Condition Code);
- o Revenue code 636 in FL 42 (Revenue Code), along with HCPCS code 90732 in FL 44 (HCPCS Code);
- o Revenue code 771 in FL 42 (Revenue Code), along with HCPCS code G0009 in FL 44 (HCPCS Code);
- o "Medicare" on line A of FL 50 (Payer);
- o The words "See Attached Roster" on line A of FL 51 (Provider Number); and
- o Diagnosis code V03.82 in FL 67 (Principal Diagnosis Code).

When conducting mass immunizations, you are required to complete the following FLs on the preprinted HCFA-1450:

- o FL 4 (Type of Bill);
- o FL 47 (Total Charges);
- o FL 85 (Provider Representative); and
- o FL 86 (Date).

NOTE: Medicare Secondary Payer (MSP) utilization editing is by-passed in CWF for all mass immunizer roster bills. However, if you know that a particular group health plan covers the PPV and all other MSP requirements for the Medicare beneficiary are met, the primary payer must be billed.

If you do not mass immunize, continue to bill for PPV using the normal billing method i.e., submission of a HCFA-1450 or electronic billing for each beneficiary.

537. BILLING FOR MAMMOGRAPHY SCREENING

537.1. MAMMOGRAPHY QUALITY STANDARDS ACT (MQSA)

A. Background.--The MQSA requires the Secretary to ensure that all facilities that provide mammography services meet national quality standards. Effective October 1, 1994, all facilities providing screening and diagnostic mammography services (except VA facilities) must have a certificate issued by the Food and Drug Administration (FDA) to continue to operate. On September 30, 1994, HCFA stopped conducting surveys of screening mammography facilities. The responsibility for collecting certificate fees and surveying mammography facilities (screening and diagnostic) was transferred to FDA, Center for Devices and Radiological Health.

B. General.--Your intermediary will pay diagnostic and screening mammography services for claims submitted by you only if you have been issued a MQSA certificate by the FDA. Your intermediary is responsible for determining that you have a certificate prior to payment. In addition, it is responsible for ensuring that payment is not made in situations where your certificate has expired, or it has been suspended or revoked or you have been issued a written notification by FDA stating that you must cease conducting mammography examinations because you are not in compliance with certain critical FDA certification requirements.

C. Under Arrangements.--When you obtain mammography services for your patients under arrangements with another facility, you must ensure that the facility performing the services has been

issued a MQSA certificate by FDA.

D. Denied Services.--When your intermediary determines the facility that performed the mammography service has not been issued a certificate by FDA or the certificate is suspended or revoked, your claim will be denied utilizing the denial language in §537.2G, related to certified facilities.

537.2 MAMMOGRAPHY SCREENING

Section 4163 of the Omnibus Budget Reconciliation Act of 1990 added §1834(c) of the Act to provide for Part B coverage of mammography screening for certain women entitled to Medicare for screenings performed on or after January 1, 1991. The term "screening mammography" means a radiologic procedure provided to an asymptomatic woman for the purpose of early detection of breast cancer and includes a physician's interpretation of the results of the procedure. Unlike diagnostic mammographies, there do not need to be signs, symptoms, or history of breast disease in order for the exam to be covered.

There is no requirement that the screening mammography examination be prescribed by a physician for an eligible beneficiary to be covered. A screening mammography may be furnished to a woman at her direct request. Whether or not payment can be made is determined by a woman's age and statutory frequency parameters.

Prior to October 1, 1994, if you perform screening mammographies, you must request and be recommended for certification by the State certification agency and approved by HCFA before payment is made. Effective October 1, 1994, if you perform mammography services (diagnostic and screening), you must be issued a certificate from the Food and Drug Administration (FDA) before payment is made. (See §538 for more detailed instructions.) If you arrange for another entity to perform a screening mammography for one of your patients prior to October 1, 1994, you must assure that the entity is certified to perform the screening, or on or after October 1, 1994, you must assure that the entity has been issued a certificate by FDA. Your intermediary will deny claims when it determines that the entity that performed the screening is not certified. It will utilize denial language in subsection G.

Section 4101 of the Balanced Budget Act (BBA) of 1997 provides for annual screening mammographies for women over 39 and waives the Part B deductible. Coverage applies as follows:

- o No payment may be made for a screening mammography performed on a woman under 35 years of age;
- o You will be paid for only one screening mammography performed on a woman between her 35th and 40th birthdays (ages 35 thru 39); and
- o For a woman over 39, you will be paid for a screening mammography performed after 11 full months have passed following the month in which the last screening mammography was performed.

A. Determining 11 Month Period.--To determine the 11 and 23 month periods, your intermediary starts their count beginning with the month after the month in which a previous screening mammography was performed.

EXAMPLE: The beneficiary received a screening mammography in January 1999. Intermediaries start their count beginning with February 1999. The beneficiary is eligible to receive another screening mammography in January 2000 (the month after 11 full months have elapsed).

B. Payment Limitations.--There is no Part B deductible. However, coinsurance is applicable. Following are three categories of billing for mammography services:

- o Professional component of mammography services (that is, for the physician's interpretation of the results of the examination);
- o Technical component (all other services); and
- o Both professional and technical components (global). Bill globally if your staff performed the entire service or you have an arrangement with a physician by which you bill.

When the technical and professional components of the screening mammography are billed separately, the payment limit is adjusted to reflect either the professional or technical component only. That is, the limitation (\$62.10 in calendar year 1996, \$63.34 in calendar year 1997, \$64.73 in calendar year 1998 by 68 percent, \$66.22 in calendar year 1999, and \$67.81 in calendar year 2000 by 68 percent) applicable to global billing for screening is allocated between the professional and technical components as set forth by regulations. For example, in calendar year 2000, 32 percent of the \$67.81 limit, or \$21.69, is used in determining payment for the professional component, and 68 percent of the \$67.81 limit, or \$46.12, is used in determining payment for the technical component.

Payment for the technical component equals 80 percent of the least of the:

- o Actual charge for the technical component of the service;
- o Amount determined for the technical component of a bilateral diagnostic mammogram (HCPCS code 76091) for the service under the radiology fee schedule in 1991 or for services furnished on or after January 1, 1992 under the Medicare physicians' fee schedule; or
- o Technical portion of the screening mammography limit. This is an amount determined by multiplying the screening mammography limit (\$60.88 in calendar year 1995, \$62.10 for calendar year 1996, \$63.34 in calendar year 1997, \$64.73 in calendar year 1998, \$66.22 in calendar year 1999, and \$67.81 for calendar year 2000) by 68 percent.

The amount of payment for the global charge equals 80 percent of the least of:

- o The actual charge for the procedure;
- o The amount determined with respect to the global procedure under the Medicare Fee Schedule; or
- o The limit for the procedure. The amount for 2000 is \$67.81 (\$66.22 in 1999).

On January 1 of each subsequent year, the overall limit is updated by the percentage increase in the Medicare Economic Index. Bill your intermediary on Form HCFA-1450 for the technical component portion of the screening and/or globally if an agreement exists to do so.

C. Billing Requirements.--Bill the technical component portion of the screening mammography on Form HCFA-1450 under bill type 22X or 23X along with HCPCS code 76092 and modifier 26 (technical component billing only). A separate bill is required. Include on the bill only charges for mammography screening.

Bill global mammography services on Form HCFA-1450 under bill type 22X or 23X using the same HCPCS code (76092) without a modifier. A separate bill is required. Include on the bill only charges for mammography screening.

On every screening claim, with dates of service October 1, 1997 thru December 31, 1997, where the patient is not a high risk individual, enter in FL 67, "Principal Diagnosis Code," the following code:

- o V76.12 "Other screening mammography."

If the screening is for a high risk individual, enter in FL 67, "Principal Diagnosis Code," the following code:

- o V76.11 "Screening mammogram for high risk patient."

In addition, for high risk individuals, report one of the following applicable codes in FL 68, "Principal Diagnoses Codes":

- o V10.3 "Personal history - Malignant neoplasm female breast;"
- o V16.3 "Family history - Malignant neoplasm breast;" and
- o V15.89 "Other specified personal history representing hazards to health."

The following chart indicates the ICD-9 diagnosis codes to be reported for each high risk category:

<u>High Risk Category</u>	<u>Appropriate Diagnosis Code</u>
A personal history of breast cancer	V10.3
A mother, sister, or daughter who has breast cancer	V16.3
Not given birth prior to age 30	V15.89
A personal history of biopsy-proven benign breast disease	V15.89

On every screening claim with dates of service on or after January 1, 1998, you must enter in FL 67, "Principal Diagnosis Code," the following code:

- o V76.12 "Other screening mammography."

NOTE: Code ICD-9 diagnosis code for mammography to the applicable fourth or fifth digit. Omit decimal points for data entry purposes. In addition, due to the BBA of 1997, there is no need for you to continue to report the high risk diagnosis code effective January 1, 1998.

D. Actions Required.--Your intermediary will consider the following when determining whether payment may be made:

- o Presence of revenue code 403;
- o Presence of HCPCS code 76092;
- o Presence of high risk diagnosis code indicator;
- o Date of last screening mammography; and
- o Age of beneficiary.

E. Determining Payment Amount for Global or Technical Component.-Following are payment calculations for either mammography global billing or technical component billing. Technical component is paid when modifier TC is reported. For services in 2000, your intermediary will pay the lower of:

- o Billed charges for HCPCS code 76092 with modifier TC;
- o \$46.12; or
- o The physicians' fee schedule amount for the technical component of HCPCS code 76091.

EXAMPLE: \$90.00 Facility charges
 \$75.00 Physicians' fee schedule amount
 \$46.12 Technical portion screening mammography limit (68% of \$67.81)

Payment is 80 percent of the lower of:

\$90.00 Hospital charges;
 \$75.00 Physicians' fee schedule amount for the technical component; or
 \$46.12 Technical portion screening mammography limit.

To calculate the payment, your intermediary selects the lower of:

\$90.00 Charges;
 \$75.00 Physicians' fee schedule amount for the technical component; or
 \$46.12 Technical portion of screening mammography limit.

Your intermediary will pay 80 percent of the remainder. This is a final payment to you.

In this case:

$\$46.12 \times 80\% = \$36.90.$

To determine the patient's liability to you, multiply the actual charge by 20 percent. The result plus the unmet deductible is the patient's liability.

In this case:

$\$90.00 \times 20\% = \18.00 (coinsurance)

In this example, \$18.00 is the coinsurance.

Global payment is made when a modifier is not reported on the claim.

The amount of payment for the global charge equals 80 percent of the least of:

- The actual charge for the procedure;
- The amount determined with respect to the global procedure under the Medicare Fee Schedule;
- or
- The limit for the procedure. The amount for 2000 is \$67.81(\$66.22 in 1999).

F. Special Billing Instructions When a Radiologist Interpretation Results in Additional Films.--Radiologists who interpret screening mammographies are allowed to order and interpret additional films based on the results of the screening mammogram while the beneficiary is still at your facility for the screening exam. Where a radiologist interpretation results in additional films, the mammography is no longer considered a screening exam for application of age and frequency standards or for payment purposes. When this occurs, the claim will be paid as a diagnostic mammography instead of a screening mammography. However, since the original intent for the exam was for screening, for statistical purposes, the claim is considered a screening.

Prepare the claim reflecting the diagnostic revenue code (401) along with HCPCS code 76090 or 76091 and modifier GH "Diagnostic mammogram converted from screening mammogram on same day". Payment will be made to you on a fee schedule basis. Statistics will be collected based on the presence of modifier GH. A separate claim is not required. Regular billing instructions remain in place for mammographies that do not fit this situation. (See subsection C for appropriate bill types.)

G. Medicare Summary Notice (MSN) and Explanation of Your Medicare Benefits (EOMB) Messages.--If your intermediary has converted to MSN, they should utilize the following MSN messages. If your intermediary has NOT converted to MSN, they should utilize the following EOMB messages.

If the claim is denied because the beneficiary is under 35 years of age, your intermediary states on the EOMB or MSN the following message:

"Screening mammography is not covered for women under 35 years of age."
(MSN message number 18-3, or EOMB message under 18.18)

If the claim is denied for a woman 35-39 because she has previously received this examination, your intermediary states on the EOMB or MSN the following message:

"A screening mammography is covered only once for women age 35-39."
(MSN message number 18-6 or EOMB message number 18.19)

If the claim is denied because the period of time between screenings for the woman based on age has not passed, your intermediary states on the EOMB or MSN the following message:

"This service is being denied because it has not been 12 months since your last examination of this kind."
(MSN message number 18-4 or EOMB message number 18.20)

If the claim is denied because the provider that performed the screening is not certified, your intermediary states on the EOMB or MSN the following message:

"This service cannot be paid when provided in this location/facility."
(MSN message number 16-2 or EOMB message number 16.4)

In addition to the above denial messages, your intermediary has the option of using the following message on the EOMB or MSN:

"Screening mammograms are covered annually for women 40 years of age and older."
(MSN message number 18-12 or EOMB message number 18.21)

If the claim is denied because the provider that performed the screening is not certified, your intermediary states on the EOMB or MSN the following message:

“This service cannot be paid when provided in this location/facility.”
(MSN message number 16-2 or EOMB message number 16.4)

In addition to the above denial messages, your intermediary has the option of using the following message on the EOMB or MSN:

“Screening mammograms are covered annually for women 40 years of age and older.”
(MSN message number 18-12 or EOMB message number 18.21)

I. Remittance Advice Messages.--If the claim is denied because the beneficiary is under 35 years of age, your intermediary uses existing American National Standard Institute (ANSI) X-12-835 claim adjustment reason code/message 6, “The procedure code is inconsistent with the patient's age” along with line level remark code M37, “Service is not covered when the beneficiary is under age 35.” If the claim is denied for a woman 35-39 because she has previously received this examination, your intermediary uses existing ANSI X-12-835 claim adjustment reason code/message 119, “Benefit maximum for this time period has been reached” along with line level remark code M89, “Not covered more than once under age 40.”

If the claim is denied for a woman age 40 and above because she has previously received this examination within the past 12 months, your intermediary uses existing ANSI X-12-835 claim adjustment reason code/message 119, “Benefit maximum for this time period has been reached” along with line level remark code M90, “Not covered more than once in a 12-month period.”

If the claim is denied because the provider that performed the screening is not certified, your intermediary uses existing ANSI X-12-835 claim adjustment reason code/message B7, “This provider was not certified for this procedure/service on this date of service.”

539. BILLING FOR AMBULANCE SERVICES

A. General.-Your intermediary processes claims for ambulance services provided under arrangements between you and an ambulance company or ambulance services furnished directly by you. Whether or not the patient is admitted as an inpatient, bill ambulance services as a Part B service on a reasonable cost basis. For consolidated billing, ambulance claims may be billed by the supplier or the SNF (Type of Bill 22X or 23X) if one of the following is true:

- Ambulance transportation to receive dialysis services. Either one of any HCPCS ambulance modifier codes is G or J,
- An ambulance trip that transports a beneficiary to the SNF for the initial admission or from the SNF following a final discharge. The first character (origin) of any HCPCS ambulance modifier is N (SNF) and date of ambulance service is the same date as the inpatient SNF through date if the SNF patient status (FL22) is other than 30, or the second character (destination) of any ambulance HCPCS modifier is N (SNF) other than modifier QN and the date of service is the same as the from date on the inpatient SNF bill.
- Ambulance services to receive any of the services excluded from consolidate billing. Either one of any HCPCS ambulance modifier codes is N or H.

Furnish the following data when needed by your intermediary. Your intermediary will make arrangements with you about the method and media for submitting the data, i.e., with the claim or upon your intermediary's written request, paper or the electronic record, Addenda A and B, record type 75.

- A detailed statement of the condition necessitating the ambulance service;
- Your statement indicating whether or not the patient was admitted as an inpatient. If applicable, show the name and address of the facility;

- Name and address of certifying physician;
- Name and address of physician ordering service if other than certifying physician;
- Point of pickup (identify place and completed address);
- Destination (identify place and complete address);
- Number of loaded miles (the number of miles traveled when the beneficiary was in the ambulance);
- Cost per mile;
- Mileage charge;
- Minimum or base charge; and
- Charge for special items or services. Explain.

B. Applicable Bill Types.--The appropriate bill type is 23X.

C. Revenue Code/HCPCS Reporting.--You must report revenue code 54X and one of the following HCFA Common Procedure Coding System (HCPCS) codes in FL 44 "HCPCS/Rates" for each ambulance trip provided during the billing period: A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328 or A0330. In addition, report one of the following mileage HCPCS codes: A0380 or A0390. No other HCPCS codes are acceptable for reporting ambulance services and mileage. For purposes of revenue code reporting, report one of the following codes: 540, 542, 543, 545, 546, or 548. Do not report revenue codes 541, 544, 547, and 549.

Since billing requirements do not allow for more than one HCPCS code to be reported per revenue code line, you must report revenue code 54X (ambulance) on two separate and consecutive line items to accommodate both the ambulance service and the mileage HCPCS codes for each ambulance trip provided during the billing period. Each loaded (i.e., a patient is onboard) one-way ambulance trip must be reported with a unique pair of revenue code lines on the claim. Unloaded trips and mileage are NOT reported.

However, in the case where the beneficiary was pronounced dead after the ambulance was called but before pickup, the service to the point of pickup is covered. In this situation, report the appropriate HCPCS code of either A0322 (if a basic life support (BLS) vehicle is used) or A0328 (if an advanced life support (ALS) vehicle is used.) Report the mileage HCPCS code A0380 (BLS) or A0390 (ALS) from the point of dispatch to the point of pickup. No further mileage is billed (e.g., the mileage after the ambulance arrives at the point of pickup is neither billed nor covered.) (See §262.3.H for a more detailed explanation.)

D. Modifier Reporting.--You must report an origin and destination modifier for each ambulance trip provided in FL 44 "HCPCS/Rates". Origin and destination modifiers used for ambulance services are created by combining two alpha characters. Each alpha character, with the exception of X, represents an origin code or a destination code. The pair of alpha codes creates one modifier. The first position alpha code equals origin; the second position alpha code equals destination. Origin and destination codes and their descriptions are listed below:

- D: Diagnostic or therapeutic site other than "P" or "H" when these are used as origin codes;
- E: Residential, Domiciliary, Custodial facility (other than an 1819 facility);
- G: Hospital based dialysis facility (hospital or hospital related);
- H: Hospital;
- I: Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport;
- J: Non-hospital based dialysis facility;
- N: Skilled Nursing Facility (SNF) (1819 facility);
- P: Physician's office (Includes HMO non-hospital facility, clinic, etc.);
- R: Residence;

- S: Scene of accident or acute event; or
- X: (Destination Code Only) intermediate stop at physician's office enroute to the hospital. (Includes HMO non-hospital facility, clinic, etc.)

In addition, you must report one of the following modifiers with every HCPCS code to describe whether the service was provided under arrangement or directly:

- QM: Ambulance service provided under arrangement by a provider of services; or
- QN: Ambulance service furnished directly by a provider of services.

E. Line-Item Dates of Service Reporting.--You are required to report line-item dates of service per revenue code line. This means that you must report two separate revenue code lines for every ambulance trip provided during the billing period along with the date of each trip. This includes situations in which more than one ambulance service is provided to the same beneficiary on the same day. Line-item dates of service are reported in FL 45 "Service Date" (MMDDYY). (See examples below.) (For an exception to the rule for loaded miles see §262.3.H.)

F. Service Units Reporting.--For line items reflecting HCPCS codes A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328 or A0330, you are required to report in FL 46 "Service Units" each ambulance trip provided during the billing period. Therefore, the service units for each occurrence of these HCPCS codes are always equal to one. In addition, for line items reflecting HCPCS code A0380 or A0390, you must also report the number of loaded miles. (See examples below.)

G. Total Charges Reporting.--For line items reflecting HCPCS codes A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328 or A0330, you are required to report in FL 47 "Total Charges" the actual charge for the ambulance service including all supplies used for the ambulance trip but excluding the charge for mileage. For line items reflecting HCPCS codes A0380 or A0390, report the actual charge for mileage.

NOTE: There are cases where you do not incur any cost for mileage (e.g., you receive a subsidy from a local municipality or the transport vehicle is owned and operated by a governmental or volunteer entity.) In these situations, report the ambulance trip in accordance with Subsections C through G above. In addition, for purposes of reporting mileage, report on a separate line item the appropriate HCPCS code, modifiers, and units. For the related charges, report \$1.00 in FL 48 "Non-covered Charges." Prior to submitting the claim to CWF, your intermediary will remove the entire revenue code line containing the mileage amount reported in FL 48 "Non-covered Charges" to avoid nonacceptance of the claim.

Examples.--The following provides examples of how bills for ambulance services should be completed based on the reporting requirements above. These examples reflect ambulance services furnished directly by you. Ambulance services provided under arrangement between you and an ambulance company are reported in the same manner except you report a QM modifier instead of a QN modifier.

Example 1 - Claim containing only one ambulance trip.

For the UB-92 Flat File, report as follows:

<u>Record Type</u>	<u>Revenue Code</u>	<u>HCPCS</u>	<u>Modifier #1</u>	<u>Modifier #2</u>	<u>Date of Service</u>	<u>Units</u>	<u>Total Charges</u>
61	540	A0320	RH	QN	082797	1 (trip)	100.00
61	540	A0380	RH	QN	082797	4 (mileage)	8.00

For the hard copy UB-92 (HCFA-1450), report as follows:

<u>FL 42</u>	<u>FL 44</u>	<u>FL 45</u>	<u>FL 46</u>	<u>FL 47</u>
540	A0320RHQN	082797	1 (trip)	100.00
540	A0380RHQN	082797	4 (mileage)	8.00

Example 2 - Claim containing multiple ambulance trips. For the UB-92 Flat File, report as follows:

<u>Record Type</u>	<u>Revenue Code</u>	<u>HCPCS</u>	<u>Modifier #1</u>	<u>Modifier #2</u>	<u>Date of Service</u>	<u>Units</u>	<u>Total Charges</u>
61	540	A0322	RH	QN	082897	1 (trip)	100.00
61	540	A0380	RH	QN	082897	2 (mileage)	4.00
61	540	A0324	RH	QN	082997	1 (trip)	400.00
61	540	A0390	RH	QN	082997	3 (mileage)	6.00
61	540	A0326	RH	QN	083097	1 (trip)	500.00
61	540	A0390	RH	QN	083097	5 (mileage)	10.00

For the hard copy UB-92 (HCFA-1450), report as follows:

<u>FL 42</u>	<u>FL 44</u>	<u>FL 45</u>	<u>FL 46</u>	<u>FL 47</u>
540	A0322RHQN	082897	1 (trip)	100.00
540	A0380RHQN	082897	2 (mileage)	4.00
540	A0324RHQN	082997	1 (trip)	400.00
540	A0390RHQN	082997	3 (mileage)	6.00
540	A0326RHQN	083097	1 (trip)	500.00
540	A0390RHQN	083097	5 (mileage)	10.00

Example 3 - Claim containing more than one ambulance trip provided on the same day. For the UB-92 Flat File, report as follows:

<u>Record Type</u>	<u>Revenue Code</u>	<u>HCPCS</u>	<u>Modifier #1</u>	<u>Modifier #2</u>	<u>Date of Service</u>	<u>Units</u>	<u>Total Charges</u>
61	540	A0322	RH	QN	090297	1 (trip)	100.00
61	540	A0380	RH	QN	090297	2 (mileage)	4.00
61	540	A0322	HR	QN	090297	1 (trip)	100.00
61	540	A0380	HR	QN	090297	2 (mileage)	4.00

For the hard copy UB-92 (HCFA-1450), report as follows:

<u>FL 42</u>	<u>FL 44</u>	<u>FL 45</u>	<u>FL 46</u>	<u>FL 47</u>
540	A0322RHQN	090297	1 (trip)	100.00
540	A0380RHQN	090297	2 (mileage)	4.00
<u>FL 42</u>	<u>FL 44</u>	<u>FL 45</u>	<u>FL 46</u>	<u>FL 47</u>
540	A0322HRQN	090297	1 (trip)	100.00
540	A0380HRQN	090297	2 (mileage)	4.00

H. Edits--Your intermediary will edit to assure proper reporting as follows:

- o Each pair of revenue codes 54X must have one of the following ambulance HCPCS codes A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328 or A0330 and one of the following mileage HCPCS codes A0380 or A0390;
- o The presence of an origin and destination modifier and a QM or QN modifier for every line item containing revenue code 54X;
- o The units field is completed for every line item containing revenue code 54X; and
- o Service units for line items containing HCPCS codes A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328 and A0330 always equal "1".

541. BILLING FOR LABORATORY TESTS

A General

Section 1833(h)(5) of the Act (as enacted by The Deficit Reduction Act of 1984, P.L. 98-369) requires the establishment of a fee schedule for clinical diagnostic laboratory tests paid under Part B. Under consolidated billing, the SNF must bill for all lab services rendered. You are not required to obtain a CLIA number to bill for tests performed by CLIA labs.

Laboratory tests performed for your Medicare inpatients covered under Part A are included in the PPS SNF payment. Part B clinical diagnostic lab services are paid based on the clinical diagnostic lab fee schedule. Pathologists services are considered physician's services and may be billed to the carrier by the physician. You may obtain pathologists services under arrangements and bill your intermediary. They are paid based on the Physician Fee Schedule.

Record charges for patients occupying beds in non-Medicare certified areas as non Medicare charges for the purpose of apportioning the SNF's laboratory costs. Bill as 22X type of bill. Payment is based on the lab fee schedule.

Bill lab tests on Form 1450 (U 92). Report the HCPCS code for the lab in the HCPCS field, the number of times the specific test was done in units, and the date in the date of service fields.

One of the diagnoses in the diagnoses fields should reflect a diagnosis for which the lab service applies.

Use bill type 22X for lab services to Part B residents and 23X for non residents.

Neither deductible nor coinsurance applies to lab fee schedule payments.

B Specimen Collection Fee

The SNF may be paid separately for Part B residents for drawing or collecting specimens. Only one collection fee is allowed for each type of specimen (e.g., blood, urine) for each patient encounter, regardless of the number of specimens drawn. When a series of specimens is required to complete a single test (e.g., glucose tolerance test), treat the series as a single encounter. A specimen collection fee is allowed in circumstances such as drawing a blood sample through venipuncture (i.e., inserting into a vein a needle with syringe or vacutainer to draw the specimen) or collecting a urine sample by catheterization.

Special rules apply when such services are furnished to dialysis patients. The specimen collection fee is not separately payable for any patients dialyzed in the facility or for any patients dialyzed at home under payment Method I. Payment for this service is included under the ESRD composite rate (Provider Reimbursement Manual, Part 1 §2711.1B4) for separately billable laboratory tests, as well as those included in the composite rate. Fees for taking specimens from home dialysis patients who have elected payment Method II (Provider Reimbursement Manual, Part 1 §§2740ff.) may be paid separately, provided all other criteria for payment are met.

A specimen collection fee is not allowed for blood samples where the cost of collecting the specimen is minimal (such as a throat culture or a routine capillary puncture for clotting or bleeding time). The intermediary will not make payment for routine handling charges where a specimen is referred by one laboratory to another.

A specimen collection fee is allowed when it is medically necessary for a laboratory technician to draw a specimen from either a nursing home or homebound patient. The technician must personally draw the specimen, e.g., venipuncture or urine sample by catheterization. A specimen collection fee is not allowed for the visiting technician where a patient in a facility is not confined to the facility.

Payment may be made to the SNF regardless whether SNF staff or lab staff perform the specimen collection.

Specimen collection performed by nursing home personnel for patients covered under Part A is paid for as part of the facility's payment for its PPS amount, not on the basis of the specimen collection fee.

Use the following HCPCS codes for billing.

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

Show the revenue code, HCPCS code, date of service, allowable units and charges on the UB 92.

For all specimen collection codes, payment is the lesser of the charge or \$3 per patient.

C Travel Allowance.-- In addition to a specimen collection fee allowed under subsection B, a travel allowance is payable to cover the costs of collecting a specimen from a nursing home or homebound patient.

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 average trip to patients' homes is longer than 20 miles round trip, and is to be pro-rated in situations where specimens are drawn or picked up from non-Medicare patients in the same trip. The lab is responsible for providing the SNF with the pro-rate information. 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 laboratory be allowed to bill 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 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 patient's home 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 average trips are less than 20 miles round trip. The flat rate travel fee is to be pro-rated for more than one blood drawn at the same address, and for stops at the homes of Medicare and non-Medicare patients. The pro-ration is done by the laboratory when the claim is submitted based on the number of patients seen on that trip. The specimen collection fee will be paid for each patient encounter.

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 patient's home 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 nursing home 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.

541.1 CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)

A. **Background.**--CLIA of 1988 changes clinical laboratories' certification. Effective September 1, 1992, clinical laboratory services are paid only if the entity furnishing the services has been issued a CLIA number. However, laboratories may be paid for a limited number of laboratory services if they have a CLIA certificate of waiver or a certificate for physician-performed microscopy procedures. These laboratories are not subject to routine on-site surveys.

B. **Verification Responsibilities.**--You are responsible for verifying CLIA certification prior to ordering laboratory services under arrangements. The survey process validates that laboratory services are provided by approved laboratories.

C. **CLIA Numbers.**--The CLIA number construction is:

- o Positions 1 and 2 are the State code (based on the laboratory's physical location at time of registration);
- o Position 3 is an alpha letter "D"; and
- o Positions 4-10 are a unique number assigned by the CLIA billing system. (No other lab in the country will have this number.)

D. Certificate for Physician-Performed Microscopy Procedures.--Effective January 19, 1993, a laboratory that holds a certificate for physician-performed microscopy procedures may perform only those tests specified as physician-performed microscopy procedures and waived tests, as described in §541.2 E. below, and no others. The following codes may be used:

<u>HCPCS Code</u>	<u>Test</u>
Q0111	Wet mounts, including preparations of vaginal, cervical or skin specimens;
Q0112	All potassium hydroxide (KOH) preparations;
Q0113	Pinworm examinations;
Q0114	Fern test;
Q0115	Post-coital direct, qualitative examinations of vaginal or cervical mucous; and
81015	Urine sediment examinations.

E. Certificate of Waiver.--Effective September 1, 1992, all laboratory testing sites (except as provided in 42 CFR 493.3(b)) must have either a CLIA certificate of waiver or certificate of registration to legally perform clinical laboratory testing anywhere in the United States. A grace period starting May 1, 1993, and ending on July 31, 1993, has been granted to allow providers time to adapt to the new coding system. Physicians, suppliers, and providers may submit claims for services furnished this grace period with 1992 or 1993 lab codes. Claims for services provided prior to the grace period (prior to May 1, 1993) must reflect 1992 codes even if received after the end of the grace period (after July 1, 1993). Claims with dates of services prior to May 1, 1993, which reflect 1993 codes, are denied. Payment for covered laboratory services furnished on or after September 1, 1992, by laboratories that have a waiver is limited to the following eight procedures:

<u>HCPCS Code</u>		<u>Test</u>
<u>1992</u>	<u>1993</u>	
Q0095	81025	Urine pregnancy test; visual color comparison tests;
Q0096	84830	Ovulation test; visual color comparison test for human luteinizing hormone;
Q0097	83026	Hemoglobin; by copper sulfate method, non-automated;
Q0098	32962	Glucose, blood; by glucose monitoring devices cleared by the FDA specifically for home use;
82270	82270	Blood, occult; feces;
Q0100	81002	Urinalysis by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketone, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of constituents; non-automated, without microscopy;
Q0101	85013	Microhematocrit; spun;
Q0102	85651	Sedimentation rate, erythrocyte; non-automated.

Effective January 19, 1993, a ninth test was added to the waived test list:

Q0116 Hemoglobin by single analyte instruments with self-contained or component features to perform specimen/reagent interaction, providing direct measurement and readout.

F. Under Arrangements.--When you obtain laboratory tests for outpatients under arrangements with independent laboratories or hospital laboratories, be sure that the laboratory performing the service has a CLIA number.

G. Certificate of Registration.--Initially, you are issued a CLIA number when you apply to the CLIA program.

541.2 Screening Pap Smears.--Sections 1861(s)(14) and 1861(nn) of the Act, (as enacted by Section 6115 of the Omnibus Budget Reconciliation Act of 1989) provides for coverage of screening pap smears for services provided on or after July 1, 1990. Screening pap smears are diagnostic laboratory tests consisting of a routine exfoliative cytology test (Papanicolaou test) provided for the purpose of early detection of cervical cancer. It includes a collection of the sample of cells and a physician's interpretation of the test.

The screening pap smear examination must be prescribed by a physician for an eligible beneficiary to be covered. Payment will be made under the clinical diagnostic laboratory fee schedule.

A. Completion of Form HCFA-1450.--Use revenue code 311 (laboratory, pathology, cytology) or, if your intermediary agrees, 923 (pap smear). Report the screening pap smear as a diagnostic clinical laboratory service using one of the following HCPCS codes:

o Q0060.--Screening Papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision; or

o Q0061.--Screening Papanicolaou smear, cervical or vaginal, up to three smears requiring interpretation by physician.

Report the diagnosis codes in Item 77 (Principal) and 78 (Other). The codes are:

o V72.6 (Laboratory examination) and V76.2 (Special screening for malignant neoplasms, cervix) report these codes when the beneficiary has not has a screening pap smear in the past 3 years; or

o V72.6 (Laboratory examination) and V15.89 (Other specified personal history presenting hazards to health), when reporting a beneficiary who, based upon the physician's recommendation based upon the patient's medical history or other findings determines that the test be performed more frequently.

B. Coverage Limitation.--Coverage for screening pap smears is limited to one every 3 years unless the physician has evidence, due to the patient's medical history or other findings, that the patient is at a high risk of developing cervical cancer and the test should be performed more frequently.

542. BILLING FOR IMMUNOSUPPRESSIVE DRUGS FURNISHED TO TRANSPLANT PATIENTS

Immunosuppressive Drugs Furnished to Transplant Patients.--Part B of Medicare covers the reasonable cost of FDA-approved immunosuppressive drugs. Payment is made for those immunosuppressive drugs that have been specifically labeled as such and approved for marketing by the FDA, as well as those prescription drugs, such as prednisone, that are used in conjunction with

immunosuppressive drugs as part of a therapeutic regimen reflected in FDA-approved labeling for immunosuppressive drugs. Therefore, antibiotics, hypertensives, and other drugs that are not directly related to rejection are not covered. Deductible and coinsurance apply.

Until January 1, 1995, immunosuppressive drugs are covered for a period of one year following discharge from a hospital for a Medicare covered organ (e.g., kidney or heart) transplant. HCFA interprets the 1-year period after the date of the transplant procedure to mean 365 days from the day on which an inpatient is discharged from the hospital. Coverage of immunosuppressive drugs received as a result of a transplant is contingent upon the transplant being covered by Medicare.

Beneficiaries are eligible to receive additional Part B coverage within 18 months after the discharge date for drugs furnished in 1995; within 24 months for drugs furnished in 1996; within 30 months for drugs furnished in 1997; and within 36 months for drugs furnished after 1997. Beginning January 1, 2000, §227 of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 extended coverage to eligible beneficiaries whose coverage for drugs used in immunosuppressive therapy expires during the calendar year to receive an additional 8 months of coverage beyond the current 36 month period. This benefit does not extend to special entitlement ESRD enrollees who lose Medicare coverage 36 months after a transplant. Medicare pays for immunosuppressive drugs which are provided outside the approved benefit period if they are covered under some other provision of the law (e.g., when the drugs are covered as inpatient hospital services or are furnished incident to a physician's service).

During a covered stay, payment for these drugs is included in Medicare's Part A payment to you. If the same patient receives a subsequent transplant operation the immunosuppressive coverage period begins anew (even if the patient is mid-way through the coverage period when the subsequent transplant operation was performed).

The FDA has identified and approved for marketing only the following specifically labeled immunosuppressive drugs:

- o Sandimmune (cyclosporine), Sandoz Pharmaceutical (oral or parenteral form);
- o Imuran (azathioprine), Burroughs-Wellcome (oral);
- o Atgam (antithymocyte/globuline), Upjohn (parenteral);
- o Orthoclone (OKT3 (muromonab-CD3), Ortho Pharmaceutical (parenteral);
- o Prograf (tacrolimus), Fujisawa USA, Inc.; and
- o Cellcept (mycophenolate mofetil), Roche Laboratories.

In addition to the above listed drugs, prescription drugs used in conjunction with immunosuppressive drugs as part of a therapeutic regimen reflected in FDA-approved labeling for immunosuppressive drugs are also covered. Your intermediary is expected to keep you informed of FDA additions to the list of the immunosuppressive drugs. Prescriptions generally should be non-refillable and limited to a 30 day supply. The 30 day guideline is necessary because dosage frequently diminishes over a period of time, and further, it is not uncommon for the physician to change the prescription. Also, these drugs are expensive and the coinsurance liability on unused drugs could be a financial burden to the beneficiary. Unless there are special circumstances, your intermediary does not consider a supply of drugs in excess of 30 days to be reasonable and necessary and denies payment accordingly.

A. Billing Requirements.--Bill on HCFA-1450 or its electronic equivalent with bill type 22X with the following entries:

- o Occurrence code 36 and date in FLs 32-35;
- o Revenue code 636 in FL 42;
- o HCPCS code of the immunosuppressive drug in FL 44;
- o Number of units in FL 46 (the number of units billed must accurately reflect the definition of one unit of service in each code narrative. For example, if fifty 10 mg. Prednisone tablets are dispensed, bill J7506, 100 units (1 unit of J7506 = 5 mg); and
- o Narrative description in FL 43.

Complete the remaining items in accordance with regular billing instructions

B. MSN Messages.--If the claim for an immunosuppressive drug is denied because it was not approved by the FDA, your intermediary states on the MSN to the beneficiary:

6.2 "Drugs not specifically classified as effective by the Food and Drug Administration are not covered."

If the claim for an immunosuppressive drug is denied because the benefit period has expired, your intermediary states on the MSN to the beneficiary:

4.2 "This service is covered up to (insert appropriate number) months after transplant and release from the hospital."

If the claim for an immunosuppressive drug is partially denied because of the 30 day limitation, the following message is used:

4.3 "Prescriptions for immunosuppressive drugs are limited to a 30-day supply."

If the claim for an immunosuppressive drug is denied because a transplant was not covered, the following message is use::

6.1 "This drug is covered only when Medicare pays for the transplant."

543. EPOETIN (EPO)

EPO is a biologically engineered protein which stimulates the bone marrow to make new red blood cells. The FDA approved labeling for EPO states that it is indicated in the treatment of anemia induced by the drug zidovudine (commonly called AZT), anemia associated with chronic renal failure, and anemia induced by chemotherapy in patients with non-myeloid malignancies. EPO is covered for these indications when it is furnished incident to a physician's service. Patients with anemia associated with chronic renal failure include all ESRD patients regardless of whether they are on dialysis. Chronic renal failure patients with symptomatic anemia considered for EPO therapy should have a hematocrit less than 30 percent or a hemoglobin less than 10 when therapy is initiated.

In addition to coverage incident to a physician's service, EPO is covered for the treatment of anemia for patients with chronic renal failure who are on dialysis when:

- o It is administered in a renal dialysis facility; or
- o It is self-administered in the home by any dialysis patient (or patient caregiver) who is determined competent to use the drug and meets the other conditions detailed below.

For patients with chronic renal failure (but not yet on dialysis), Medicare pays for EPO administered in a SNF on the fee schedule. When billing for these services, use revenue codes 634 (EPO with less than 10,000 units) and 635 (EPO with 10,000 or greater units).

In addition to revenue codes, you must report either the hemoglobin or hematocrit reading taken before the last administration of epoetin (EPO). Use value code 48 to report the hemoglobin reading or value code 49 for the hematocrit. The value amount associated with hemoglobin is usually reported in three positions with a decimal. Use the right of the delimiter for the third digit. The hematocrit reading is usually reported in two positions (a percentage) to the left of the dollar/cents delimiter. If the reading is provided with a decimal, use the position to the right of the delimiter for the third digit. Also use value code 68 to indicate EPO units administered during the billing period. Report units of EPO administered in the value amount associated with value code 68 in whole units to the left of the dollar/cents delimiter.

NOTE: The total amount of EPO injected during the billing period is reported. If there were 2 doses, the sum of the units administered for the 2 doses is reported as the value to the left of the dollar/cents delimiter.

The coinsurance and deductible are based upon the Medicare allowance payable. This service is not included in PPS or Consolidated Billing and may be billed separately if coverage guidelines are met.

544. BILLING FOR ENTERAL AND PARENTERAL NUTRITIONAL THERAPY COVERED AS A PROSTHETIC DEVICE

A. Billing Procedure--Parenteral and enteral nutritional (PEN) therapies including the necessary equipment, medical supplies and nutrients provided to an inpatient (where Part A payment cannot be made), or to individuals who are not inpatients are covered as a prosthesis under the Part B prosthetic device benefit as long as the requirements in the Coverage Issues Manual, §§65-10 through 65-10.3 are met, and the required documentation is submitted.

Consolidated billing under Part B for these services has been deferred for further study. Until further notice either the SNF or the supplier must bill the DMERC. If the SNF bills it must obtain a supplier number from the National Supplier Clearinghouse and must bill on Form HCFA-1500 or the related NSF or ANSI X12 EDI format.

DMERC jurisdictions, based on the biller's (SNF or supplier) home office address are:

A - Region A - Healthcare Now

Maine	Vermont	New Hampshire	Massachusetts
Rhode Island	Connecticut	New York	New Jersey
Pennsylvania	Delaware		

B - Region B - Administar Federal

Maryland	Washington, D.C.	Virginia	West Virginia
Ohio	Indiana	Illinois	Wisconsin
Minnesota	Michigan		

C - Region C - Palmetto Government Benefits Administration

North Carolina	South Carolina	Georgia	Florida
Alabama	Mississippi	Kentucky	Arkansas
Louisiana	Oklahoma	New Mexico	Colorado
Texas			

D - Region D - Connecticut General Life Insurance Co. (CIGNA)

Tennessee	Alaska	Montana	Hawaii
Iowa	Washington	Kansas	California
Nebraska	Nevada	South Dakota	Oregon
North Dakota	Missouri	Wyoming	Utah
Arizona	Idaho		

In preparation for billing, request from the DMERC:

- o A supply of certification forms; and
- o A supply of buff colored form HCFA-1500s, unless you are to bill electronically. (The buff color form is used to identify enteral/parenteral therapy.)

B. Preparation of Form HCFA-1500 for Supplies and Equipment Provided for Enteral and Parenteral Nutrition Therapies.--Prepare the buff color form HCFA-1500 for services to be billed.

- o FL 24B-Enter code 31 (SNF), Place of Service.
- o FL 24C-Enter all applicable five position HCPCS codes identifying appliances, supplies and solutions. Enter the 2 position modifier next to the code where necessary. Refer to the most recent HCPCS directory or billing instructions distributed by the DMERC for current HCPCS coding information.

Uniform Billing

560. COMPLETION OF FORM HCFA-1450 FOR INPATIENT AND/OR OUTPATIENT BILLING

This form, also known as the UB-92, serves the needs of many payers. Some data elements may not be needed by a particular payer. All items on the HCFA-1450 are described, but detailed information is given only for items required for Medicare claims.

This section details only the data elements which are required for Medicare billing. When billing multiple third parties, complete all items required by each payer who is to receive a copy.

Instructions for completion are the same for inpatient and outpatient claims unless otherwise noted.

Form Locator (FL) 1. (Untitled) Provider Name, Address, and Telephone Number

Required. The minimum entry is the your name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine-digit ZIP codes are acceptable. This information is used in connection with the Medicare provider number (FL 51) to verify provider identity. Phone and/or Fax numbers are desirable.

FL 2. (Untitled)

Not required. This is one of four State use fields which have not been assigned for national use. Use of the field, if any, is assigned by the SUBC and is uniform within a State.

FL 3. Patient Control Number

Required. The patient's control number may be shown if you assign one and need it for association and reference purposes.

FL 4. Type of Bill

Required. This three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is a "frequency" code.

Code Structure (only codes used to bill Medicare are shown).

1st Digit-Type of Facility

- 1 - Hospital
- 2 - Skilled Nursing Facility
- 4 - Religious Non-Medical (Hospital)
- 5 - Religious Non-Medical (Extended Care)
- 6 - Intermediate Care
- 7 - Clinic or Hospital Based Renal Dialysis Facility (requires special information in second digit below)
- 8 - Special facility or hospital ASC surgery (requires special information in second digit below)
- 9 - Reserved for National Assignment

2nd Digit-Bill Classification (Except Clinics and Special Facilities)

- 1 - Inpatient (Part A)
- 2 - Hospital Based or Inpatient (Part B) (includes HHA visits under a Part B plan of treatment).
- 3 - Outpatient (includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment)

- 4 - Other - Part B - (includes HHA medical and other health services not under a plan of treatment)
- 7 - Subacute Inpatient (revenue Code 19X required)
- 8 - Swing Bed (may be used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement)
- 9 - Reserved for National Assignment

3rd Digit-FrequencyDefinition

- | | |
|--|---|
| A - Hospice Admission Notice | Use when the hospice is submitting the HCFA-1450 as an Admission Notice. |
| B - Hospice Termination/
Revocation Notice | Use when the hospice is submitting the HCFA-1450 as a notice of termination/revocation for a previously posted hospice election. |
| C - Hospice Change of
Provider Notice | Use when the HCFA-1450 is used as a Notice of Change to the hospice provider. |
| D - Hospice Election Void/
Cancel | Use when the HCFA-1450 is used as a Notice of a Void/Cancel of hospice election. |
| E - Hospice Change of Ownership | Use when the HCFA-1450 is used as a Notice of Change in Ownership for the hospice. |
| 0 - Nonpayment/zero claims | Use this code when you do not anticipate payment from the payer for the bill, but is informing the payer about a period of nonpayable confinement or termination of care. The "Through" date of this bill (FL 6) is the discharge date for this confinement. Medicare requires "nonpayment" bills only to extend the spell-of-illness in inpatient cases. Other nonpayment bills are not needed and may be returned to you. |
| 1 - Admit Through Discharge
Claim | Use this code for bill encompassing an entire inpatient confinement or course of outpatient treatment for which you expect payment from the payer or which will update deductible for inpatient or Part B claims when Medicare is secondary to an EGHP. |
| 2 - Interim-First Claim | Use this code for the first of an expected series of bills for which utilization is chargeable or which will update inpatient deductible for the same confinement of course of treatment. |
| 3 - Interim-Continuing Claims
(Not valid for PPS Bills) | Use this code when a bill for which utilization is chargeable for the same confinement or course of treatment had already been submitted and further bills are expected to be submitted later. |

<u>Code</u>	<u>Title</u>	<u>Definition</u>
A2	Coinsurance Payer A	Enter the amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer.
B2	Coinsurance Payer B	Enter the amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer.
C2	Coinsurance Payer C	Enter the amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer.
A3	Estimated Responsibility Payer A	Enter the amount estimated to be paid by the indicated payer.
B3	Estimated Responsibility Payer B	Enter the amount estimated to be paid by the indicated payer.
C3	Estimated Responsibility Payer C	Enter the amount estimated to be paid by the indicated payer.
D3	Estimated Responsibility Patient	Enter the amount estimated to be paid by the indicated patient.
A4	Covered Self-administerable Drugs - Emergency	The amount included in covered charges for self-administerable drugs administered to the patient in an emergency situation. (The only covered Medicare charges for an ordinarily non-covered, self-administered drug are for insulin administered to a patient in a diabetic coma.)

FL42. Revenue Code

Required. Enter the appropriate revenue codes from the following list to identify specific accommodation and/or ancillary charges. Enter the appropriate numeric revenue code on the adjacent line in FL 42 to explain each charge in FL 47. This data takes the place of fixed line item descriptions on the billing form.

Additionally, there is no fixed "Total" line in the charge area. Enter revenue code 0001 instead in FL 42. Thus, the adjacent charges entry in FL 47 is the sum of charges billed. This is the same line on which non-covered charges, in FL 48, if any, are summed. Right justify all 3 digits revenue codes to prevent confusion.

To assist in bill review, list revenue codes in ascending numeric sequence and do not repeat on the same bill to the extent possible. To limit the number of line items on each bill, sum revenue codes at the "zero" level to the extent possible.

Provide detail level coding for the following revenue code series:

290s	- rental/purchase of DME
304	- renal dialysis/laboratory
330s	- radiology therapeutic
367	- kidney transplant
420s	- therapies
520s	- type or clinic visit (RHC or other)
550s - 590s	- home health services
636	- hemophilia blood clotting factors
800s - 850s	- ESRD services

Zero level billing is encouraged for all other services; however, your intermediary may require detailed breakouts of other revenue code series.

001 Total Charge

02X SNF PPS HIPPS Code

Code used to identify a PPS HIPPS code for Skilled Nursing Facilities on Prospective Payment system. This code must be reported on Part A PPS claims with revenue code 0022. Report the HIPPS code in the HCPCS /Rate field. The first three digits are the RUG code. The last two are the Assessment Code.

<u>Subcategory</u>	<u>Standard Abbreviations</u>
2 - PPS Payment	PPS/PAY

03X
to

06X Reserved for National Assignment

07X
to

09X Reserved for State Use

ACCOMMODATION REVENUE CODES (10X - 21X)

10X All Inclusive Rate

Flat fee charge incurred on either a daily basis or total stay basis for services rendered. Charge may cover room and board plus ancillary services or room and board only.

<u>Subcategory</u>	<u>Standard Abbreviations</u>
0 - All-Inclusive Room and Board Plus Ancillary	ALL INCL R&B/ANC
1 - All-Inclusive Room and Board	ALL INCL R&B

11X Room & Board - Private (Medical or General)

Routine service charges for single bed rooms.

98X Professional Fees (Cont.)SubcategoryStandard Abbreviations

1 - Emergency Room	PRO FEE/ER
2 - Outpatient Services	PRO FEE/OUTPT
3 - Clinic	PRO FEE/CLINIC
4 - Medical Social Services	PRO FEE/SOC SVC
5 - EKG	PRO FEE/EKG
6 - EEG	PRO FEE/EEG
7 - Hospital Visit	PRO FEE/HOS VIS
8 - Consultation	PRO FEE/CONSULT
9 - Private Duty Nurse	FEE/PVT NURSE

99X Patient Convenience Items

Charges for items that are generally considered by the third party payers to be strictly convenience items and, as such, are not covered.

Rationale: Permits identification of particular services as necessary.

SubcategoryStandard Abbreviation

0 - General Classification	PT CONVENIENCE
1 - Cafeteria/Guest Tray	CAFETERIA
2 - Private Linen Service	LINEN
3 - Telephone/Telegraph	TELEPHONE
4 - TV/Radio	TV/RADIO
5 - Nonpatient Room Rentals	NONPT ROOM RENT
6 - Late Discharge Charge	LATE DISCHARGE
7 - Admission Kits	ADMIT KITS
8 - Beauty Shop/Barber	BARBER/BEAUTY
9 - Other Patient Convenience Items	PT CONVENIENCE/OTH

FL 43. Revenue Description

Not Required. Enter a narrative description or standard abbreviation for each revenue code shown in FL 42 on the adjacent line in FL 43. The information assists clerical bill review. Descriptions or abbreviations correspond to the revenue codes. "Other" code categories description are locally defined and individually described on each bill. The investigational device exemption (IDE) or procedure identifies a specific device used only for billing under the specific revenue code 624. The IDE will appear on the paper format of Form HCFA-1450 as follows: **FDA IDE# A123456 (17 spaces)**. HHAs identify the specific piece of DME or nonroutine supplies for which they are billing in this area on the line adjacent to the related revenue code. This description must be shown in HCPCS coding. (Also, see FL 84, Remarks.)

FL 44. HCPCS/Rates

Required. When coding HCPCS for outpatient services (i.e., outpatient surgery bills, clinical diagnostic laboratory bills for outpatients or nonpatients, radiology, other diagnostic services, orthotic/prosthetic devices, take home surgical dressings, therapies, other rehabilitation services, preventive services, drugs and SNF Part B inpatient services) enter the HCPCS code describing the procedure here. On inpatient SNF bills, the accommodation rate or HIPPS code is shown here.

Effective April 1, 1995, a line item date of service is required on all laboratory claims that span 2 or more dates.

FL 45. Service Date

Required for SNF outpatient and SNF inpatient Part B. Report line item dates of service for every line where a Part B HCPCS code is required effective April, 2001, including claims where the from and thru dates are equal. Effective April 1, 1995, a line item date of service is required on all laboratory claims.

FL 46. Units of Service

Required. Enter the number of digits or units of service on the line adjacent to revenue code and description where appropriate, e.g., number of covered days in a particular type of accommodation, pints of blood. However, when HCPCS codes are required for Part B services, the units are equal to the number of times the procedure/service being reported was performed. Provide the number of covered days, visits treatments, tests, etc. as applicable for the following:

- Accommodation days - 100s-150s, 200s, 210s (days)
- Blood pints - 380s (pints)
- DME - 290s (rental months)
- Emergency room visits - 450, 452, and 459 (HCPCS code definition for visit or procedure)
- Clinic visits - 510s and 520s (visits) (HCPCS code definition for visit or procedure)
- Dialyses treatments - 800s (sessions or days)
- Orthotic/prosthetic devices - 274 (items)
- Outpatient therapy visits - 410, 420, 430, 440, 480, 910, and 943 (visits)
- Outpatient clinical diagnostic laboratory tests - 30X-31X (tests)
- Radiology - 32x, 34x, 35x, 40x, 61x, and 333 (HCPCS code definition of tests or services)
- Oxygen - 600s (rental months, feet, or pounds)
- Hemophilia blood clotting factors - 636

Enter up to seven numeric digits. Show charges for noncovered services as noncovered.

NOTE: Hospital outpatient departments report the number of visits/sessions when billing under the partial hospitalization program.

FL 47. Total Charges

Required. Sum the total charges for the billing period by revenue code (FL 42) or in the case of diagnostic laboratory tests for outpatient or nonpatients by HCPCS procedure code and enter them on the adjacent line in FL 47. The last revenue code entered in FL 42 "0001" represents the grand total of all charges billed. FL 47 totals on the adjacent line. Each line allows up to nine numeric digits (0000000.00).

HCFA policy is for providers to bill Medicare on the same basis that they bill other payers. This policy provides consistency of bill data with the cost report so that bill data may be used to substantiate the cost report.

Medicare and non-Medicare charges for the same department must be reported consistently on the cost report. This means that the professional component is included on, or excluded from, the cost report for Medicare and non-Medicare charges. Where billing for the professional components is not consistent for all payers, i.e., where some payers require net billing and others require gross, the provider must adjust either net charges up to gross or gross charges down to net for cost report preparation. In such cases, adjust your provider statistical and reimbursement (PS&R) reports that you derive from the bill. For outpatient Part B billing, only charges believed to be covered are submitted in FL 47. Non-covered charges are omitted from the bill.

561. FREQUENCY OF BILLING

Your intermediary will inform you about the frequency with which it can accept billing records and the frequency with which you may bill on individual cases.

In its requirements, your intermediary considers your systems operation, intermediary systems requirements, and Medicare program and administrative requirements.

Inpatient Billing.--SNFs and non-PPS hospitals (i.e., excluded units or hospitals) bill upon discharge or after 30 days (and if necessary, every 30 days thereafter.) You may bill more frequently if you bill electronically. Your intermediary will inform you of the frequency of billing that is acceptable. Each bill must include all diagnoses and procedures applicable to the admission. However, do not include charges that were billed on an earlier bill. The from date must be the day after the through date on the earlier bill. If you receive PIP, you may not submit interim bills.

Outpatient Billing.--Bill repetitive Part B services to a single individual monthly (or at the conclusion of treatment). These instructions also apply to Home Health Agency and hospice services billed under Part A. This avoids Medicare processing costs in holding such bills for monthly review and reduces bill processing costs for relatively small claims. Services are:

<u>Service</u>	<u>Revenue Code</u>
DME Rental	290-299
Therapeutic Radiology	330-339
Therapeutic Nuclear Medicine	342
Respiratory Therapy	410-419
Physical Therapy	420-429
Occupational Therapy	430-439
Speech Pathology	440-449
Home Health Visits	550-599
Hospice Services	650-659
Kidney Dialysis Treatments	820-859
Cardiac Rehabilitation Services	482, 943
Psychological Services	(910-919 in a psychiatric facility)

Where there is an inpatient stay, or outpatient surgery, during a period of repetitive outpatient services, you may submit one bill for the entire month if you use an occurrence span code 74 to encompass the inpatient stay. This permits you to submit a single bill for the month, and simplifies the review of these bills. This is in addition to the bill for the inpatient stay of outpatient surgery. Other one time Part B services must be billed upon completion of the services.

Bills for outpatient surgery must contain on a single bill all services provided on the day of surgery except kidney dialysis services, which are billed on a 72X bill type. These services normally include:

- Nursing services, services of technical personnel, and other related services;
- The patient's use of the hospital's facilities;
- Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances, and equipment;
- Diagnostic or therapeutic items and services (except lab services);
- Blood, blood plasma, platelets, etc.; and
- Materials for anesthesia.

562. GUIDELINES FOR SUBMITTING CORRECTED BILLS

A. General.--When an initial bill has been submitted and you or the intermediary discover an error

on the bill, submit an adjustment bill if the change involves one of the following:

- A change in the inpatient cash or Part B deductible of more than \$1;
- A change in the number of inpatient days;
- A change in the blood deductible;
- A change in provider number;
- A change in coinsurance which involves an amount greater than \$1.99; or
- Effective for changes for services June 1, 2000, change in HIPPS code. (Such adjustments are required within 120 days of the through date on the initial bill.)

Where there are money adjustments other than a coinsurance amount greater than \$1.99, record the difference on a record sufficiently documented to establish an accounting data trail broken out by patient name and HICN, admission, from and thru dates, difference in charge broken out by the ancillary services for the difference, and any unique numbering or filing code necessary for you to associate the adjustment charge with the original billing.

B. Billing Late Charges.--Late charge billing (type of bill XX5) is not acceptable for SNF Part A services. Late charge (XX5 type of bill) is acceptable to report additional unbilled services for SNF inpatient B residents and SNF outpatients. Should a pattern of an excessive volume of late charge bills be determined through audit, you may be required to adjust your billing schedule and procedures by the intermediary. If a you fail to include a particular item or service on its initial bill, an adjustment request to include such an item or service is not permitted after the expiration of the time limitation for filing a bill. Late charge(s) bills are subject to the same requirements for timely filing as original bills. However, to the extent that an adjustment request otherwise corrects or supplements information previously submitted on a timely bill about specified services or items furnished to a specified individual, it is subject to the rules governing administrative finality, rather than the time limitation for filing.

C Procedures.-- Follow the procedures for bill completion in § 560. Complete all items as applicable for the initial bill except:

FL 37 - Internal Control Number (ICN)/ Document Control Number (DCN) of the claim to be adjusted is required for adjustments and late charges. This is in Record Type 31, Positions 15 - 177 of the UB 92 EDI format version 6. The intermediary reports this to you on the remittance record.

For late charge bills use Type of Bill 225 or 235, as appropriate, and in FL 42 - 48, report only the services not reported on first bill (revenue code, HCPCS code, units, dates of service). For adjustments use Type of Bill 217, 227, or 237, as appropriate, and in FL 42 - 48, report all services applicable including those correctly reported on the first bill. See instructions for FLs 24, 25, 26, 27, 28, 29, or 30 (Condition Codes) for reporting the reason for the adjustment (Claim Change Reasons). This is reported in Record Type 41 of the UB 92 EDI format version 6. Claim Change Reason Codes Applicable to SNFs are:

D0	Changes to Service Dates	D5	Cancel to Correct HICN or Provider ID
D1	Changes to Charges	D6	Cancel only to repay a duplicate OIG payment
D2	Changes in Revenue Codes/HCPCS	D7	Change to Make Medicare Secondary Payer
D4	Changes in HPPPS code	D8	Change to Make Medicare Primary Payer
		D9	Any Other Change

Select the one code that best describes the change reason. You may make multiple changes even though only one reason code is reported.

Standard System and CWF Edits and Error Resolution Procedures

595 CONSOLIDATED BILLING EDITS AND RESOLUTION

Following is a general description of Medicare systems edits relating to SNF Part A PPS and Part B consolidated billing.

In general:

- Where a claim is received for services that are considered included in the SNF Part A PPS rate and a SNF PPS paid claim is on record, the claim with the duplicate services will be rejected. In connection with this some claims may be developed instead of rejected.
- Where a SNF PPS claim is received and there is a claim on record that contains services that are considered included in the PPS rate, the PPS claims will be paid and the claim on record will be auto-canceled by CWF.
- When consolidated billing for Part B is implemented similar processes will be implemented for services that must be billed by the SNF.
- Where a claim encounters a claim on record for the same HCPCS code and for the same date the second claim will be rejected or developed.

Your intermediary will furnish processing instructions.

The following remark and reason codes are used on the remittance to identify the situation for the SNF:

Claim level remark code MA101 (A SNF is responsible for payment of outside providers who furnish these services/supplies to its residents.) will be used on the supplier remittance where a supplier bills for services included in the Part A PPS amount or effective January 1, 2002 the supplier bills for services subject to SNF Part B consolidated billing.

Claim level remark code MA 133 (Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.)

Claim adjustment reason code 97: (Payment is included in the allowance for the basic service/procedure with group code CO.)

Claim adjustment reason code B6 (This service/procedure is denied/reduced when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty) with group code CO .)

Claim level remark code MA67: Correction to a prior claim.

The following remark and reason codes are used on the remittance to identify duplicates.

Claim adjustment reason code 18: Duplicate claim/service.

Line level remark code M86: (Service denied because payment already made for similar procedure.)