SUBJECT: FEE SCHEDULE AND CONSOLIDATED BILLING FOR SNF SERVICES

I  General

This PM contains instructions about:

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

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

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

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

II  Fee Schedule for SNF Part B Services

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

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

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

A  Application of Part B Deductible and Coinsurance

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

Neither deductible nor coinsurance apply to clinical diagnostic lab services.

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

Deductible does not apply to screening mammography services.

B Services Not Covered by SNF Part B Fee Schedule

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

Medical Supplies
A4570 A4212 A4580 A4590

Therapeutic Shoes
A5500 A5501 A5502 A5503 A5504 A5505 A5506 A5507

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

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

EMG Device
E0746

Salivation Device
E0755

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

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

V2630 V2631 V2632

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

All Drugs

Drug payment methodology is not changed.

C Publication of Fee Schedules

SNF fee schedule prices and related installation instructions will be provided to intermediaries through the Mainframe Telecommunications System in the same manner that other fee schedule information is provided.
Analysis is not yet completed on whether SNF fee schedule data for intermediaries will be included with other data or whether a separate file will be released.

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

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

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

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

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

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

For codes billable by SNFs:

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

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

**D Special Payment Rules Relating to Fee Schedules for SNFs**

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

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

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

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

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

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

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

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

Neither deductible nor coinsurance apply to specimen collection payments.

3 Travel Allowance

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

- lab
- radiology
- EKG

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

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

a Travel Allowance to Collect Lab Specimen

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

- P9603 -- Travel allowance - one way, in connection with medically necessary laboratory specimen collection drawn from a SNF resident; prorated miles actually traveled (intermediary allowance on per mile basis); or
- P9604 -- Travel allowance - one way, in connection with medically necessary laboratory specimen collection drawn from a SNF resident; prorated trip charge (intermediary allowance on flat fee basis).

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

The per mile allowance was computed using the Federal mileage rate of 31 cents a mile plus an additional 44 cents a mile to cover the technician's time and travel costs. Contractors have the option of establishing a higher per mile rate in excess of the minimum of 75 cents a mile if local
conditions warrant it. The minimum mileage rate will be reviewed and updated in conjunction with the clinical lab fee schedule as needed. At no time will the SNF be paid for more miles than are reasonable or for miles not actually traveled by the laboratory technician.

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

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

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

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

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

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

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

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

**b Travel Allowance for Radiology and EKG**

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

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

R0070 - For transportation of portable X ray equipment where only one patient seen
R0075 - For transportation of portable X ray equipment where more than one patient seen (this
code is billed for each patient)
R0076 - For transportation of portable EKG equipment (this code is billed for each patient)
99082 - Unusual travel

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

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

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

4 Questions on Special Payment Rules

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

III Consolidated Billing for SNF Part B Residents

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

A Implementation Schedule

Implementation will be in two phases.

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

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

These will be implemented April 1, 2001.

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

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

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

B Definition of SNF Resident

A SNF resident is defined as a beneficiary who is admitted to a Medicare-participating SNF (or to the nonparticipating portion of a nursing home that also includes a Medicare-participating SNF), regardless of whether Part A covers the stay. If the SNF has one or more Medicare
certified beds consolidated billing applies. This is applicable regardless of whether the beneficiary is in a certified or non-certified bed. The beneficiary remains a resident until residency status ends as defined below.

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

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

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

Services on and after this day are included in consolidated billing unless excluded as described in Section II, or unless otherwise not covered.

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

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

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

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

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

The SNF need not submit a discharge bill where this situation applies. CWF edits allow hospitals and critical access hospitals to bill for these services identified in section IV C.5 for a SNF resident.

Receipt of outpatient services from another provider does not normally result in termination of SNF residency status. However, the rendering provider may submit a claim to the Medicare program where provided in section IV.

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

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

If a discharge bill has been processed when the beneficiary returns, the SNF should submit an adjustment bill (whether Part A or Part B) changing the patient status code and bill type, with the next scheduled billing submission. The adjustment should include any new charges for services after the patient's return.
C UB 92 Bill Types, Frequency of Billing, and Late Charges

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

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

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

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

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

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

Adjustment bills remain necessary to delete charges.

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

Late charge bills remain unacceptable for Part A SNF bills.

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

IV Exceptions to Consolidated Billing

A Facilities Excluded From Consolidated Billing

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

Examples:

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

B Physicians and Practitioners Excluded From Consolidated Billing

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

1. Physician's services other than physical, occupational and speech-language therapy
services furnished to SNF residents. Respiratory therapy services are not excluded from consolidated billing except for the physician’s component.

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

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

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

4. Certified nurse-midwives;

5. Qualified psychologists;

6. Certified registered nurse anesthetists;

C Services Excluded From Consolidated Billing

The following services may be billed separately under Part B.

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

2. Erythropoietin (EPO) as described in section IVF12

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

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

5. The following services which are considered beyond the scope of SNF care when furnished in a Medicare participating hospital or critical access hospital. This exception does not apply if the service is furnished in an ASC. Specific HCPCS and/or revenue codes describing these services are described in the edit instructions that follow.
   • Cardiac catheterization
   • Computerized axial tomography (CT) scans
   • Magnetic resonance imaging (MRIs)
   • Angiography
   • Lymphatic and Venous Procedures
   • Ambulatory surgery involving the use of an operating room
   • Radiation therapy
   • Emergency services
   • Ambulance services when related to an excluded service (listed above)
   • Ambulance transportation related to dialysis services.

6. The following services when provided by any Medicare provider licensed to provide them. Specific HCPCS describing these services are in section IV.F items 1 though 4.
   • Some chemotherapy and chemotherapy administration services
• Radioisotope services
• Some customized prosthetic devices

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

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

D Beneficiaries Excluded From Consolidated Billing

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

E Codes to Identify Services Included in Consolidated Billing

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

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

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

Revenue Codes

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

Rehabilitation (Therapy) Services

11040  11041  11042  11043  11044  29065  29075  29085  29105
29125  29126  29130  29131  29200  29220  29240  29260  29280
29345  29365  29405  29445  29505  29515  29520  29530  29540
29550  29580  29590  64550  90901  90911  92506  92507  92508
92510  92525  92526  92527  92598  95831  95832  95633  95834
95851  95852  96105  96110  96111  96115  97001  97002  97003
97004  97010****  97012  97014  97016  97018  97020  97022
97024  97026  97028  97032  97033  97034  97035  97036  97039
97110  97112  97113  97116  97124  97139  97140  97150  97504**
** Code 97504 should not be reported with code 97116 unless separate anatomic sites are involved. (CWF will reject the claim if both codes are reported on the same claim, unless modifier 59 is reported to indicate separate anatomic sites.)

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

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

**Audiologic Function Tests**

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

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

**F Applicable Codes To Identify Services Excluded From Consolidated Billing**

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

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

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

2. **Chemotherapy Administration Services that May Be Paid Separately**

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

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3. Radioisotope Services that May Be Paid Separately

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4. Customized Prosthetic Devices That May Be Paid Separately

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

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

70450  70460  70470  70480  70481  70482  70486  70487  70488  
70490  70491  70492  71250  71260  71267  71282  71292  72125  72126  72127  
72128  72129  72130  72131  72132  72133  72192  72193  72194  
73200  73201  73202  73700  73701  73702  74150  74160  74170  
76355  76360  76365  76370  76375  76380  G0131  G0132  

7. **Cardiac catheterization Codes that May Be Paid Separately**

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

8. **MRI Codes that May Be Paid Separately**

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

9. **Radiation Therapy Codes that May Be Paid Separately**
10. **Angiography Codes that May Be Paid Separately**

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

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

**THESE CODES MAY NOT BE PAID SEPARATELY**

10040  10060  10080  10120  11040  11041  11042  11043  11044
11055  11056  11057  11200  11300  11305  11400  11719  11720
11721  11740  11900  11901  11920  11921  11922  11950  11951
11952  11954  11975  11976  11977  15780  15781  15782  15783
15786  15787  15788  15789  15792  15793  15810  15811  16000
16020  17000  17003  17004  17110  17111  17250  17340  17360
17380  17999  20000  20974  21084  21085  21497  26010  29058
29065  29075  29085  29105  29125  29126  29130  29131  29200
29220  29240  29260  29280  29345  29355  29358  29365  29405
29425  29435  29440  29445  29450  29505  29515  29540  29550
29580  29590  29700  29705  29710  29715  29720  29730  29740
29750  29799  30300  30901  31720  31725  31730  36000  36140
12. **EPO Services**: EPO for dialysis patients is not included in the SNF Part A PPS rate and is excluded from Part B consolidated billing for dialysis patients. It may be billed by other providers and paid separately. EPO for dialysis patients is identified with the following revenue codes on the UB 92:

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

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

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

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

**Diagnosis Codes:**
40301 40311 40391 40402 40412 40492 5845 5846
5847 5848 5849 585 586 7885 9585

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

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

14. **Medicare Beneficiaries Enrolled in a Medicare Managed Care program are Excluded from Consolidated Billing.** – SNF consolidated billing applies only to Medicare fee-for-service beneficiaries. Managed care beneficiaries are identified on CWF with an applicable Plan ID, entitlement and termination periods on the GHOD screen. The Plan ID is a 4 position number preceded with ‘H’. Claims received on or after the MCO effective date and prior to the MCO termination date are exempt from consolidated billing. In addition, Condition code ’04’ on the UB-92 identifies a risk-based MCO enrollee.
15. Use of the PC/TC Indicators to Identify Technical and Professional Component. The PC/TC indicator in the Medicare Physician Fee Schedule (MPFS) will be used in the SNF fee schedule to identify the applicability of technical and/or physician component for the HCPCS codes. The following table describes intermediary processing for the PC/TC indicator.

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

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<tr>
<th>PC/TC Indicator</th>
<th>SNF Consolidated Billing/Payment Policy for Intermediaries for MPFS Services</th>
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</table>
| 0               | Physician Service Code: Codes with a 0 indicator are not considered to have a separately identifiable professional or technical components. They will never be seen with a TC or 26 modifier.  
Intermediaries reject the service and notify the SNF to request the physician to bill the carrier.  
Physicians submit these services to the carrier for processing and reimbursement. |
| 1               | Diagnostic Tests or Radiology Services: An indicator of 1 signifies a global code that when billed without a modifier includes both the PC and TC. The code can also be submitted using a 26 or TC modifier to bill just the PC or TC of that service (e.g., G0030, G003026 and G0030TC).  
Intermediaries pay the service when submitted with the TC modifier  
If a global code is submitted, e.g., G0030 with no modifier, reject the service and notify the SNF to resubmit only the TC.  
If modifier 26 is submitted, reject the service and notify the SNF that the 26 must be billed by the physician to the carrier. |
| 2               | Professional Component Only Codes: Codes with an indicator of 2 signify services that only have a PC.  
Intermediaries reject these services and notify the SNF that the service must be billed to the carrier. |
| 3               | Technical Component Only Codes: Codes with an indicator of 3 signify services that have only a TC.  
Intermediaries pay these without a modifier.  
Carriers reject these services and notify the physicians to have the SNF bill to the intermediary. |
| 4               | Global Test Only Codes: Codes with an indicator of 4 signify services that include both the PC and TC. The 26 and TC modifiers are not applicable. However, there are associated codes that describe only the technical and professional components of the service.  
Reject the service and notify the SNF to resubmit the service using the code that represents the TC only. |
### SNF Consolidated Billing/Payment Policy for Intermediaries for MPFS Services

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<th>PC/TC Indicator</th>
<th>SNF Consolidated Billing/Payment Policy for Intermediaries for MPFS Services</th>
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<td>5</td>
<td>Incident To Codes: These codes are not considered physician services in the SNF setting. These codes are paid by the intermediary. Carriers reject the services and notify the physician that the SNF must bill the FI for payment.</td>
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<td>6</td>
<td>Laboratory Physician Interpretation Codes: These codes are for physician services to interpret lab tests. Intermediaries do not pay for these services. Reject the service and notify the SNF that the services must be billed to the carrier. Considered a billable physician service and may be paid by the carrier.</td>
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<td>Physician Therapy Services: These services are only billable by the SNF to the FI. Intermediaries pay. Carriers notify the physician to have the SNF bill the FI for payment. These codes are paid by the intermediary.</td>
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<td>8</td>
<td>Physician Interpretation Codes: An indicator of 8 signifies codes that represent the professional component of a clinical lab code for which separate payment may be made. It only applies to codes 88141, 85060 and P3001-26. A TC indicator is not applicable. Intermediaries do not pay for these services. Reject the service and notify the SNF that the services must be billed to the carrier. Carriers reimburse the physician for these codes when submitted.</td>
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<td>9</td>
<td>Concept of a Professional/Technical Component Does Not Apply: An indicator of 9 signifies a code that is not considered to be a physician service. Intermediaries pay for these services. Carriers reject the service and notify the physician to have the SNF bill the FI for payment.</td>
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### 16 Ambulance Services Excluded from Consolidated Billing

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

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

- A trip for an inpatient admission to a Medicare participating hospital or critical care access hospital (CAH);
• After a discharge from the SNF, a trip to the beneficiary's home if medical necessity exists to receive services from a Medicare participating home health agency under a plan of care;

• A round trip to a Medicare participating hospital or CAH for the specific purpose of receiving emergency services or certain other intensive outpatient services that lie well beyond the scope of the care that SNFs would ordinarily furnish. The intensive outpatient services are listed below. HCPCS codes identifying these services are found in section II F items 5 through 11. A discharge bill and readmission bill are not appropriate in this circumstance.
  - Cardiac catheterization;
  - Computerized axial tomography (CT) scans;
  - Magnetic resonance imaging (MRI);
  - Ambulatory surgery involving the use of an operating room or comparable facilities such as a GI suite;
  - Radiation therapy;
  - Angiography;
  - Lymphatic and venous procedures.

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

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

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

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

• Ambulance transportation related to dialysis services.

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

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

V SNF Provider Agreements

A General Requirements

The SNF must exercise professional responsibility over the arranged-for services. The facility's professional supervision over arranged-for services requires application of many of the same quality controls as are applied to services furnished by salaried employees. The SNF must accept the patient for treatment in accordance with its admission policies; maintain a complete and timely clinical record of the patient which includes diagnosis, medical history, physician's orders, and progress notes relating to all services received; maintain liaison with the attending physician on the progress of the patient and the need for revised orders or, in the case of outpatient physical therapy, occupational therapy, or speech pathology services, to assure that the required plan of treatment is periodically reviewed by the physician; secure from the physician the required certifications and recertifications; and see to it that the medical necessity of such services is reviewed on a sample basis by its utilization review committee.
The SNF does not have to receive the supplier's bill before billing Medicare but it must know that the service has been performed.

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

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

B Verification of Supplier/Provider Medicare Status

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

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

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

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

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

C Provisions of Agreements between SNFs and Suppliers

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

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

VI Edits for CWF and Contractors

A General

Effective for services beginning January 1, 2001, for Part A residents and January 1, 2002 for
Part B residents, CWF will reject outpatient bills received from intermediaries or carriers where a history record already exists for a SNF inpatient Part A or an inpatient Part B stay and the outpatient or carrier CWF record includes specified services.

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

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

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

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

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

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

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

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

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

### B Intermediary Resolution of Edits

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

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

<table>
<thead>
<tr>
<th>Error code</th>
<th>EXPLANATION</th>
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<tbody>
<tr>
<td>To Be Assigned (1)</td>
<td>Outpatient Therapy Claim Within Inpatient Part A SNF Claim History</td>
</tr>
</tbody>
</table>

An outpatient bill type (outpatient CWF record) is rejected because the
Error code  EXPLANATION

services are physical, occupational, speech therapy or audiologic function tests for an inpatient SNF patient (inpatient CWF record). The dates of service are **within or equal** the inpatient stay.

**Purpose:**

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

**Resolution:**

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

**Remittance codes:**

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

Use Group Code CO: Contractual Obligation

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

**MSN codes:**

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

---

**To Be Assigned (1)**

**Outpatient Therapy Claim Overlaps Inpatient Part A SNF History**

An outpatient claim (outpatient CWF record) is rejected because the services are physical, occupational, speech therapy or audiologic function tests for an inpatient SNF patient. The dates of service **overlap** the inpatient stay (inpatient CWF record). The services within or equal to the SNF dates must be billed by the SNF. The outpatient services outside the SNF stay may be billed by the rendering provider.

**Purpose:**

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

**Resolution:**

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

**Remittance codes:**

For Reject, use Claim Adjustment Reason Code 97: Payment is included in the allowance for the basic service/procedure.
Use Group Code CO: Contractual Obligation

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

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

MSN codes:

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

To Be Assigned (2) Outpatient Claim (no therapy) Against Inpatient Part A SNF Claim History

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

Purpose:

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

Resolution:

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

Remittance codes:

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

Use Group Code CO: Contractual Obligation

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

MSN codes:

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

To Be Assigned (2) Outpatient Claim (no therapy) Against Inpatient Part A SNF Claim History

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

Purpose:

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

Resolution:

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

Remittance codes:

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

Use Group Code CO: Contractual Obligation

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

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

MSN codes:

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

To Be Assigned

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

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

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

Resolution:

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

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

Remittance code:

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

Use Group Code CR: Correction
To Be Assigned

(5)

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

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

Purpose:

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

Resolution:

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

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

Remittance codes:

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

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

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

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

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

MSN codes:

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

To Be Assigned

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

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

Purpose:

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

Resolution:

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

Cancel the outpatient claim(s) on history.

Remittance codes:

Retract the incorrect payment.

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

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

MSN codes:

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

To Be Assigned

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

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

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

Resolution:

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

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

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

Remittance codes:

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

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

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

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

   Retract the incorrect payment.

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

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

MSN codes:

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

To Be Assigned

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

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

**Purpose:**

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

**Resolution:**

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

The intermediary will process the claim.

**Remittance codes:**

No special processing applies for intermediary claims.

**MSN codes:**

No special processing applies for intermediary claims.

---

**To Be Assigned (7)**

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

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

**Purpose:**

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

**Resolution:**

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

The intermediary will process the claim.

**Remittance codes:**

No special processing applies for intermediary claims.

**MSN codes:**

No special processing applies for intermediary claims.

---

**To Be Assigned (8)**

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

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

**Purpose:**

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

**Resolution:**

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

The intermediary will process the inpatient claim.

**Remittance codes:**

No special processing applies for intermediary claims.

**MSN codes:**

No special processing applies for intermediary claims.

---

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

**Purpose:**

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

**Resolution:**

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

The intermediary will process the inpatient claim.

**Remittance codes:**

No special processing applies for intermediary claims.

**MSN codes:**

No special processing applies for intermediary claims.

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

<table>
<thead>
<tr>
<th>Error code</th>
<th>EXPLANATION</th>
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<tbody>
<tr>
<td>To Be Assigned (8)</td>
<td>Inpatient Part A SNF Claim (or effective for services 1-1-2002 SNF inpatient B) Overlaps Outpatient (no therapy Claim History)</td>
</tr>
<tr>
<td></td>
<td>An inpatient Part A SNF claim is received and the dates of service overlap the dates of service of a Carrier Part B claim on history. The services on the Carrier Part B claim are not excluded from consolidated billing. The services must be billed by the SNF.</td>
</tr>
<tr>
<td></td>
<td>Purpose: To ensure that certain Carrier Part B services for a SNF patient are not separately paid from the SNF bill.</td>
</tr>
<tr>
<td></td>
<td>Resolution: CWF will accept the inpatient '21X' claim (and effective 1-1-2002, '22X' type of bill) and send an unsolicited auto-cancel response to the carrier. The Carrier must initiate overpayment procedures and reflect the action taken on the Carrier Part B claim(s) on history.</td>
</tr>
<tr>
<td></td>
<td>The intermediary will process the inpatient claim.</td>
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<tr>
<td></td>
<td>Remittance codes: No special processing applies for intermediary claims.</td>
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<td>MSN codes: No special processing applies for intermediary claims.</td>
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<tr>
<td>Error code</td>
<td>EXPLANATION</td>
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</tr>
<tr>
<td>To Be Assigned (10)</td>
<td>A SNF outpatient Part B claim (23X) for ambulance services is rejected if a Carrier Part B claim is already paid with ambulances services for the same date of service.</td>
</tr>
</tbody>
</table>

**Purpose:**

To ensure that a SNF outpatient Part B (23X) claim for ambulance service is not paid if a Carrier Part B claim for the same ambulance service on the same day is already paid.

**Resolution:**

Reject the SNF Outpatient claim.

**Remittance codes:**

Use adjustment reason code 18: Duplicate claim/service.

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

**MSN codes:**

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

| To Be Assigned (11) | An Outpatient Part B claim is rejected if a SNF Inpatient Part B claim is already paid with the same HCPCS codes for the same date of service. |

**Purpose:**

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

**Resolution:**

Reject the Outpatient Hospital Part B claim.

**Remittance codes:**

Use adjustment reason code 18: Duplicate claim/service.

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

**MSN codes:**

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

| To Be Assigned (12) | An Outpatient Hospital Part B claim or Inpatient Part B SNF claim is rejected if a Carrier/DMERC Part B claim is already paid with the same HCPCS codes for the same date of service. |

**Purpose:**

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

**Resolution:**


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

Remittance codes:

Use adjustment reason code 18: Duplicate claim/service.

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

MSN codes:

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

To Be Assigned (13)

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

Purpose:

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

Resolution:

Reject the Inpatient Part B SNF claim.

Remittance codes:

Use adjustment reason code 18: Duplicate claim/service.

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

MSN codes:

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

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

<table>
<thead>
<tr>
<th>Error Code</th>
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<tbody>
<tr>
<td>EXPLANATION</td>
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</table>

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

Purpose:

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

Resolution:

Reject the outpatient or Part B claim.

Remittance codes:

Use claim adjustment reason code 97 Payment is included in the allowance
Error Code EXPLANATION
for the basic service/procedure.

Use group code CO.

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

VII Contractor Reporting Requirements

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

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

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

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

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

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

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

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

This PM should be discarded after January 1, 2002.

Contractors should contact the appropriate regional office with any questions.