CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 301 | **Date: September 17, 2004**

CHANGE REQUEST 3366

NOTE: This transmittal replaces Transmittal 251, dated July 23, 2004.

I. SUMMARY OF CHANGES: This instruction informs the Standard System Maintainer (SSM) of changes regarding the payment of services under the 12x and 22x Type of Bills (TOB) that do not meet the definition of inpatient Part B hospital services. The SSM will be required to install an edit to assure payment only for those services as defined in Pub. 100-02, Benefit Policy Manual, chapter 6, section10.

NEW/REVISED MATERIAL - EFFECTIVE DATE: January 1, 2005
***IMPLEMENTATION DATE: January 3, 2005**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	4/Table of Contents
R	4/240/Inpatient Part B Hospital Services
N	4/240/240.1/Editing of Hospital Part B Inpatient Services
R	7/Table of Contents
R	7/10/10.1/Billing for Inpatient SNF Services Paid Under Part B
N	7/10/10.1.1/Editing of Skilled Nursing Facilities Part B Inpatient Services

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	Business Requirements
X	Manual Instruction
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

Pub.100-04	Transmittal: 301	Date: September 17, 2004	Change Request 3366

NOTE: This transmittal replaces Transmittal 251, dated July 23, 2004.

SUBJECT: Editing Of Hospital and Skilled Nursing Facility Part B Inpatient Services

I. GENERAL INFORMATION

A. Background: Medicare pays under Part B for physician services and for non-physician medical and other health services listed below when furnished by a participating hospital to an inpatient of the hospital or by a participating SNF to its inpatients when patients are not eligible or entitled to Part A benefits or the patient has exhausted their Part A benefits.

It has been brought to the attention of CMS that some Medicare Fiscal Intermediaries are paying for services under the 12X and 22X Types of Bills (TOBs) that do not meet the definition of inpatient Part B services. This instruction requires the SSM to install an edit to assure payment is made on 12X and 22X TOBs only for those services defined in §10, Chapter 6, of the Policy Manual, Publication 100-2 as an inpatient Part B service.

B. Policy: In accordance with Pub. 100-2 Benefit Policy Manual, chapter 6 section10, Medicare pays for inpatient Part B services provided by a participating provider either directly or under arrangements to an inpatient of that provider, but only if payment for these services cannot be made under Part A.

Payable services under inpatient Part B are:

- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests;
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;
- Surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations;
- Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices;
- Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition;
- Outpatient physical therapy, outpatient speech pathology services, and outpatient occupational therapy (see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, "Covered Medical and Other Health Services," §220);
- Screening mammography services;
- Screening pap smears;

- Influenza, pneumococcal pneumonia, and hepatitis B vaccines;
- Colorectal screening;
- Bone mass measurements;
- Diabetes self-management;
- Prostate screening;
- Ambulance services;
- Hemophilia clotting factors (for hemophilia patients competent to use these factors without supervision);
- Immunosuppressive drugs;
- Oral anti-cancer drugs;
- Oral drug prescribed for use as an acute anti-emetic used as part of an anti-cancer chemotherapeutic regimen; and
- Epoetin Alfa (EPO).

The following revenue codes should never be paid:

010x	011x	012x	013x	014x	015x	016x	017x
018x	019x	020x	021x	022x	023x	024x	0250
0251	0252	0253	0256	0257	0258	0259	0261
0269	0270	0273	0277	0279	029x	0339	036x
0370	0374	0379	041x	045x	0472	0479	049x
050x	051x	052x	053x	0541	0542	0543	0544
0546	0547	0548	0549	055x	057x	058x	059x
060x	0630	0631	0632	0633	0634	0635	0637
064x	065x	066x	067x	068x	072x	0762	078x
079x	093x	0940	0941	0943	0944	0945	0946
0947	0948	0949	095x	096x	097x	098x	099x
100x	210x	310x					

C. Provider Education: A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VM	CW	
3366.1	The SSM shall edit to assure that payment is not made on type of bill 12x and 22x for claims containing the revenue codes listed in the table in the Policy section.					X				
3366.2	The SSM shall deny lines containing the prohibited revenue codes with the appropriate MSN.					X				
3366.3	The FIs shall use MSN message 21.21, when denying services in these revenue codes.	X								
3366.4	The FIs shall place reason code M28 on the remittance advice when denying services on the specified revenue codes.	X								

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

B. Design Considerations: N/A

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: January 1, 2005 **Implementation Date:** January 3, 2005 **Pre-Implementation Contact(s):** Diana Motsiopoulos at dmotsiopoulos@cms.hhs.gov or Bill Ruiz at wruiz@cms.hhs.gov **Post-Implementation Contact(s):** Regional Offices	**These instructions shall be implemented within your current operating budget.**

Medicare Claims Processing Manual

Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

Table of Contents

(Rev. 301, 09-17-04)

Crosswalk to Old Manuals

240 - Inpatient Part B Hospital Services

240.1 - Editing of Hospital Part B Inpatient Services

240 - Inpatient Part B Hospital Services

(Rev. 301, Issued: 09-17-04, Effective: 01-01-05, Implementation: 01-03-05)

Inpatient Part B services which are paid under OPPS include:

- Diagnostic x-ray tests, and other diagnostic tests (excluding clinical diagnostic laboratory tests);
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;
- Surgical dressings applied during an encounter at the hospital and splints, casts, and other devices used for reduction of fractures and dislocations (splints and casts, etc., include dental splints);
- Implantable prosthetic devices;
- Hepatitis B vaccine and its administration, and certain preventive screening services (pelvic exams, screening sigmoidoscopies, screening colonoscopies, bone mass measurements, and prostate screening.)
- *Bone Mass measurements;*
- *Prostate screening;*
- *Immunosuppressive drugs;*
- *Oral anti-cancer drugs;*
- *Oral drug prescribed for use as an acute anti-emetic used as part of an anti-cancer chemotherapeutic regimen; and*
- *Epoetin Alfa (EPO)*

NOTE: Payment for some of these services is packaged into the payment rate of other separately payable services.

Inpatient Part B services paid under other payment methods include:

- Clinical diagnostic laboratory tests, prosthetic devices other than implantable ones and other than dental which replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices;
- Leg, arm, back and neck braces; trusses and artificial legs; arms and eyes including adjustments, repairs, and replacements required because of breakage,

wear, loss, or a change in the patient's physical condition; take home surgical dressings; outpatient physical therapy; outpatient occupational therapy; and outpatient speech pathology services;

- Ambulance services;
- Screening pap smears, screening colorectal tests, and screening mammography;
- Influenza virus vaccine and its administration, pneumococcal vaccine and its administration;
- *Diabetes self-management;*
- *Hemophilia clotting factors for hemophilia patients competent to use these factors without supervision).*

See Chapter 6 of the Medicare Benefit Policy Manual for a discussion of the circumstances under which the above services may be covered as Part B Inpatient services.

204.1 – EDITING OF HOSPITAL PART B INPATIENT SERVICES

(Rev. 301, Issued: 09-17-04, Effective: 01-01-05, Implementation: 01-03-05)

Medicare pays under Part B for physician services and for non-physician medical and other health services listed in section 240 above when furnished by a participating hospital to an inpatient of the hospital when patients are not eligible or entitled to Part A benefits or the patient has exhausted their Part A benefits.

The SSM shall edit to prevent payment on Type of Bill 12x for claims containing the revenue codes listed in the table below.

010x	*011x*	*012x*	*013x*	*014x*	*015x*	*016x*	*017x*
018x	*019x*	*020x*	*021x*	*022x*	*023x*	*024x*	*0250*
0251	*0252*	*0253*	*0256*	*0257*	*0258*	*0259*	*0261*
0269	*0270*	*0273*	*0277*	*0279*	*029x*	*0339*	*036x*
0370	*0374*	*0379*	*041x*	*045x*	*0472*	*0479*	*049x*
050x	*051x*	*052x*	*053x*	*0541*	*0542*	*0543*	*0544*
0546	*0547*	*0548*	*0549*	*055x*	*057x*	*058x*	*059x*
060x	*0630*	*0631*	*0632*	*0633*	*0634*	*0635*	*0637*

064x	*065x*	*066x*	*067x*	*068x*	*072x*	*0762*	*078x*
079x	*093x*	*0940*	*0941*	*0943*	*0944*	*0945*	*0946*
0947	*0948*	*0949*	*095x*	*096x*	*097x*	*098x*	*099x*
100x	*210x*	*310x*					

When denying lines containing the above revenue codes on TOB 12x, the FI shall use MSN message 21.21– This service was denied because Medicare only covers this service under certain circumstances.

FIs shall place reason code M28 on the remittance advice when denying services on the specified revenue codes.

Medicare Claims Processing Manual

Chapter 7 - SNF Part B Billing (Including Inpatient Part B and Outpatient Fee Schedule)

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(Rev. 301, 09-17-04)

Crosswalk to Old Manuals

10.1 - Billing for Inpatient SNF Services Paid Under Part B

10.1.1 - Editing of SNF Part B Inpatient Services

10.1 - Billing for Inpatient SNF Services Paid Under Part B

(Rev. 301, Issued: 09-17-04, Effective: 01-01-05, Implementation: 01-03-05)

When the beneficiary in a Medicare-certified SNF is not entitled to Part A benefits, limited benefits are provided under Part B. Reasons for not being entitled to have payment made under Part A are that:

- The beneficiary does not have Medicare Part A Health Insurance;
- The beneficiary is not in a Medicare-certified bed;
- The inpatient stay is not at a covered level of care and no Part A program payment is possible; or
- The inpatient stay is not covered because the beneficiary did not have a 3-day qualifying stay.

When 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. The following services may be billed by the SNF or the rendering provider or supplier under an arrangement with the SNF:

- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests;
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;
- Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations;
- Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices;
- Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition;
- *Outpatient physical therapy, outpatient speech pathology services, and outpatient occupational therapy (see Pub. 100-0,2 Medicare Benefit Policy Manual, chapter 15, "Covered Medical and Other Health Services," §220);*
- *Screening mammography services;*
- *Screening pap smears;*

- *Influenza, pneumococcal pneumonia, and hepatitis B vaccines;*
- *Colorectal screening;*
- *Bone mass measurements;*
- *Diabetes self-management;*
- *Prostate screening;*
- *Ambulance services;*
- *Hemophilia clotting factors for hemophilia patients competent to use these factors without supervision);*
- *Immunosuppressive drugs;*
- *Oral anti-cancer drugs;*
- *Oral drug prescribed for use as an acute anti-emetic used as part of an anti-cancer chemotherapeutic regimen; a*
- *Epoetin Alfa (EPO).*

See chapter 6 of Pub. 100-02, Medicare Benefit Policy Manual for a discussion of the circumstances under which the above services may be covered as Part B Inpatient services.

Coverage rules for these services are described in Pub. 100-02, Medicare Benefit Policy Manual, Chapters 10, 14, or 15. Specific billing instructions are found in the Medicare Claims Processing Manuals, Chapters 13, 15, 16, 18, 20, or 23.

Outpatient physical therapy, outpatient speech pathology services, and outpatient occupational therapy (see Chapter 10, §§60) are billable services for SNF inpatients not in a Part A stay. However, they must be billed by the SNF even when another entity renders the services under an arrangement with the SNF.

The determination of whether to use TOB 22x or 23x is a function of the type of facility in which the beneficiary resides. If the facility is not Medicare-certified, it is not a SNF, although it may have a Medicare-certified distinct part unit (DPU). If the beneficiary is in a SNF or SNF DPU, Part B services must be billed on TOB 22x.

All services rendered to SNF patients residing in the non-Medicare-certified portion of an *institution* that is not primarily engaged in the provision of skilled services must be billed on TOB 23x. Beneficiaries residing in such portions of the facility are considered outpatients of the SNF for Medicare purposes.

If the entire facility qualifies as a Medic are-certified SNF, all Part B services rendered to residents are billed on TOB 22x.

10.1.1 - Editing of Skilled Nursing Facilities Part B Inpatient Services

(Rev. 301, Issued: 09-17-04, Effective: 01-01-05, Implementation: 01-03-05)

Medicare pays under Part B for physicians' services and for non-physician medical and other health services listed below when furnished by a participating hospital to an inpatient of the SNF when patients are not eligible or entitled to Part A benefits or the patient has exhausted their Part A benefits.

The SSM shall edit to prevent payment on Type of Bill 22x for claims containing the revenue codes listed in the table below.

010x	*011x*	*012x*	*013x*	*014x*	*015x*	*016x*	*017x*
018x	*019x*	*020x*	*021x*	*022x*	*023x*	*024x*	*0250*
0251	*0252*	*0253*	*0256*	*0257*	*0258*	*0259*	*0261*
0269	*0270*	*0273*	*0277*	*0279*	*029x*	*0339*	*036x*
0370	*0374*	*0379*	*041x*	*045x*	*0472*	*0479*	*049x*
050x	*051x*	*052x*	*053x*	*0541*	*0542*	*0543*	*0544*
0546	*0547*	*0548*	*0549*	*055x*	*057x*	*058x*	*059x*
060x	*0630*	*0631*	*0632*	*0633*	*0634*	*0635*	*0637*
064x	*065x*	*066x*	*067x*	*068x*	*072x*	*0762*	*078x*
079x	*093x*	*0940*	*0941*	*0943*	*0944*	*0945*	*0946*
0947	*0948*	*0949*	*095x*	*096x*	*097x*	*098x*	*099x*
100x	*210x*	*310x*					

When denying lines containing the above revenue codes on TOB 22x, the FI shall use MSN message 21.21– This service was denied because Medicare only covers this service under certain circumstances.

FIs shall place reason code M28 on the remittance advice when denying services on the specified revenue codes.