CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 92 | **Date: February 6, 2004**

CHANGE REQUEST 3070

I. SUMMARY OF CHANGES: Update to the January 2004 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing Enforcement

NEW/REVISED MATERIAL - EFFECTIVE DATE: April 1, 2004
***IMPLEMENTATION DATE:** April 5, 2004

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will only receive the new\revised information, 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
	6/ Table of Contents – SNF Inpatient Part A Billing
R	6/ 10.1- Consolidated Billing Requirements for SNFs
R	6/ 20 – Services Included in Part A PPS Payment Not Billable Separately by the SNF
R	6/ 20.1.2 – Other Excluded Services Beyond the Scope of a SNF Part A Benefit
D	6/ 20.1.2.1 – Cardiac Catheterization
D	6/ 20.1.2.2 – Computerized Axial Tomography (CAT) Scans
D	6/ 20.1.2.3 – Magnetic Resonance Imaging (MRIs)
D	6/ 20.1.2.4 – Outpatient Surgery and Related Procedures – Inclusion
D	6/ 20.1.2.5 – Radiation Therapy
D	6/ 20.1.2.6 – Angiography, Lymphatic, Venous and Related Procedures
R	6/20.1.2.1 – Emergency Services
R	6/20.2 – Services Excluded from Part A PPS Payment and the Consolidated Billing Requirement on the Basis of Beneficiary Characteristics and Election
R	6/ 20.2.1.1 – ESRD Services
R	6/ 20.2.1.3 – Coding Applicable to Services Provided in a RDF or SNF as Home
R	6/ 20.2.1.4 – Coding Applicable to EPO Services
R	6/ 20.3 – Other Services Excluded from SNF PPS and Consolidated Billing
R	6/ 20.3.1 – Ambulance Services
D	6/ 20.3.2 – Chemotherapy, Chemotherapy Administration, and Radioisotope Services

D	6/ 20.3.3 – Certain Customized Prosthetic Devices
R	6/ 20.4 – Screening and Preventive Services
N	6/ 20.5 – Therapy Services

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

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

***Medicare contractors only**

Medicare Claims Processing Manual
Chapter 6 - SNF Inpatient Part A Billing

Table of Contents

Crosswalk to Old Manuals

10 - Skilled Nursing Facility (SNF) Prospective Payment System (PPS) and Consolidated Billing Overview

10.1 - Consolidated Billing Requirement for SNFs

10.2 - Types of Facilities Subject to the Consolidated Billing Requirement for SNFs

10.3 - Types of Services Subject to the Consolidated Billing Requirement for SNFs

20 - Services Included in Part A PPS Payment Not Billable Separately by the SNF

20.1 – Services Beyond the Scope of the Part A SNF Benefit

20.1.1 - Physician's Services and Other Professional Services Excluded From Part A PPS Payment and the Consolidated Billing Requirement

20.1.1.1 - Correct Place of Service (POS) Code for SNF Claims

20.1.2 - Other Excluded Services Beyond the Scope of a SNF Part A Benefit

20.1.2.*1* - Emergency Services

20.2 - Services Excluded from Part A PPS Payment and the Consolidated Billing Requirement on the Basis of Beneficiary Characteristics and Election

20.2.1 – Dialysis and Dialysis Related Services to a Beneficiary With ESRD

20.2.1.1 - ESRD Services

20.2.1.2 - Coding Applicable to Services Provided in a Renal Dialysis Facility (RDF)

20.2.1.3 - Coding Applicable to Services Provided in a RDF or SNF as Home

20.2.1.4 - Coding Applicable to EPO Services

20.2.2 – Hospice Care for a Beneficiary's Terminal Illness

20.3 – Other Services Excluded from SNF PPS and Consolidated Billing

20.3.1. - Ambulance Services

20.4 - Screening and Preventive Services

20.5 - Therapy Services

30 - Billing SNF PPS Services

30.1 - Health Insurance Prospective Payment System (HIPPS) Rate Code

- 30.2 – Special Billing Requirements Where a Single OMRA, SCSA, or SCPA ARD is Set Within the Window of a Medicare-Required Assessment
- 30.3 – Special Billing Requirements Where There are Multiple Assessments (i.e., OMRA, SCSA, or SCPA) Within the Window of a Medicare-Required Assessment
- 30.4 - Coding PPS Bills for Ancillary Services
- 30.5 - Adjustment to Health Insurance Prospective Payment System (HIPPS) Codes Resulting From Long Term Care Resident Assessment Instrument (RAI) Corrections
  - 30.5.1 - Adjustment Requests

40 - Special Inpatient Billing Instructions
- 40.1 - Submit Bills in Sequence
- 40.2 - Reprocessing Inpatient Bills in Sequence
- 40.3 - Determining Part A Admission Date, Discharge Date, and Utilization Days
  - 40.3.1 - Date of Admission
  - 40.3.2 - Patient Readmitted Within 30 Days After Discharge
  - 40.3.3 - Same Day Transfer
  - 40.3.4 - Day of Discharge, Death, or Leave of Absence
  - 40.3.5 - Determine Utilization on Day of Discharge, Death, or Day Beginning a Leave of Absence
    - 40.3.5.1 - Day of Discharge or Death Is the Day Following the Close of the Accounting Year
    - 40.3.5.2 - Leave of Absence
- 40.4 - Accommodation Charges Incurred in Different Accounting Years
- 40.5 - Billing Procedures for Periodic Interim Payment (PIP) Method of Payment
- 40.6 - Total and Noncovered Charges
  - 40.6.1 - Services in Excess of Covered Services
  - 40.6.2 - Showing Discounted Charges
  - 40.6.3 - Reporting Accommodations on the Claim
  - 40.6.4 - Bills with Covered and Noncovered Days
  - 40.6.5 - Notification of Limitation on Liability Decision
- 40.7 - Other Billing Situations

50 - SNF Payment Bans, or Denial of Payment for New Admissions (DPNA)

50.1 - Effect on Utilization Days and Benefit Period
- 50.2 - Billing When Ban on Payment Is In Effect
  - 50.2.1 - Tracking Days to Calculate the Part A Benefit Period
  - 50.2.2 - Provider Liability Billing Instructions

50.2.3 - Beneficiary Liability Billing Instructions

50.2.4 - Part B Billing

50.3 - Sanctions Lifted: Procedures for Beneficiaries Admitted During the Sanction Period

50.3.1 - Tracking the Benefit Period

50.3.2 - Determining Whether Transfer Requirements Have Been Met

50.4 – Conducting Resident Assessments

50.5 - Physician Certification

50.6 - Intermediary Responsibilities

50.7 - Retroactive Removal of Sanctions

60 - Billing Procedures for a Provider With Multiple Provider Numbers or a Change in Provider Number

70 - Billing for Services After Termination, Expiration, or Cancellation of Provider Agreement, or After Payment is Denied for New Admissions

70.1 - General Rules

70.2 - Billing for Covered Services

70.3 - Part B Billing

80 - Billing Related to Physician's Services

80.1 - Reassignment Limitations

80.2 - Payment to Employer of Physician

80.3 - Information Necessary to Permit Payment to a Facility

80.4 - Services Furnished Within the SNF

80.5 - Billing Under Arrangements

80.6 - Indirect Contractual Arrangement

80.7 - Establishing That a SNF Qualifies to Receive Part B Payment on the Basis of Reassignment

90 - SNF Billing to HMOs

90.1 - Beneficiary Involuntarily Disenrolled from Terminated Medicare+Choice (M+C) Plans

100 – Part A SNF PPS for Hospital Swing Bed Facilities

100.1 - Swing Bed Services Not Included in the Part A PPS Rate

10.1 - Consolidated Billing Requirement for SNFs

(Rev. 92, 2-06-04)

Section 4432 (b) of the Balanced Budget Act (BBA) requires consolidated billing for SNFs. Under the consolidated billing requirement, the SNF must submit ALL Medicare claims for ALL the services that its residents receive under Part A, **except** for certain excluded services described in §§20.1 – 20.3, **and** for all physical, occupational and speech-language pathology services received by residents under Part B. A SNF resident is defined as a beneficiary who is admitted to a Medicare participating SNF or the participating, Medicare-certified, distinct part unit of an NF. When such a beneficiary leaves the facility, (or the DPU) 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. It may be triggered by any one of the following events:

- The beneficiary is admitted as an inpatient to a Medicare-participating hospital or critical access hospital (CAH), or as a resident to another SNF;
- The beneficiary is moved out of the Medicare-certified DPU of the facility (which renders primarily less than skilled care) and placed elsewhere in the facility;
- The beneficiary dies; or
- The beneficiary is formally discharged (or otherwise departs) from the SNF or DPU, unless the beneficiary is readmitted (or returns) to that or another SNF before midnight of the same day.

These requirements apply only to Medicare fee-for-service beneficiaries residing in a participating SNF or DPU.

Claims are submitted to the FI on Form CMS-1450 *or its electronic equivalent*. All services billed by the SNF (including those furnished under arrangements with an outside supplier) for a resident of a SNF in a covered Part A stay are included in the SNF's Part A bill. If a resident is not in a covered Part A stay (Part A benefits exhausted, posthospital or level of care requirements not met), the SNF is required to bill for all physical, occupational, and/or speech language therapy services provided to a SNF resident under Part B. The consolidated billing provision requires that effective for services and items furnished on or after July 1, 1998, payment is made directly to the SNF.

Thus, SNFs are no longer able to "unbundle" services to an outside supplier that can then submit a separate bill directly to a Part B carrier or DMERC for residents in a Part A stay, or for SNF residents receiving physical, occupational and, or speech language therapy services paid under Part B. Instead, the SNF must furnish the services either directly or under an arrangement with an outside supplier or provider of services in which the SNF (rather than the supplier or provider of services) bills Medicare. Medicare does not pay amounts that are due a provider to any other person under assignment, or power of

attorney, or any other direct payment arrangement. As a result, the outside supplier must look to the SNF (rather than the Medicare carrier or FI or the beneficiary) for payment. The SNF may collect any applicable deductible or coinsurance from the beneficiary.

Enforcement of SNF consolidated billing is done through editing in Medicare claims processing systems using lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of SNF PPS. In order to assure proper payment in all settings, Medicare systems must edit for services, provided to SNF beneficiaries, both included and excluded from SNF CB. Transmittals with instructions provide updates to previous lists of the exclusions, and some inclusions, to SNF CB. Such transmittals can be found on the CMS Web site at:

www.cms.hhs.gov/manuals/

The list of HCPCS codes enforcing SNF CB may be updated each quarter. For the notice on SNF CB for the quarter beginning January, separate instructions are published for FIs and carriers/DMERCs. Since this is the only quarter in which new permanent HCPCS codes are produced, this recurring update is referred to as an annual update. Other updates for the remaining quarters of the year will occur as needed prior to the next annual update. In lieu of another update, editing based on the prior list of codes remains in effect. Some non-January quarterly updates may apply to both FIs and carriers/DMERCs, and the applicability of the instruction will be clear in each update. All future updates will be submitted via a Recurring Update Notification form.

- **Effective July 1, 1998**, consolidated billing became effective for those services and items that were not specifically excluded by law from the SNF prospective payment system (PPS) when they were furnished to residents of a SNF in a covered Part A stay and also includes physical, occupational, and speech therapies in a noncovered stay. SNFs became subject to consolidated billing once they transitioned to PPS. Due to systems limitations, consolidated billing was not implemented at that time for residents not in a Part A covered stay (Part A benefits exhausted, post-hospital or level of care requirements not met). Section 313 of the Benefits Improvement and Protection Act (BIPA) of 2000 subsequently repealed this aspect of consolidated billing altogether, except for physical, occupational, and speech therapies. In addition, for either type of resident, the following requirements were also delayed: (1) that the physicians forward the technical portions of their services to the SNF; and (2) the requirement that the physician enter the facility provider number of the SNF on the claim.

- **Effective July 1, 1998**, under 42 CFR 411.15(p)(3))(iii) published on May 12, 1998, a number of other services are excluded from consolidated billing. The hospital outpatient department will bill these services directly to the FI when furnished on an outpatient basis by a hospital or a critical

access hospital. Physician's and other practitioner's professional services will be billed directly to the carrier. Hospice care and the ambulance trip that initially conveys an individual to the SNF to be admitted as a resident, or that conveys an individual from the SNF when discharged and no longer considered a resident, are also excluded from SNF PPS consolidated billing.

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

- **Effective January 1, 2001**, §313 of the BIPA, restricted SNF consolidated billing to the majority of services provided to beneficiaries in a Medicare Part A covered stay and only to therapy services provided to beneficiaries in a noncovered stay.

- **Effective for claims with dates of service on or after April 1, 2001**, for those services and supplies that were not specifically excluded by law and are furnished to a SNF resident covered under the Part A benefit, physicians are required to forward the technical portions of any services to the SNF to be billed by the SNF to the FI for payment.

20 - Services Included in Part A PPS Payment Not Billable Separately by the SNF

(Rev. 92, 2-06-04)

SNF-515

For cost reporting periods beginning on and after July 1, 1998, SNF services paid under Part A include posthospital SNF services for which benefits are provided under Part A, and all items and services which, prior to July 1, 1998, had been paid under Part B but furnished to SNF residents during a Part A covered stay regardless of source, except for the exclusions listed in the SNF Help File. View the SNF Help file at http://cms.hhs.gov/manuals/104_claims/clm104c06snfhelp.pdf. This file lists services by HCPCS code and describes their status with respect to whether the service is included in

the Part A PPS payment or if the service can be billed separately under Part B. For separately billable services the file also describes whether the SNF is required to bill or whether the rendering provider/supplier must bill. Some services must be billed by the SNF while others must be billed by the rendering provider (SNF or otherwise). Services paid under Part A cannot be billed under Part B. Any service paid under Part A that is billed separately will not be paid separately, or payment will be recovered if already paid at the time of the SNF billing. The following subsections list the types of services that can be billed under Part B for SNF residents for whom Part A payment is made

20.1.2 - Other Excluded Services Beyond the Scope of a SNF Part A Benefit

(Rev. 92, 2-06-04)
SNF-516.3

The following services are not included in Part A PPS payment when furnished in a Medicare participating hospital or CAH and may be paid to the provider rendering them. This exception does not apply if the service is furnished in an ambulatory surgical center (ASC) or other independent (non-hospital) facility. *In transmittals for FI billing providing the annual update list of HCPCS codes affected by SNF consolidated billing, such services are referred to as " Major Category I" of SNF consolidated billing editing. Note that of the types of services listed, only ambulatory surgeries are listed as inclusions, rather than exclusions, to consolidated billing.*

- Certain cardiac catheterizations;
- Certain computerized axial tomography (CT) scans;
- Certain magnetic resonance imaging (MRIs);
- Certain ambulatory surgeries involving the use of a hospital operating room; For Part A inpatients, the professional portion of these services is billed by the rendering practitioner to the carrier. Any hospital outpatient charges are billed to the FI.
- Certain radiation therapies;
- Certain angiographies, and lymphatic and venous procedures;
- Emergency services;
- Ambulance services when related to an excluded service within this list; and
- Ambulance transportation related to dialysis services.

These relatively costly services are beyond the general scope of care in SNFs. Even though it may be medically appropriate for a beneficiary to be cared for in a SNF while receiving radiation therapy, the SNF is not responsible for paying for *excluded* radiation therapy itself when the beneficiary receives it as a hospital outpatient. Similarly, angiography codes and codes for some lymphatic and venous procedures are considered

beyond the general scope of services delivered by SNFs. The hospital or CAH must bill the FI for the services. *Excluded services provided to Medicare beneficiaries in swing beds subject to SNF PPS are to be billed on TOB 13x.*

Services directly related to these services, defined as services billed for the same place of service and with the same line item date of service as the services listed below, are also excluded from SNF CB, with exceptions as listed below.

- *Note that anesthesia, drugs incident to radiology and supplies (revenue codes 037x, 0255, 027x and 062x) will be bypassed by enforcement edits when billed with CT Scans, Cardiac Catheterizations, MRIs, Radiation Therapies, or Angiographies or surgeries.*

- *In general, bypasses also allow CT Scans, Cardiac Catheterization, MRI, Radiation Therapy, Angiography, and Outpatient Surgery HCPCS codes 0001T – 0021T, 0024T – 0026T, or 10021 - 69990 (except HCPCS codes listed in the table below) to process and pay. This includes all other revenue code lines on the incoming claim that have the same line item date of service (LIDOS).*

<u>Outpatient Surgery and Related Procedures– INCLUSION</u>

Inclusions, rather than exclusions, are given in this one case, because of the great number of surgical procedures that are excluded and can only be safely performed in a hospital operating room setting. It is easier to automate edits around the much shorter list of inclusions under this category, representing minor procedures that can be performed in the SNF itself. Additionally, this was the approach originally taken in the regulation to present this information.

- Note that anesthesia, drugs, supplies and lab services (revenues codes 037x, 0250, 027x, 062x and 030x) will be bypassed by enforcement edits when billed with outpatient surgeries <u>excluded</u> from SNF CB.

See §10.1 above for the link to where transmittals providing current lists of HCPCS codes used for Major Category I SNF consolidated billing editing can be found.

20.1.2.*1* - Emergency Services

(Rev. 92, 2-06-04)

SNF-516.3

These services are identified on claims submitted to FIs by a hospital or CAH using revenue code 045x (Emergency Room - "x" represents a varying third digit). Related services are also excluded. These are defined as those services having the same line item date of services (LIDOS) as the emergency room visit. *Note that in order to get a match on the LIDOS there must be a LIDOS and HCPCS in revenue code 045x.*

20.2 - Services Excluded from Part A PPS Payment and the Consolidated Billing Requirement on the Basis of Beneficiary Characteristics and Election

(Rev. 92, 2-06-04)
SNF-516

These services must be provided to specific beneficiaries, either: (A) End Stage Renal Disease (ESRD) beneficiaries, or (B) beneficiaries who have elected hospice, by specific licensed Medicare providers, and are excluded from SNF PPS and consolidated billing. SNFs will not be paid for Category II.A. services (dialysis, etc.) when the SNF is the place of service. To receive Medicare payment, these services must be provided in a renal dialysis facility. Hospices must also be the only type of provider billing hospice services.

In transmittals for FI billing that provide the annual update list of HCPCS codes affected by SNF consolidated billing, such services are referred to as " Major Category II" of SNF consolidated billing editing. See §10.1 above for the link to where transmittals providing current lists of HCPCS codes used for edits for these types of services, known as "Major Category II" in SNF consolidated billing editing for FIs.

20.2.1.1 - ESRD Services

(Rev. 92, 2-06-04)
SNF-516.6, PM A-02-118

Home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies (other than those that are furnished or arranged for by the SNF itself) are not included in the Part A PPS payment. They may be billed separately to the FI by the hospital or ESRD facility as appropriate.
Specific coding is used to differentiate dialysis and related services that are excluded from SNF consolidated billing for ESRD beneficiaries in three cases:

1. When the services are provided in a renal dialysis facility (RDF) (including ambulance services);
2. Home dialysis when the SNF constitutes the home of the beneficiary; and
3. When the drug EPO *or Aranesp* is used for ESRD beneficiaries.

Note that SNFs may not be paid for home dialysis supplies.

20.2.1.3 - Coding Applicable to Services Provided in a RDF or SNF as Home

(Rev. 92, 2-06-04)

RDFs use the following revenue codes for such billing on a Form CMS-1450 or ANSI ASC X12N 837 I:

- 825 - Hemodialysis OPD/Home Support Services;
- 835 - Peritoneal OPD/Home Support Services;
- 845 - Continuous Ambulatory Peritoneal Dialysis OPD/Home Support Services; or
- 855 - Continuous Cycling Peritoneal Dialysis OPD/Home Support Services.

20.2.1.4 - Coding Applicable to EPO Services

(Rev. 92, 2-06-04)
SNF-543

Epoetin alfa (trade name EPO) is a drug Medicare approved for use by end stage renal disease (ESRD) beneficiaries. FI EPO claims for ESRD beneficiaries are identified with the following revenue codes when services are provided in RDF:

- 634 (EPO with less than 10,000 units); and
- 635 (EPO with 10,000 or greater units).

Total units given in the period are placed in value code 48.

A new drug is now also covered for ESRD beneficiaries for treatment of anemia. The newly covered drug is darbepoetin alfa, and the trade name is Aranesp. Darbepoetin alfa will always be billed in revenue code 636.

20.3 – Other Services Excluded from SNF PPS and Consolidated Billing

(Rev. 92, 2-06-04)
SNF-515.1

The following services may be billed separately under Part B by the rendering provider, supplier, or practitioner (other than the SNF that receives the Part A PPS payment) and paid to the entity that furnished the service. These services may be provided by any Medicare provider licensed to provide them, other than the SNF that receives the Part A PPS payment, and are excluded from Part A PPS payment and the requirement for

consolidated billing*, and are referred to as "Major Category III" for consolidated billing edits applied to claims submitted to FIs.*

- An ambulance trip (other than a transfer to another SNF) that transports a beneficiary to the SNF for the initial admission or from the SNF following a final discharge;
- Certain chemotherapy and chemotherapy administration services. The chemotherapy administration codes are included in SNF PPS payment for beneficiaries in a Part A stay when performed alone or with other surgery, but are excluded if they occur with the same line item date of service as an excluded chemotherapy agent. A chemotherapy agent must also be billed when billing these services, and physician orders must exist to support the provision of chemotherapy;
- Certain radioisotope services;
- Certain customized prosthetic devices;
- For services furnished during 1998 only, the transportation costs of electrocardiogram equipment for electrocardiogram test services; and
- **All services** provided to risk based MCO beneficiaries. These beneficiaries may be identified with a label attached to their Medicare card and/or a separate health insurance card from an MCO indicating all services must be obtained or arranged through the MCO.

HCPCS code ranges for chemotherapy, chemotherapy administration, radioisotopes, and customized prosthetic devices are set in statute. The statute also gives the Secretary authority to make modifications in the particular codes that are designated for exclusion within each of these service categories. *See §10.1 above for the link to where transmittals providing current lists of HCPCS codes used for Major Category III SNF consolidated billing editing for FIs can be found.*

20.3.1. - Ambulance Services

(Rev. 92, 2-06-04)

SNF-516.2

The following ambulance transportation and related ambulance services for residents in a Part A stay are not included in the Part A PPS payment. Except for specific exclusions, consolidated billing includes those medically necessary ambulance trips that are furnished during the course of a covered Part A stay. Carriers are responsible for assuring that payment is made only for ambulance services that meet established coverage criteria.

In most cases, ambulance trips are excluded from consolidated billing when resident status has ended. The ambulance company then must bill the carrier directly for payment. Listed below are a number of specific circumstances under which a beneficiary may

receive ambulance services that are covered by Medicare, but excluded from consolidated billing.

The following ambulance services may be billed as Part B services by the supplier in the following situations only.

- The ambulance trip is to the SNF for admission (the second character (destination) of any ambulance HCPCS modifier is N (SNF) other than modifier QN, and the date of service is the same as the SNF 21X admission date.);
- The ambulance trip is from the SNF after discharge, to the beneficiary's home where the beneficiary will receive services from a Medicare participating home health agency under a plan of care (the first character (origin) of any HCPCS ambulance modifier is N (SNF)), and date of ambulance service is the same date as the SNF through date and the SNF patient status is other than 30;
- The ambulance trip is to a hospital based or nonhospital based ESRD facility (either one of any HCPCS ambulance modifier codes is G (Hospital based dialysis facility) or J (Non-hospital based dialysis facility) for the purpose of receiving dialysis and related services excluded from consolidated billing;
- The ambulance trip is from the SNF to a Medicare participating hospital or a CAH for an inpatient admission;
- The ambulance trip after a formal discharge or other departure from the SNF to any destination other than another SNF, and the beneficiary does not return to that or any other SNF by midnight of that same day; and
- Ambulance service that conveys a beneficiary to a hospital or CAH and back to the SNF, for the specific purpose of receiving emergency or other excluded services.

Note that ambulance trips associated with services provided in renal dialysis facilities (RDFs) are also excluded from SNF consolidated billing. Effective April 1, 2002, payment shall be the amount prescribed in the ambulance fee schedule.
NOTE: A beneficiary's transfer from one SNF to another before midnight of the same day is not excluded from consolidated billing. The first SNF is responsible for billing the services to the FI.

See Chapter 15 for Ambulance Services.

20.4 - Screening and Preventive Services

(Rev. 92, 2-06-04)
SNF-515.7

The Part A SNF benefit is limited to services that are reasonable and necessary to "diagnose or treat" a condition that has already manifested itself and, thus, does not include screening services (which detect the presence of a condition that is still in an asymptomatic stage) or preventive services (which are aimed at avoiding the occurrence

of a particular condition altogether). Coverage of screening and preventive services (e.g., screening mammographies, pneumococcal pneumonia vaccine, influenza vaccine, hepatitis vaccine) is a separate Part B inpatient benefit when rendered to beneficiaries in a covered Part A stay and is paid outside of the Part A payment rate. For this reason, screening and preventive services must not be included on the global Part A bill. However, screening and preventive services remain subject to consolidated billing and, thus, must be billed separately by the SNF under Part B. Accordingly, even though the SNF itself must bill for these services, it submits a separate Part B inpatient bill for them rather than including them on its global Part A bill. Screening and preventive services must be billed with a 22X type of bill. *Swing Bed providers must use TOB 12x for eligible beneficiaries in a Part A SNF level of care.*

In transmittals for FI billing providing the annual update list of HCPCS codes affected by SNF consolidated billing, such services are referred to as " Major Category IV". See §10.1 above for the link to where transmittals providing current lists of HCPCS codes used for Major Category IV can be found.

Formerly, bone mass measurement (screening) was listed as a preventive service excluded from SNF consolidated billing. ***This was incorrect****. Such services are diagnostic, not screening, procedures, and therefore are bundled into SNF PPS payment and subject to consolidated billing.*

20.5 – Therapy Services

(Rev. 92, 2-06-04)

Therapy services are edited as inclusions, rather than exclusions, to consolidated billing. Therapies must be billed by the SNF alone for its Part B residents and non-residents. In transmittals for FI billing providing the annual update list of HCPCS codes affected by SNF consolidated billing, such services are referred to as " Major Category V" of SNF consolidated billing. See §10.1 above for the link to where transmittals providing current lists of HCPCS codes used for Major Category V can be found.

Recurring Update Notification

Pub. 100-04	Transmittal: 92	Date: February 6, 2004	Change Request 3070

SUBJECT: April Quarterly Update to January 2004 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing Enforcement – Revenue Code Correction to January Update

I. GENERAL INFORMATION

A. Background: The CMS periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the SNF Prospective Payment System (SNF PPS). Services appearing on this list submitted on claims to both Medicare fiscal intermediaries (FIs) and carriers, including Durable Medical Equipment Regional Carriers (DMERCs), will not be paid by Medicare to providers, other than a SNF, when **included** in SNF CB. For non-therapy services, SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay; however, SNF CB applies to physical, occupational or speech-language therapy services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay. Services **excluded** from SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay. In order to assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB. **This notification provides a list of the exclusions, and some inclusions, to SNF CB.**

For the annual notice on SNF CB each January, separate instructions are published for FI and carriers/DMERCs. **However, this quarterly update applies to both FIs and carriers/DMERCs.** This recurring update is the first quarterly SNF consolidated billing update for Fiscal Year (FY) 2004, following the January annual update, affecting claims with dates of service on or after the effective date of this instruction, printed below, as specified by the CMS Change Management process.

The codes below are listed as being added or removed from the annual update, mentioned above. Additions to what is noted as Major Category I below means these codes may only be billed by hospitals and CAHs for beneficiaries in SNF Part A stays, and will only be paid when billed by these providers. Additions to therapy inclusions, Major Category V below, mean SNFs alone can bill and be paid for these services when delivered to beneficiaries in a SNF, whereas codes being removed from this therapy inclusion list now can be billed and potentially paid to other types of providers for beneficiaries NOT in a Part A stay.

Magnetic Resonance Imaging (MRIs) *(Major Category I, FI Annual Update, EXCLUSION)*

Add 72198* - MR angio pelvis w/o & w/dye

Angiography, Lymphatic, Venous and Related Procedures *(Major Category I, FI Annual Update, EXCLUSION)*

Add G0269 -** occlusive device in vein art
Add G0275 -** renal artery angio, cardiac cath

Therapies *(Major Category V, FI Annual Update, for FI billing use revenues codes 42x (physical therapy), 43x (occupational therapy), 44x (speech-language pathology))* The following changes are to the HCPCS codes SNFs are required to bill as Therapies.

Remove 92613* -** flexible fiberoptic endoscopic evaluation of swallowing by cine or video recording
Remove 92615* -** flexible fiberoptic endoscopic evaluation, laryngeal sensory testing
Add 92597 – eval for use and/or fitting voice prosthetic device to supplement oral speech
Add 0020T– electrical stimulation involving plantar fascia
Add G0295 - electromagnetic therapy onc

Notes on Codes above:
* While this code can be submitted by CAHs and hospitals not subject to OPPS, OPPS hospitals submit C8918 – C8920 instead, and these alternate codes are already edited for SNF CB.
** Carrier claims processing systems will not require changes for MRI and angiography codes.
*** Editing these codes as consolidated billing inclusions will end effective with this instruction since they are physician procedures; Note this instruction is not requiring FIs to pay for physician services, but rather just correcting existing edits and providing pertinent FI/carrier information.

Correct Revenue Codes for Epoetin Alfa (trade name EPO) and Darbepoetin Alfa (trade name Aranesp) for FI Billing. These drugs are Medicare approved for use by end stage renal disease (ESRD) beneficiaries. The FI EPO claims for ESRD beneficiaries are identified with the following revenue codes when services are provided in a Renal Dialysis Facility (RDF):

- 634 (EPO with less than 10,000 units); and
- 635 (EPO with 10,000 or greater units).

Do not use revenue code 636 to bill EPO on RDF claims.

A new drug is now covered for ESRD beneficiaries for treatment of anemia. The newly covered drug is darbepoetin alfa, and will always be billed in revenue code 636, exclusively using HCPCS code Q4054.

B. Policy: Section 1888 of the Social Security Act codifies SNF PPS and CB. The new coding identified in each update describes the same services that are subject to SNF PPS payment by law. No additional services will be added by these routine updates; that is, new updates are required by changes to the coding system, not because the services subject to SNF CB are being redefined. Other regulatory changes beyond code list updates will be noted when and if they occur.

C. Provider Education: The FIs and local carriers shall inform affected providers by posting either a summary or relevant portions of this document on their Web site within 2

weeks. Also, FIs and carriers shall publish this same information in their next regularly scheduled bulletin. If FIs or local carriers have a listserv that targets affected providers, they shall use it to notify subscribers that information about the "Annual Update of HCPCS Codes Used for SNF Consolidated Billing Enforcement" is available on their Web site. Local Carriers must additionally follow the instruction in business requirement 3070.4, and note that this requirement exempts DMERCs, a subset of carriers other than local carriers, from performing education for this CR.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
3070.1	For FI processing, the Common Working File (CWF), part of Medicare claims processing systems, shall modify the existing list of codes used to enforce consolidated billing using the list of HCPCS and revenue codes in the background section of this business requirement document. **[Systems Requirement]**	CWF – FI Edits
3070.2	For carrier claims processing, effective **only** for dates of service on or after 4/1/04, CWF shall delete 92613 and 92615 from the list of therapy codes. **[Systems Requirement]**	CWF – Carrier Edits
3115.3	For carrier claims processing, effective **only** for dates of service on or after 4/1/04, CWF shall add 92597 and 0020T to the list of therapy codes that shall be consolidated and shall not be paid separately by the carriers. **[Systems Requirement]**	CWF – Carrier Edits
3070.3.1	For carrier claims processing, effective **only** for dates of service on or after 4/1/04, CWF shall delete 92597 and 0020T from category 75. **[Systems Requirement]**	CWF – Carrier Edits
3070.4	If you have a listserv that targets the affected provider communities, you must use it to notify subscribers that information is available about the 2004 First Quarterly Update for Skilled Nursing Facility Consolidated Billing. The coding files for skilled nursing facility consolidated billing will be updated effective April 1, 2004. These updates will appear on the CMS Web site at cms.hhs.gov/medlearn/snfcodes.asp. In order to correctly bill services, carriers must notify physicians, non-physician practitioners, and suppliers that they should carefully review the revised code files.	Local Carriers excluding DMERCs (Note general educational requirements which include FIs in I.C. above)

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
N/A	

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements
N/A	

C. Interfaces: N/A

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

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. OTHER CHANGES

Citation	Change
N/A	

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: April 1, 2004 **Implementation Date:** April 5, 2004 **Pre-Implementation Contact(s):** Elizabeth Carmody, (410) 786-7533, ecarmody@cms.hhs.gov for FI billing; Leslie Trazzi (410) 786-7544, ltrazzi@cms.hhs.gov for carrier billing. **Post-Implementation Contact(s):** Regional offices	These instructions should be implemented within your current operating budget.

Attachments