Program Memorandum Carriers

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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CHANGE REQUEST 1256

SUBJECT: Consolidated Billing for SNF Residents

This Program Memoranda (PM) supersedes any and all carrier claims processing information previously published on consolidated billing (CB) for skilled nursing facilities (SNFs).

<u>This instruction applies to services and supplies furnished to a SNF resident in a Part A covered stay. EXCEPTION: Physical, occupational and speech therapy services in the Part B stay are also included in CB and must be billed by the SNF. Additional CB requirements will not apply to other Part B stay services until further notice.</u>

Section I.

A. <u>Background</u>.--Section 4432(b) of the Balanced Budget Act (BBA) requires CB for SNFs. Under the CB requirement, the SNF must submit Medicare claims to the fiscal intermediary (FI) for all the Part A and Part B services that its residents receive, except for certain excluded services listed in section I-G. The CB requirement essentially confers on the SNF itself the Medicare billing responsibility for the entire package of care that its residents receive, except for a limited number of specifically excluded services.

For services and supplies furnished to a SNF resident covered under the Part A benefit, SNFs will no longer be able to unbundle services to an outside provider of services or supplies that can then submit a separate bill directly to the Medicare carrier. Instead, the SNF must furnish the services or supplies either directly or under an arrangement with an outside provider. The SNF, rather than the provider of the service or supplies, bills Medicare. Medicare does not pay amounts that are due a provider of the services or supplies to any other entity under assignment, power of attorney, or any other direct payment arrangement. (See 42 CFR 424.73.) As a result, the outside provider of the service or supplies must look to the SNF, rather than to the beneficiary or the Medicare carrier, for payment. The SNF may collect any applicable deductible or coinsurance from the beneficiary. Most covered services and supplies billed by the SNF, including those furnished under arrangement with an outside provider, for a resident of a SNF in a covered Part A stay are included in the SNF's bill to the FI.

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.

<u>Effective July 1, 1998</u>, CB became effective for those services and items that were not specifically excluded by law that were furnished to residents of a SNF in a covered Part A stay and also includes physical, occupational and speech therapies in a Part B stay. SNFs became subject to CB once they transitioned to the prospective payment system (PPS). Due to systems limitations, CB 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). 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 to be billed to the FI for payment; and 2) the requirement that the physician enter the facility provider number of the SNF on the claim.

Effective July 1, 1998, through 42 CFR §411.15(p)(3))(iii) published on May 12, 1998, HCFA extended interpretation of the BBA to allow for a number of other services to be excluded from CB.

These services will be billed by the hospital or outpatient department directly to the FI. HCPCS codes for these services are included in section II, F.

Also excluded were 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.

Effective April 1, 2000, §103 of the Balanced Budget Refinement Act (BBRA) excluded additional services and drugs from CB 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 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. These specific services and drugs are listed by HCPCS codes in section II, E.

B. New Procedures.--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, the following requirements will be made effective in addition to all other previously implemented requirements for this category of residents:

- Physicians will be required to forward the technical portions of any services to the SNF to be billed by the SNF to the FI for payment. Medicare carriers will no longer make payment to physicians and suppliers for technical components of physician services furnished to beneficiaries in the course of a Medicare Part A covered stay.

- Providers will be required to enter the facility provider number of the SNF on the claim.

C. Determining the End of a SNF Stay.--When a beneficiary leaves the SNF, their status as a SNF resident for CB purposes, along with the SNF's responsibility to furnish or make arrangements for needed services, ends when one of the following events occurs:

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

- The beneficiary has been discharged from the SNF and receives services from a Medicare-participating home health agency under a plan of care;

- The beneficiary receives emergency or other excluded outpatient services;

- The beneficiary is formally discharged or otherwise departs from the SNF. However, if the beneficiary is readmitted or returns to that or another SNF before midnight of the same day, the beneficiary will still be considered to be in a SNF stay.

NOTE: This instruction only applies to Medicare fee-for-service beneficiaries residing in a participating SNF or in the nonparticipating portion of a nursing home that also includes a participating distinct part SNF. Further, this instruction only applies to the Part A SNF stay.

D. Types of Facilities Included in CB.--

- A participating SNF; and

- Any part of a nursing home that includes a participating distinct part SNF. In this situation, place of service must always be coded as "SNF" even if the beneficiary was in a nursing facility (NF) for part of the time.

E. Types of Facilities Excluded from CB.--

o A nursing home that has no Medicare certification, such as a nursing home that does not participate at all in either the Medicare or Medicaid programs; and

o A nursing home that exclusively participates only in the Medicaid program as a nursing facility.

F. Types of Services Included in CB.--The CB requirement confers on the SNF the billing responsibility for the entire package of care that Part A residents receive **and** physical, occupational and speech therapy services in the Part B stay. Exception: a limited number of specifically excluded services are outlined below in section I-G.

G. Types of Services Excluded from Consolidated Billing.--The following services and supplies provided by the following types of providers, are excluded from consolidated billing and are still billed separately to the Medicare carrier. If a service or supply does not appear on this list, or fit into one of these categories, then it is not excluded from CB and should be consolidated by the SNF to the FI for payment. Effective July 1, 1998, per the BBA and by HCFA regulation; the **exclusions** are:

? The professional component (PC) of physician's services furnished to SNF residents except physical, occupational and speech-language therapy services and audio logic function tests. A physician is defined for Medicare purposes in §1861(r) of the Social Security Act.

? In addition, certain services are excluded only when furnished on an outpatient basis by a hospital or a critical access hospital:

- cardiac catheterization services;
- computerized axial tomography (CT) scans;
- magnetic resonance imaging (MRIs);
- ambulatory surgery involving the use of an operating room;
- radiation therapy;
- emergency services;
- angiography;
- lymphatic and venous procedures; and
- ambulance services to a facility to receive any of the previously mentioned excluded outpatient hospital services.

o Physician assistants working under a physician's supervision;

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

o Clinical nurse specialist;

o Certified nurse-midwives;

o Qualified psychologists;

o Certified registered nurse anesthetists;

o Certain dialysis-related services including covered ambulance transportation to obtain the dialysis services;

o Erythropoietin (EPO) for certain dialysis patients;

o Hospice care related to a beneficiary's terminal condition; and

o An ambulance trip that transports a beneficiary to the SNF for the initial admission or from the SNF following a final discharge.

Effective for services provided on or after April 1, 2000, to residents in a Part A covered stay, the BBRA excluded from CB a subset of HCPCS codes in the following categories:

- o Chemotherapy;
- o Chemotherapy administration services;
- o Radioisotope services; and
- o Customized prosthetic devices.

o **FOR 1998 ONLY** - The transportation costs of electrocardiogram equipment for electrocardiogram test services (HCPCS code R0076) furnished during 1998. This reflects §4559 of the BBA, which temporarily restored separate Part B payment for the transportation of portable electrocardiogram equipment used in furnishing tests during 1998.

H. Risk-Based HMO Beneficiaries.--Services to risk-based HMO enrollees are not included in consolidated billing. Managed care beneficiaries are identified on CWF with applicable Plan ID, entitlement and termination periods on the CWF GHOD screen. Claims received on or after the HMO enrollment effective date and prior to the HMO termination date are exempt from consolidated billing.

I. Clarification of Ambulance Services.--Except as listed under exclusions in section I-G, CB includes those medically necessary ambulance trips that are furnished during the course of a covered Part A residential stay.

In most cases, ambulance trips are excluded from CB when resident status has ended. (See section I-C, Determining the End of SNF Stay.) 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 after residency has ended. These ambulance trips are covered by Medicare and are not subject to CB. These consist of:

o A medically necessary round trip to a Medicare participating hospital or CAH for the specific purpose of receiving emergency or other excluded services. (See section I-G.)

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

o Medically necessary ambulance trips after a formal discharge or other departure from the SNF is excluded from CB, unless the beneficiary is readmitted or returns to that or another SNF before midnight of the same day.

o An ambulance trip for the purpose of receiving dialysis-related services is excluded from CB.

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

o After a discharge from the SNF, a medically necessary trip to the beneficiary's home where the beneficiary will receive services from a Medicare participating home health agency under a plan of care.

A beneficiary's transfer from one SNF to another before midnight of the same day is not excluded from CB. The first SNF is responsible for billing the services to the FI.

Carriers are responsible for assuring that payment for ambulance services meet coverage criteria and determining when the services are included in CB and when the supplier may submit a separate bill.

J. <u>Information for Providers and Suppliers on SNF Contracting with Outside Entities for Ancillary Services</u>.--Except for those services and supplies specifically excluded, under CB an outside provider or supplier can no longer submit a separate bill directly to Medicare for services furnished to a SNF resident. Instead, it must look to the SNF for its payment. This means that in making program payment for services furnished to SNF residents, Medicare deals exclusively with the SNF itself rather than with an outside provider or supplier that the SNF may elect to use.

The law is silent regarding specific terms of a SNF's payment to the outside provider or supplier and currently does not authorize the Medicare program to impose any requirements in this regard. Thus, the issue of the outside provider or supplier's payment by the SNF is a private, contractual matter that must be resolved through direct negotiations between the two parties themselves.

o Services provided under CB arrangements must be provided only by Medicare certified providers that are licensed to provide the service involved.

o Payment may not be made if the provider or supplier is subject to OIG sanctions that would prohibit Medicare payment for the service if the provider or supplier were billing independently.

Section II. CLAIMS PROCESSING INSTRUCTIONS, CARRIER and CWF EDITS

A. <u>Requirements for Entry of the SNF's Medicare Facility Provider Number</u>.-- Per §4432(b)(4) of the BBA, when physicians provide services to a beneficiary residing in a SNF, the physician must include the Medicare facility provider number of the SNF on the claims form or electronic record. The Medicare provider facility number of the SNF is the number assigned to the SNF by the HCFA regional office when they are certified as a Medicare facility. This number is referred to as the OSCAR number.

Effective April 1, 2001, for claims with dates of service on or after April 1, 2001, verify that on physician bills for professional services furnished to SNF residents in a covered Part A stay, that the Medicare provider number of the SNF, (which must be preceded by the prefix "SNF"), has been entered in the appropriate block of the claims form or electronic record.

1. If the SNF is the location where the services were rendered (Place of Service Code 31), the SNF provider number must be entered in Item 32 of the Form HCFA-1500.

For electronic submissions, when the physician renders services in a SNF (Place of Service Code 31) to a beneficiary residing in a SNF, the Medicare facility provider number of the SNF should be reported in:

<u>The National Standard Format</u>: Record EA1, field EA1.04 (Facility/Lab ID); or

<u>The ANSI X12N 837</u>: Table 2, Position 250, segment/element NM109(Facility ID).

2. If the services were rendered to a SNF beneficiary outside of the SNF, the physician must enter the Medicare facility provider number of the SNF in Item 23 of the Form HCFA-1500.

For electronic submission, when the beneficiary resides in a SNF and a provider renders services to the beneficiary at another facility, the Medicare facility provider number of the SNF where the beneficiary resides must be reported in:

<u>The National Standard Format</u>: Record FB1, field 23, positions 280-294 (this is currently filler); or

<u>The ANSI X12N 837</u>: Line level loop, 2-500-NM1, with a value of "P0" (Patient Facility - facility where patient resides) in NM101, a value of "FA" (Facility ID) or "ZZ" (NPI - when implemented) in NM108, and the SNF ID in NM109.

Use the following Remittance Advice (RA) if the required information is missing:

Claim Adjustment Reason Code 16, Claim/service lacks information which is needed for adjudication; and

Claim Level Remark Code MA134, Missing/incomplete/invalid provider number of the facility where the patient resides.

In addition, per Medicare Carriers Manual (MCM) §2010, enter the name and address or Provider Identification Number of the facility where the service was performed in Item 32 of the Form HCFA-1500. For electronic submissions, the facility where services were rendered must be reported in:

The National Standard Format: Record EA1, field 04, (Facility ID/NPI); or

The ANSI X12N 837: Claim level loop, 2-250-NM1, with a value of "61" (Performed at the facility where work was performed) in NM101, a value of "FA" (Facility ID) or "ZZ" (NPI - when implemented) in NM108, and the facility ID in NM109.

Effective April 1, 2001, for claims with dates of service on or after April 1, 2001, for beneficiaries in a Part A covered stay, verify that the name and address of the facility where services are provided is entered in the appropriate block of the claims form or electronic record. Use the following RA if the required information is missing:

Claim Adjustment Reason Code 16, Claim/service lacks information which is needed for adjudication; and

Claim Level Remark Code MA114, Did not complete or enter accurately the name and address, or the carrier assigned PIN, of the entity where services were furnished. (Substitute NPI for PIN when effective.)

In all cases, when the above required information is missing from the submitted claim, reject assigned and non-claims.

B. Use of the PC/TC Indicators to Identify Physician's Services.--Codes for diagnostic tests may include both a technical portion, i.e., the test itself and a professional component, i.e., the physician's interpretation of the test. To identify the professional components of physician's services for SNF residents that are billable to the carrier, use the information in the Professional Component/Technical Component (PC/TC) indicator field of the Medicare Physician Fee Schedule (MPFS) for payment. For Medicare purposes, physicians and physician's services are defined per §1861(q) and (r) of the Social Security Act.

Effective April 1, 2001, for claims with dates of service on or after April 1, 2001, for beneficiaries in a Part A covered stay, pay the physician only for the professional component of physician services that have both technical and professional components or for those physician services that have only professional components. If technical components are billed, either separately or globally, reject that portion of the claim per MCM §3005.

Listed below are examples of how claims should be processed based on the PC/TC indicator on the MPFSDB. In subsequent years, definitions of the indicators may change. Every year, it will be the responsibility of the carrier to review the current MPFSDB indicators and adjust reimbursement rules in claims processing logic as appropriate. Anesthesia services have no separately identifiable technical component and should be billed to the carrier as physician's professional services.

PC/TC Indicator	SNF Consolidated Billing/Payment Policy for MPFS Services
0	Physician Service Code: Codes with a 0 indicator are not considered to have a separately identifiable professional or technical component. They will never be seen with a TC or 26 modifier. 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, G03026 and G0030TC). Pay the service when submitted with the 26 modifier. The global codes should be rejected. The TC codes should be denied.
2	Professional Component Only Codes: Codes with an indicator of 2 signify services that only have a PC. Physicians submit these services to the carrier for processing and reimbursement.
3	Technical Component Only Codes: Codes with an indicator of 3 signify services that only have a TC. Carriers should deny these claims and notify the physicians to have the SNF bill to the FI through CB.
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. If the physician submits the global code, reject the service (unless the code is an exception to consolidated billing and may be paid). Notify the physician to resubmit the service using the code that represents the PC only.
5	Incident To Codes: These codes are not considered physician services in the SNF setting. Carriers should deny these claims and notify the physician that the SNF must bill the FI for payment.
6	Laboratory Physician Interpretation Codes: These codes are for the interpretation of clinical lab services. Physicians submit these services to the carrier for processing and reimbursement
7	Physician Therapy Services: These services are only billable by the SNF to the FI. Carriers should deny these claims and notify the physician to have the SNF bill the FI for payment.
8	Physician Interpretation Codes: An indicator of 8 signifies codes that represent the professional component of a clinical lab code for which separate payment may be made. It only applies to codes 88141, 85060 and P3001-26. A TC indicator is not applicable. Physicians submit these services to the carrier for processing and reimbursement.
9	Concept of a Professional/Technical Component Does Not Apply: An indicator of 9 signifies a code that is not considered to be a physician service. Carriers should deny these claims and notify the physician to have the SNF bill the FI for payment.

Effective April 1, 2001, for claims with dates of service on or after April 1, 2001, for beneficiaries in a Part A covered stay, verify that payment is not made for any technical components of claims based on the PC/TC indicators. Use the following RA messages if the required information is missing:

Claim adjustment reason code 16, Claim/service lacks information which is needed for adjudication; and

Line level remark code M96, The technical component of a service furnished to an impatient may only be billed by that inpatient facility. You must contact the inpatient facility for your payment for the technical component. If not already billed, you should bill us for the professional component only.

C. HCPCS Codes to Identify Physical, Occupational and Speech Language Therapy Services and Audiologic Function Tests That Are Subject to CB. Both Part A and Part B stays are subject to CB for therapy services. When coded with the following HCPCS codes with a POS code of 31, carriers must reject the services.

Rehabilitation Services - Physical, Occupational and Speech Language Therapy

11040	11041	11042	11043	11044
29065	29075	29085	29105	29125
29126	29130	29131	29200	29220
29240	29260	29280	29345	29365
29405	29445	29505	29515	29520
29530	29540	29550	29580	29590
64550	90901	90911	92506	92507
92508	92510	92525	92526	92597
92598	95831	95832	95633	95834
95851	95852	96105	96110	96111
96115	97001	97002	97003	97004
97010	97012	97014	97016	97018
97020	97022	97024	97026	97028
97032	97033	97034	97035	97036
97039	97110	97112	97113	97116
97124	97139	97140	97150	97504
97520	97530	97535	97537	97542
97545	97546	97703	97750	97770
97799	G0169	V5362	V5363	V5364

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

Code 97504 should not be reported with code 97116. Codes should be rejected.

Code 97770 is not considered to be an outpatient rehabilitation service when delivered by a clinical psychologist (specialty 68), psychiatrist (specialty 26), or clinical social worker (specialty 80) for the treatment of a psychiatric condition (ICD-9-CM code range 2900 through 319). Edit appropriately.

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		

Reject the codes listed above for the therapy and audiologic services. Use the following RA and MSN/EOMB messages:

RA

Claim adjustment reason code 97, Payment is included in the allowance for the basic service/procedure; and

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

MSN/EOMB

MSN code 13.8/EOMB code 16.96, The skilled nursing facility should file a claim for Medicare benefits because you were an inpatient.

D. Ambulance Claims.--

o Carriers must reject ambulance claims with HCPCS code A0225 through A0999 if both characters of the HCPCS modifier is N, origin and destination is SNF. These claims must be billed by the SNF to the FI.

Effective April 1, 2001, for claims with dates of service on or after April 1, 2001, for beneficiaries in a Part A covered stay, verify that claims with the ambulance HCPCS codes and modifier N are rejected. Use the following RA and MSN/EOMB messages:

RA

Claim adjustment reason code 97, Payment is included in the allowance for the basic service/procedure; and

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

MSN/EOMB

MSN code 13.8/EOMB code 16.96, The SNF should file a claim for Medicare benefits because you were an inpatient.

NOTE: The codes listed below in sections E, F, G, and H are excluded from CB and may be paid by the carrier or DMERC. Effective April 1, 2001, for claims with dates of service on or after April 1, 2001, for beneficiaries in a Part A covered stay implement necessary systems changes to allow services with these codes to be processed and paid for these residents of a SNF.

E. Specific Drugs, Services, and Supplies to be Excluded from CB.--Claims for services received using the following codes are excluded from CB and should be billed to and paid by the carrier or DMERC as appropriate. Any necessary systems changes should be implemented to allow these services to be paid for SNF residents.

Chemotherapy Drugs

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

Chemotherapy Administration Services

36260	36261	36262	36489	36530	36531	36532
36533	36534	36535	36640	36823	96405	96406
96408	96410	96412	96414	96420	96422	96423
96425	96440	96445	96450	96520	96530	96542

Radioisotope Services

79030	78035	79100	79200	79300	79400	79420
79440						

Customized Prosthetic Devices

L5050	L5060	L5100	L5105	L5150	L5160	L5200
L5210	L5220	L5230	L5250	L5270	L5280	L5300
L5310	L5320	L5330	L5340	L5500	L5505	L5510
L5520	L5530	L5535	L5540	L5560	L5570	L5580
L5585	L5590	L5595	L5600	L5610	L5611	L5613
L5614	L5616	L5617	L5618	L5620	L5622	L5624
L5626	L5628	L5629	L5630	L5631	L5632	L5634
L5636	L5637	L5638	L5639	L5640	L5642	L5643
L5644	L5645	L5646	L5647	L5648	L5649	L5650
L5651	L5652	L5653	L5654	L5655	L5656	L5658
L5660	L5661	L5662	L5663	L5664	L5665	L5666
L5667	L5668	L5669	L5670	L5672	L5674	L5675
L5676	L5677	L5678	L5680	L5682	L5684	L5686
L5688	L5690	L5692	L5694	L5695	L5696	L5697
L5698	L5699	L5700	L5701	L5702	L5704	L5705
L5706	L5707	L5710	L5711	L5712	L5714	L5716
L5718	L5722	L5724	L5726	L5728	L5780	L5785
L5790	L5795	L5810	L5811	L5812	L5814	L5816
L5818	L5822	L5824	L5826	L5828	L5830	L5840
L5845	L5846	L5850	L5855	L5910	L5920	L5925
L5930	L5940	L5950	L5960	L5962	L5964	L5966
L5968	L5970	L5972	L5974	L5975	L5976	L5978
L5979	L5980	L5981	L5982	L5984	L5985	L5986
L5988	L6050	L6055	L6100	L6110	L6120	L6130
L6200	L6205	L6250	L6300	L6310	L6320	L6350
L6360	L6370	L6400	L6450	L6500	L6550	L6570
L6580	L6582	L6584	L6586	L6588	L6590	L6600
L6605	L6610	L6615	L6616	L6620	L6623	L6625
L6628	L6629	L6630	L6632	L6635	L6637	L6640
L6641	L6642	L6645	L6650	L6655	L6660	L6665
L6670	L6672	L6675	L6676	L6680	L6682	L6684
L6686	L6687	L6688	L6689	L6690	L6691	L6692
L6693	L6700	L6705	L6710	L6715	L6720	L6725
L6730	L6735	L6740	L6745	L6750	L6755	L6765
L6770	L6775	L6780	L6790	L6795	L6800	L6805
L6806	L6807	L6808	L6809	L6810	L6825	L6830
L6835	L6840	L6845	L6850	L6855	L6860	L6865
L6867	L6868	L6870	L6872	L6873	L6875	L6880
L6920	L6925	L6930	L6935	L6940	L6945	L6950
L6955	L6960	L6965	L6970	L6975	L7010	L7015
L7020	L7025	L7030	L7035	L7040	L7045	L7170
L7180	L7185	L7186	L7190	L7191	L7260	L7261
L7266	L7272	L7274	L7362	L7364	L7366	

F. Codes for Emergency Services Excluded from CB.--Effective April 1, 2001, for claims with dates of service on or after April 1, 2001, for beneficiaries in a Part A covered stay, the following services rendered in the hospital or CAH are excluded from CB and should be paid by the carrier or DMERC. These claims are identified with place of service code 23.

CT Scans

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

Cardiac Catheterization

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

MRI

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

Radiation Therapy

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

Angiography

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	79564	75966	75968	75970	75978
75980	75982	75992	75993	75994	75995	75996

Outpatient Surgery

EXCEPT for the following codes that are included in CB:

10040	11951	17340	29358	31725	53661	69210
10060	11952	17360	29365	31730	53670	95970
10080	11954	17380	29405	36000	53675	95971
10120	11975	17999	29425	36140	54150	95972
11040	11976	20000	29435	36400	54235	95973
11041	11977	20974	29440	36405	54240	95974
11042	15780	21084	29445	36406	54250	95975
11043	15781	21085	29450	36415	55870	95976
11044	15782	21497	29505	36430	57160	
11055	15783	26010	29515	36468	57170	
11056	15786	29058	29540	36469	58300	
11057	15787	29065	29550	36470	58301	
11200	15788	29075	29580	36471	58321	
11300	15789	29085	29590	36489	58323	
11305	15792	29105	29700	36600	59020	
11400	15793	29125	29705	36620	59025	
11719	15810	29126	29710	36680	59425	
11720	15811	29130	29715	44500	59426	
11721	16000	29131	29720	51772	59430	
11740	16020	29200	29730	51784	62367	
11900	17000	29220	29740	51785	62368	
11901	17003	29240	29750	51792	64550	
11920	17004	29260	29799	51795	65205	
11921	17110	29280	30300	51797	69000	
11922	17111	29345	30901	53601	69090	
11950	17250	29355	31720	53660	69200	

Effective April 1, 2001, for claims with dates of service on or after April 1, 2001, for beneficiaries in a Part A covered stay, verify that the claims for services in this section that are excluded from CB have a POS 23. If the POS is not 23, reject the service.

Effective April 1, 2001, for claims with dates of service on or after April 1, 2001, for beneficiaries in a Part A covered stay, ensure that the outpatient surgery codes listed above that are included in CB are rejected.

Use the following RA and MSN/EOMB messages for either situation:

RA

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

MSN/EOMB

MSN code 13.9/EOMB code 16.97, Medicare Part B does not pay for this item or service since our records show that you were in a SNF on this date.

G. Erythropoietin (EPO) Services.--These services are not included in the SNF Part A PPS rate and are excluded from CB. They must be billed to the carrier or DMERC for payment as they currently are per MCM §§2049.5B, 4273 and 5202.3. EPO services are identified by the following HCPCS codes:

- o Q9920 - Injection of EPO, per l,000 units, at patient HCT of 20 or less;

- o Q9921 through Q9939 - Injection of EPO, per 1,000 units, at patient HCT of 2l through 39; or

- o Q9940 - Injection of EPO, per l,000 units at patient HCT of 40 or above.

H. Dialysis.--Home dialysis equipment, home dialysis support services, institutional dialysis services and supplies are excluded from CB and should be billed separately by the supplier to the DMERC or by the ESRD facility to the FI for payment. Claims for services for dialysis patients must have one of the following ICD-9-CM diagnosis codes:

403.01	403.11	403.91	404.02	404.12	404.92	584.5
584.6	584.7	584.8	584.9	585	586	788.5
958.5						

Verify that for SNF residents, claims for home dialysis equipment and home dialysis support services and supplies have at least one of the above diagnosis codes on the claim. Claims submitted without the appropriate diagnosis code should be rejected.

I. CWF Edits.--When an inpatient Part A 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 recoup the incorrect outpatient or Part B payment.

J. Notification.--Carriers should provide notification of these changes to physicians, non-physician practitioners and suppliers in their next regularly scheduled bulletins.

The *implementation date* of this 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 April 1, 2002.

Contractors should contact the appropriate regional office with any questions.

Attachment

ATTACHMENT

Carrier Edits for SNF Consolidated Billing
November 17, 2000

Listed below are CWF edits related to carriers for SNF Consolidated Billing as related to a Medicare Part A SNF in-patient stay.

The edits requested do not alter or change any existing CWF A/B crossover or duplicate edits.

These edits include a new functionality in CWF to auto-cancel already posted claims and standard systems to handle the auto-cancel message from CWF. Auto-cancel transactions are intended to allow an inpatient Part A claim to process when a paid outpatient or carrier Part B claim was already posted to history for services that are subject to Part A consolidated billing. To facilitate standard system automation, we request two separate auto cancel error codes. One error code to identify posted Part B claim service dates that are within the service dates on an inpatient claim and another error code to identify the posted Part B service dates that overlap the service dates on the inpatient SNF claim.

Also effective April 1, 2001, we request two new data elements. The first must be added to CWF and carrier claims including DMERC. The new data element is the SNF provider number. Its purpose is to identify the SNF on a carrier/DMERC claim in which the Part B services were rendered to a SNF resident by a physician or supplier. Bill preparation requirements were released in Program Memorandum AB-99-90. Related edits are described below.

Duplicate edits identify services billed by the SNF and another provider or suppler. These edits compare the date of service, HCPCS code and modifier if present. We request that CWF duplicate edits be performed after CWF consistency edits.

In general, rules for services for which edits are effective April 1, 2001, are:

? Services considered included in the SNF Part A PPS rate cannot be billed by other providers. Such billing would be duplicate billing. Services that may be billed separately are identified by HCPCS code and modifiers (if necessary) in the edit rules.

? Therapy services to a SNF Part A resident must be billed by the SNF for the service to be covered.

? Duplicate crossover edits to assure that payment is not made to each the SNF and a supplier or provider are included. These edits compare HCPCS codes (modifiers, where applicable) and dates of service.

Use the line item date of service, HCPCS codes and modifiers where indicated for carrier claims in performing the edits.

Contractor action (carrier or intermediary) on rejects or non solicited CWF responses will be to:

? Adjust/cancel the erroneously processed claim on history where an inpatient SNF Part A bill is received and an outpatient or carrier Part B history bill exists for specified services. CWF will auto-cancel the outpatient or carrier Part B history claim and send an auto-cancel message to the carrier or intermediary. The carrier or intermediary will have to process a transaction to update their history records and recover the overpayment.

? 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.)

? Reject the pending claim where the services are included in consolidated billing and must be billed by the SNF or where the claim fails a consistency edit.

Specific contractor resolution procedures are described in section I-C of this memo. Edits are effective April 1, 2001.

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 in a SNF inpatient Part A stay. Managed care beneficiaries are identified on CWF with applicable Plan ID, entitlement and termination periods on the GHOD screen. The Plan ID is a four position number preceded with 'H'. Claims received on or after the HMO effective date and prior to the HMO termination date are exempt from Part A PPS and consolidated billing.

RECOMMENDED EDIT LOGIC

A. CWF Utilization Edits for Consolidated Billing for Services on and After April 1, 2001.

Add the following new Part A PPS consolidated billing edits to accommodate SNF Part A Consolidated Billing. Any line item failing the edit will cause the entire claim to reject.

1. Carrier Part B Physical Therapy Claim Against an Inpatient SNF 21X Claim.

Reject if a carrier Part B claim is received containing physical therapy (type of service of 'W'), occupational therapy (type of service of 'U'), or speech therapy with HCPCS codes in section II A.1 (therapies) and From/Thru Dates overlap or are within the From/Thru Dates on an SNF inpatient claim (21X).

Use separate error codes where (1) dates are within (contractor will reject claim) or (2) where dates overlap (contractor will automate a separate denial message to provider).

Bypass the edit in the following situations:

? The 21X type of bill contains a cancel date.

? The incoming claim from date equals the SNF 21X history claim discharge date or incoming through date equals the SNF 21X history claim admission date.

2. Carrier Part B Claim Without Therapy Against an Inpatient SNF.

Reject if a carrier Part B claim is received with From/Thru Dates overlapping or are within the From/Thru Dates on an SNF Inpatient claim (21X). If the SNF 21X claim on history has patient status '30' and occurrence code '22' (Date Active Care Ended), use occurrence 22 date instead of the through date.

Use separate error codes where (1) dates are within (contractor will reject claim); or (2) where dates overlap (contractor will automate a separate denial message to provider).

Bypass the edit in the following situations:

? The 21X history claim contains a cancel date greater than zero.

? The incoming Part B claim from date equals the SNF 21X history claim discharge date. The incoming Part B claim through date equals the SNF 21X history claim admission date.

? A diagnosis code in any position on the incoming claim is for renal disease. These codes are listed in section II.A.6.

o The Part B claim contains ambulance HCPCS codes (A0021 through A0999) with modifiers other than 'N' (SNF) in both the origin and destination on the same claim.

o The Part B claim is a CANCEL ONLY (Action Code '4') claim.

o The Part B claim is denied.

o The Part B service has a Payment Process Indicator other than 'A' (allowed).

o The Part B claim contains only services listed in section II.A.4.

o The Part B claim contains services rendered in the emergency room. These claims are identified with place of service code '23'.

o The Part B claim contains only services listed in section II.A.5.

o The Part B claim contains services allowed based on the payment/policy (TC/PC) guidelines in the MFS table in II.A.3.

o The Part B claim contains services for EPO identified by the codes in section II.A.7.

3. Inpatient SNF Part A Claim Against a Carrier Part B Therapy Claim on History.

If a SNF '21X' claim is received with dates of service that are within or overlap a carrier Part B history claim containing physical therapy (type of service of 'W'), occupational therapy (type of service of 'U'), or speech therapy with HCPCS codes in section II A.1 (therapies), CWF will process the inpatient claim and auto-cancel the Part B therapy history claim.

Use separate error codes where (1) dates are within (contractor will reject claim); or (2) where dates overlap (contractor will automate a separate denial message to provider).

Bypass the edit in the following situations:

? The incoming '21X' claim contains a cancel date.

? The incoming SNF '21X' claim discharge date equals the history Part B claim from date or the incoming SNF '21X' admission date equals the history claim through date.

? The Part B history claim is a CANCEL ONLY (Action Code '4') claim.

? The Part B history claim is denied.

? The Part B service on history has a Payment Process Indicator other than 'A' (allowed).

4. Inpatient SNF Part A Claim Against a Carrier Part B Claim (no therapy) on History.

If a SNF inpatient claim ('21X') is received against a posted carrier Part B history claim and the Part B history claim From/Thru Dates are within or overlap the SNF inpatient From/Thru Dates or, if present, the Span Code '72' From/Thru Dates, CWF will process the inpatient claim and CWF will auto-cancel the Part B history claim. If the '21X' inpatient claim is '213' or '214', determine the start date for comparison as the from date on the preceding '212' claim.

Use separate error codes where (1) dates are within (contractor will reject claim); or (2) where dates overlap (carrier will automate a separate denial message to provider).

Bypass the edit in the following situations:

? The carrier Part B history claim contains any of the HCPCS codes listed in item IIA4.

? The carrier Part B history claim contains HCPCS ambulance modifiers other than 'N' (SNF) in both the origin and destination on the same claim.

? A diagnosis code in any position on the Part B history claim is for renal disease. These codes are listed in item IIA6.

? The professional/technical indicator and billing/payment policy guidelines in II.A.3 allows payment to a physician as a separately billable service.

? The carrier Part B history claim from date equals the SNF '21X' claim discharge date or carrier Part B history claim through date equals the SNF '21X' claim admission date.

? The carrier Part B history claim is for emergency room services (place of service is '23') or contains any of the HCPCS codes identified in II.A.5. (Note items in last section of section II.A.5 that can not be paid separately and should reject).

? The incoming inpatient SNF claim contains a no-pay code of 'B', 'C', 'N' or 'R'.

? The incoming 21X claim contains a cancel date.

? The Part B history claim is a CANCEL ONLY (Action Code '4') claim.

? The Part B history claim is denied.

? The Part B service on the history claim has a Payment Process Indicator other than 'A' (allowed).

? The Part B history claim contains services for EPO identified by the codes in section II.A.7.

5. Duplicate Edit: Carrier Part B Ambulance Claim Against an Outpatient Part B SNF Ambulance Claim on History.

Reject if a carrier Part B claim is received with ambulance HCPCS codes ('A0021' through 'A0999') and the Date of Service equals the Date of Service on an outpatient Part B SNF ('23X') claim with revenue code '54X' (ambulance). The modifier combinations are the same on both claims.

Bypass the edit if either the incoming or history claim contains any of the following situations:

? The claim is a CANCEL ONLY (Action Code '4') claim.

? The claim is denied.

? The incoming claim payment process indicator is other than 'A' (allowed).

6. Duplicate Edit: Carrier/DMERC or Intermediary Part B Claim Against An Inpatient B SNF (22X) Claim on History.

Reject as a duplicate claim if a carrier/DMERC Part B claim or intermediary Part B claim ('12X', '13X', '14X', '23X', '33X', '71X', '73X', '74X', '75X', '76X', '83X' or '85X') is received containing

date of service, HCPCS code and modifier if present, equal to the date of service, HCPCS code and modifier, if present, on an inpatient Part B SNF (‘221', ‘222', ‘223', ‘224' or ‘225') claim.

Bypass the edit if either the incoming or history claim contains any of the following situations:

? The claim is a CANCEL ONLY (Action Code '4') claim.

? The claim is denied.

? HCPCs code is not present on the intermediary claim.

? The carrier Part B claim payment process indicator is other than 'A' (allowed).

? For the carrier/DMERC claim only, the professional/technical indicator and billing/payment policy guidelines in II.C.3. allows payment to a physician as a separately billing service.

7. Duplicate Edit: Carrier/DMERC or Inpatient B SNF Claim Against Outpatient B Claim on History.

Reject as a duplicate claim if a carrier Part B claim or an inpatient Part B SNF (‘221', ‘222', ‘223', ‘224' or ‘225') is received containing date of service, HCPCS and modifier codes, if applicable, equal to the date of service, HCPCS and modifier codes, if applicable on a outpatient Part B claim ('12X', '13X', '14X', '23X', '33X', ‘71X’, ‘73X’, '74X', '75X', ‘76X’, ‘83X’ or ‘85X’).

Bypass the edit if either the incoming or history claim contains any of the following situations:

? The claim is a CANCEL ONLY (Action Code '4') claim.

? The claim is denied.

? HCPCs code is not present on the intermediary outpatient claim.

? The Payment Process Indicator is other than 'A' (allowed).

? For the carrier/DMERC claim only, the professional/technical indicator and billing/payment policy guidelines in section II.C.3. allows payment to a physician as a separately billing service.

B. Carrier and Cwf Consistency Edits

The following are consistency edits to be applied to carrier claims.

1. Carrier Part B Claim With Dates of Service On or After April 1, 2001 that Contains Therapy Services for a SNF Beneficiary.

Reject a carrier Part B claim received with dates of service on or after April 1, 2001 and the Place of Service is '31' (SNF) and the claim contains HCPCS codes in section II A.1 (therapies). Bypass the edit in the following situations:

? The Part B claim is a CANCEL ONLY (Action Code '4') claim.

? The incoming Part B claim is denied.

? The incoming Part B service has a Payment Process Indicator other than 'A' (allowed).

2. Carrier Part B Claim for a SNF Beneficiary Does Not Contain the SNF Provider Number B Effective for Services on or After April 1, 2001.

Reject the carrier Part B claim if place of service is '31' (SNF), and the Medicare facility provider number of the SNF is not on the claim. Physicians must identify the SNF where services were rendered to a SNF beneficiary. Services rendered to a SNF beneficiary are identified when the SNF Medicare facility provider number is present on the claim in one of the following locations.

? The National Standard Format: Record EA1, field EA1.04 (Facility/Lab ID); or

? The ANSI X12N 837: Table 2, Position 250, segment/element NM109 (Facility ID).

For electronic submission, when the beneficiary resides in a SNF and a provider renders services to the beneficiary at another facility, the Medicare facility provider number of the SNF where the beneficiary resides is to be reported in:

? The National Standard Format: Record FB1, field 23, positions 280-294 (this is currently filler); or

? The ANSI X12N 837: Line level loop, 2-500-NM1, with a value of "P0" (patient facility - facility where patient resides) in NM101, a value of "FA" (Facility ID) or "ZZ" (NPI - when implemented) in NM108, and the SNF ID in NM109.

The facility where services were rendered is to be reported in:

? The National Standard Format: Record EA1, field 04, (Facility ID/NPI); or

? The ANSI X12N 837: Claim level loop, 2-250-NM1, with a value of "61" (performed at the facility where work was performed) in NM101, a value of "FA" (Facility ID) or "ZZ" (NPI - when implemented) in NM108, and the facility ID in NM109.

3. Carrier Part B Claim for a SNF Beneficiary Does Not Contain a 5 or 6 in the SNF Provider Number.

Effective for clams received on or after April 1, 2001, reject the carrier Part B claim if the Medicare facility provider number of the SNF does not contain a 5 or 6 in the 3rd position.