PROGRAM MEMORANDUM INTERMEDIARIES

Department of Health and Human Services

Health Care Financing Administration

Transmittal No. A-00-01 **Date JANUARY 2000**

This Program Memorandum re-issues Program Memorandum A-98-37, Change Request 711 dated November 1998. The only change is the discard date; all other material remains the same.

CHANGE REQUEST #711

SUBJECT: Consolidated Billing for Skilled Nursing Facility (SNF) Patients When Receiving Outpatient/Emergency Care in a Medicare-Participating Hospital or Critical Access Hospital (CAH)

Background

Consolidated billing for SNF residents in a Part B stay and for residents in a Part A stay not yet on PPS is still delayed until further notice (PM-AB-98-35) However, this delay in no way affects any reporting requirements for therapies as stated in PM A-98-8 or subsequent therapy instructions. Consolidated billing continues to apply to all the services and supplies that a SNF resident receives while in a SNF PPS Part A stay.

Under the regulations at 42 CFR §483.20, the beneficiary's status as a SNF resident ends when the beneficiary receives outpatient services from a Medicare-participating hospital or CAH (but only with respect to those services that are not furnished pursuant to the SNF's required resident assessment or comprehensive care plan). The purpose of citing the SNF care plan in the context of an outpatient hospital visit is to clarify that the SNF retains the overall billing responsibility for essentially the entire package of care furnished during the outpatient visit, other than certain specifically excluded services. In the outpatient hospital context, this exclusion applies to a small number of exceptionally intensive services that lie well beyond the scope of the care that SNFs would ordinarily furnish (and, thus, beyond the scope of the care plan itself), as well as emergency services (which, by their nature, cannot be anticipated and planned for in advance). Under the regulations at 42 CFR §424.101, outpatient hospital emergency services are defined as services that are necessary to prevent death or serious impairment of health and, because of the danger to life or health, require use of the most accessible hospital available and equipped to furnish those services.

Further, this exclusion is not invoked merely because a particular outpatient hospital service does not appear in the individual SNF care plan of the person receiving the service; rather, the exclusion applies only to those specified categories of service that, by definition, lie well beyond the scope of SNF care plans generally. Currently, only the following categories of services (including the five services that are specifically cited as examples in the preamble to the interim final rule (63 FR 26298-99)) are excluded. These five services are cardiac catheterization, computerized axial tomography (CT) scans, magnetic resonance imaging (MRIs), ambulatory surgery involving the use of an operating room, and emergency services. In addition, based upon consultation with providers, we have added a new category of excluded services; radiation therapy. Like the above categories, these are relatively costly services which are beyond the scope of care in SNFs. Even though it may be medically appropriate for a beneficiary to be cared for in a SNF while receiving radiation therapy, we do not believe that the SNF should be responsible for paying for radiation therapy that a beneficiary receives. Similarly, we have added angiography codes and codes for lymphatic and venous procedures to the list of services that are beyond the scope of services delivered by SNFs.

Claims Processing

This PM gives additional information as to the billing requirements for an outpatient department of a hospital in situations where a Part A SNF PPS beneficiary receives outpatient services or emergency room care from a Medicare participating hospital or CAH while temporarily absent from the SNF. The outpatient department/emergency room of a hospital independently bills you on Form HCFA-1450 for these excluded services and will be reimbursed accordingly outside the SNF PPS rate. In addition, instruct your hospitals that they may also bill only for those services and supplies that are directly related and required to complete the procedure or treat the emergency condition for which the beneficiary came to the hospital, e.g., anesthesia when used during ambulatory surgery involving the use of an operating room. All other services and supplies must be bundled back to the SNF and the hospital must look to the SNF for payment.

Bill Type

Instruct your hospitals to report the appropriate bill type (13X - Hospital Outpatient) or (83X - Hospital ASC surgery) in FL 4 on Form HCFA-1450.

Revenue Codes

Hospitals are to report the applicable revenue codes in FL 42. Revenue code 45X is coded in FL 42 to designate emergency room.

Hospital Outpatient Department HCPCS Codes

Hospitals are to report the appropriate HCFA Common Procedure Coding System (HCPCS) code from the list below in FL 44, "HCPCS/Rates." (See § 3627 of the Medicare Intermediary Manual, Part 3, for an explanation of the HCPCS coding system, and §§ 3627.1 and 3627.5 for instructions for informing/educating your providers regarding HCPCS reporting.) This requirement enables you to identify individual items and services more readily on the claim and to limit the amount you pay the hospital to any applicable payment limits.

The applicable HCPCS codes that a Medicare-participating hospital or CAH can report for outpatient CT scans are:

70450	70487	71270	72131	73201	74170	76380
70460	70488	72125	72132	73202	XXXX	G0131
70470	70490	72126	72133	73700	76355	G0132
70480	70491	72127	72192	73701	76360	
70481	70492	72128	72193	73702	76365	
70482	71250	72129	72194	74150	76370	
70486	71260	72130	73200	74160	76375	

The applicable HCPCS codes that a Medicare-participating hospital or CAH can report for outpatient cardiac catheterization are:

93501	93510	93526	93530	93536	93542	93555
93503	93511	93527	93531	93539	93543	93556

93501	93510	93526	93530	93536	93542	93555
93505	93514	93528	93532	93540	93544	93561
93508	93524	93529	93533	93541	93545	93562

NOTE: Add HCPCS code 93571 and HCPCS code 93572 to the above list effective 1/1/99

The applicable HCPCS codes that a Medicare-participating hospital or CAH can report for outpatient MRI are:

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

The applicable HCPCS codes that a Medicare-participating hospital or CAH can report for outpatient radiation therapy are:

77261	77310	77336	77409	77430	77750	77784
77262	77315	77370	77411	77431	77761	77789
77263	77321	77399	77412	77432	77762	77790
77280	77326	77401	77413	77470	77763	77799
77285	77327	77402	77414	77499	77776	
77290	77328	77403	77416	77600	77777	
77295	77331	77404	77417	77605	77778	
77299	77332	77406	77419	77610	77781	
77300	77333	77407	77420	77615	77782	
77305	77334	77408	77425	77620	77783	

The applicable HCPCS codes that a Medicare-participating hospital or CAH can report for outpatient angiography are:

75600	75705	75744	75833	75898	75992
75605	75710	75790	75840	75900	75993
75625	75716	75801	75842	75940	75994
75630	75722	75803	75860	75960	75995
75650	75724	75805	75870	75961	75996
75658	75726	75807	75872	75962	
75660	75731	75809	75880	75964	

75600	75705	75744	75833	75898	75992
75662	75733	75810	75885	75966	
75665	75736	75820	75887	75968	
75671	75741	75822	75889	75970	
75676	75743	75825	75891	75978	
75680	75746	75827	75893	75980	
75685	75756	75831	75894	75982	

The applicable HCPCS codes that a Medicare-participating hospital or CAH can report for outpatient surgery are all the codes from 11040 - 69979 with some exceptions. Codes that are within the list of exceptions may not be billed by the hospital as they fall within the range of minor procedures that the SNF may provide. These exceptions are:

10040	15780	29058	29700	51772	63691
10060	15781	29065	29705	51784	64550
10080	15782	29075	29710	51785	65205
10120	15783	29085	29715	51792	69000
11040	15786	29105	29720	51795	69090
11041	15787	29125	29730	51797	69200
11042	15788	29126	29740	53601	69210
11055	15789	29130	29750	53660	
11056	15792	29131	29799	53661	
11057	15793	29200	30300	53670	
11200	15810	29220	30901	53675	
11201	15811	29240	31720	54150	
11300	16000	29260	31725	54235	
11305	16020	29280	31730	54240	
11400	17000	29345	36000	54250	
11719	17003	29355	36140	55870	
11720	17004	29358	36400	57160	
11721	17110	29365	36405	57170	
11900	17111	29405	36406	58300	
11901	17250	29425	36415	58301	
11920	17340	29435	36430	58321	
11921	17360	29440	36468	58323	
11922	17380	29445	36469	59020	
11950	17999	29450	36470	59025	

11951	20000	29505	36471	59425
11952	20974	29515	36489	59426
11954	21084	29540	36600	59430
11975	21085	29550	36620	62367
11976	21497	29580	36680	62368
11977	26010	29590	44500	63690

NOTE: Add HCPCS code 11740 to the above list. Add HCPCS code 11043 and HCPCS code11044 to the above list only when performed by a PT or OT.

These instructions should be implemented within your current operating budget.

This Program Memorandum may be discarded after January 1, 2001.

Questions concerning this Program Memorandum should be directed to your regional office.