Medicare
Carriers Manual
Part 3 - Claims Process

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

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REFER TO CHANGE REQUESTS 1764, 1955. 2082. 2391. 2360. 2453. and 2475

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents - Chapter IV	4-4.1 – 4-4.6 (6 pp.)	4-4.1 – 4-4.6 (6 pp.)
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CLARIFICATION/MANUALIZATION--*EFFECTIVE DATE: Not Applicable*
IMPLEMENTATION DATE: Not Applicable

Section 4210, Skilled Nursing Facility (SNF) Consolidated Billing, is a new section that manualizes several Program Memorandums (PMs) listed below with no substantive changes.

Section 4210.1, Determining the End of a SNF Stay, is a new section that manualizes PM Transmittal AB-01-159, Change Request (CR) 1764; PM Transmittal AB-02-021, CR 1955; PM Transmittal AB-02-037, CR 2082; PM Transmittal B-02-059, CR 2391; and PM Transmittal B-02-067, CR 2360.

Section 4210.2, Types of Facilities Included in and Excluded From Consolidated Billing, is a new that section that manualizes PM Transmittal AB-01-159, Change Request (CR) 1764; PM Transmittal AB-02-021, CR 1955; PM Transmittal AB-02-037, CR 2082; PM Transmittal B-02-059, CR 2391; and PM Transmittal B-02-067, CR 2360.

Section 4210.3, Types of Services Included in and Excluded From Consolidated Billing, is a new section that manualizes PM Transmittal AB-01-159, Change Request (CR) 1764; PM Transmittal AB-02-021, CR 1955; PM Transmittal AB-02-037, CR 2082; PM Transmittal B-02-059, CR 2391; and PM Transmittal B-02-067, CR 2360.

Section 4210.4, Risk-Based Health Maintenance Organization (HMO) Beneficiaries, is a new section that manualizes PM Transmittal AB-01-159, Change Request (CR) 1764; PM Transmittal AB-02-021, CR 1955; PM Transmittal AB-02-037, CR 2082; PM Transmittal B-02-059, CR 2391; and PM Transmittal B-02-067, CR 2360.

Section 4210.5, Clarification of Ambulance Services, is a new section that manualizes PM Transmittal AB-01-159, Change Request (CR) 1764; PM Transmittal AB-02-021, CR 1955; PM Transmittal AB-02-037, CR 2082; PM Transmittal B-02-059, CR 2391; and PM Transmittal B-02-067, CR 2360.

Section 4210.6, Information on SNF Contracting With Outside Entities for Services, is a new section that manualizes PM Transmittal AB-01-159, CR 1764; PM Transmittal AB-02-021, CR 1955; PM Transmittal AB-02-037, CR 2082; PM Transmittal B-02-059, CR 2391; and PM Transmittal B-02-067, CR 2360.

Section 4210.7, Carrier Claims Processing, is a new section that manualizes PM Transmittal AB-01-159, Change Request (CR) 1764; PM Transmittal AB-02-021, CR 1955; PM Transmittal AB-02-037, CR 2082; PM Transmittal B-02-059, CR 2391; and PM Transmittal B-02-067, CR 2360.

Section 4210.8, Special Requirements for Claims for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies, is a new section that manualizes PM Transmittal B-02-087, Change Request 2453.

Section 4210.9, Revisions to CWF Edits to Permit Payment for Certain Diagnostic Services Furnished to Beneficiaries Receiving Treatment for End Stage Renal Disease (ESRD) at an Independent or Provider-Based Dialysis Facility, is a new section that manualizes PM Transmittal AB-02-175, Change Request 2475.

NOTE: In §4210.5, Clarification of Ambulance Services, the first bullet has been revised from CR 1764 to delete the word "round" in accordance with CR 1555, Transmittal AB-01-165, Implementation of the Ambulance Fee Schedule. We now require a zip code for the origin of every single ambulance transport. A round trip must be billed as two individual transports.

These instructions should be implemented within your current operating budget.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

Medicare as Secondary Payer

Section

Submission of Claims to Medigap Insurers

Global Surgery

National Emphysema Treatment Trial

Qualifying Clinical Trials

4210. SKILLED NURSING FACILITY (SNF) CONSOLIDATED BILLING

Section 4432(b) of the Balanced Budget Act (BBA) requires consolidated billing for SNFs. Under the consolidated billing 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 during the course of a covered Part A stay, except for certain excluded services. The consolidated billing requirement essentially confers on the SNF itself the Medicare billing responsibility for the entire package of care that its Part A 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. 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.

o **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.

o **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 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.

o **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.

o **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.

o **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.

4210.1 Determining the End of a SNF Stay.--When a beneficiary leaves the SNF, their status as a SNF resident for consolidated billing purposes, along with the SNF's responsibility to furnish or make arrangements for needed services, ends when one of the following events occurs:

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

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

o The beneficiary receives emergency or other excluded outpatient hospital services; or

o 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.

4210.2 Types of Facilities Included in and Excluded From Consolidated Billing.--

Included:

o A Medicare participating SNF(including a Medicare-certified distinct part SNF).

Excluded:

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; and

o The non-participating portion of a nursing home that also contains a Medicare-certified distinct part SNF.

4210.3 Types of Services Included in and Excluded from Consolidated Billing**.**

Included:

o The consolidated billing requirement confers on the SNF the billing responsibility for the entire package of care that residents receive during a covered Part A stay **and** physical, occupational, and speech therapy services received during a noncovered stay. Payment for these services is included in the payment to the SNF from the fiscal intermediary. Providers and suppliers must look to the SNF for payment of these services.

Exception: a limited number of specifically excluded services.

Excluded:

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. Effective July 1, 1998, per the BBA and by the implementing regulations; the **exclusions** from consolidated billing are:

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

o Audiologic function tests are not considered part of the therapy services that must be consolidated. However, as with other diagnostic tests, the technical component is included in consolidated billing when provided to beneficiaries in a Part A stay.

o Certain services are excluded from consolidated billing only when furnished on an outpatient basis by a hospital or a critical access hospital:

- Cardiac catheterization services;
- Computerized axial tomography scans;
- Magnetic resonance imaging;
- Ambulatory surgery involving the use of an operating room;
- Radiation therapy;
- Emergency services;
- Angiography;
- Lymphatic and venous procedures; and
- Ambulance services furnished in connection with 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 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 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 consolidated billing a subset of HCPCS codes in the categories shown below:

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

The Web site at www.cms.hhs.gov/medlearn/snfcode.asp provides lists of separately payable codes for use by carriers, suppliers, and providers to determine whether services are separately payable by the carrier or should be submitted to the SNF for payment.

NOTE: For 1998 only, the transportation costs of electrocardiogram equipment (HCPCS code R0076) were payable but only with respect to electrocardiogram test services furnished during 1998. This reflected §4559 of the BBA that temporarily restored separate Part B payment for the transportation of portable electrocardiogram equipment used in furnishing tests during 1998.

4210.4 Risk-Based Health Maintenance Organization (HMO) Beneficiaries.--Services to risk-based HMO enrollees are not included in consolidated billing. Managed care beneficiaries are identified in the Common Working File (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.

4210.5 Clarification of Ambulance Services.--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.

- o A medically necessary trip to a Medicare participating hospital or CAH for the specific purpose of receiving emergency or other excluded outpatient hospital services.
- o Medically necessary ambulance trips after a formal discharge or other departure from the SNF, **unless** the beneficiary is readmitted or returns to that or another SNF before midnight of the same day.
- o An ambulance trip to receive dialysis-related services.
- o A trip for an inpatient admission to a Medicare participating hospital or 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.

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.

4210.6 Information on SNF Contracting with Outside Entities for Services.--Except for those services and supplies specifically excluded, under consolidated billing an outside provider or supplier can no longer submit a separate bill directly to Medicare for services furnished to a SNF resident during a covered stay. Instead, it must look to the SNF for its payment. This means that in making Part A payment for services furnished to such 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 parties. However, services provided under consolidated billing arrangements must be provided by Medicare certified providers that are licensed to provide the service involved. In addition, 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.

4210.7 Carrier Claims Processing.--

A. CWF Reject Edits.--When CWF receives a bill from the SNF that shows that a beneficiary became a resident of a SNF, that SNF stay is posted to history. Effective April 2002, for claims processed and adjusted with dates of service on or after April 1, 2001, CWF will apply the reject edits to any claims received after the SNF stay is posted that have dates of service during the periods the beneficiary is shown to have been a resident of the SNF based on that first SNF bill. These claims can be correctly rejected since it will be clear that the beneficiary was in the SNF during those spans that were shown on the SNF claim. This process will repeat when the next SNF bill is received. The process will continue until CWF posts a discharge date, date of death, or the covered number of SNF days has been used.

Based on the CWF line item rejects, carriers must deny assigned and unassigned services they have been billed that should have been consolidated and paid by the SNF and/or billed to the FI. Appeals rights must be offered on all denials. Standard systems must develop, and along with carriers must implement, an automated resolution process whereby when they receive a reject from CWF, they must pay those services correctly billed and only deny those services on the claim incorrectly billed to them.

B. CWF Unsolicited Response Edits.--Effective July 1, 2002, CWF implemented the unsolicited response edit based on the same coding files made available for the reject edits. Upon receipt of a Part A SNF claim at CWF, CWF searches paid claims history and compares the period between the SNF from and through dates to the line item service dates of the claims in history. It then identifies any services within the dates of the SNF stay that should have been subject to consolidated billing and should not have been separately paid by the carrier.

The CWF generates an unsolicited response, with a trailer that contains the identifying information regarding the claim subject to consolidated billing and a new trailer containing line item specific information that identifies all the individual services on that claim that fall within the SNF period. The unsolicited response provides all necessary information to identify the claim, including Document Control Number, Health Insurance Claim number, beneficiary name, date of birth, and beneficiary sex. CWF electronically transmits this unsolicited response to the carrier that originally processed the claim with consolidated services. These unsolicited responses are included in the CWF response file. The unsolicited responses in that file for claims to be adjusted for consolidated billing are identified with a unique transaction identifier. The previously paid claim is not canceled and remains on CWF paid claims history, pending subsequent adjustment.

Upon receipt of the unsolicited response, the carrier standard system software reads the line item information in the new trailer for each claim and performs an automated adjustment to each claim. (See §4210.9C for Durable Medical Equipment Regional Carrier action.) Services subject to consolidated billing must be denied at the line level. The adjusted claims must then be returned to CWF, so that the claim on CWF paid claims history is replaced with the adjusted record. Carriers and DMERCs must return the claims with entry code 5. Both the covered and the non-covered services must be returned to CWF on the adjustment claim.

When CWF adjusts the claim on history, the deductible is updated on the beneficiary's file and the corrected deductible information is returned to the carrier in trailer 11. To recover any monies due back to Medicare resulting from these denials, carriers must follow the criteria in the overpayment recovery instructions in §§7100-7104 and §§7116-7130 for the policy guidelines for furnishing demand letters and granting appeals rights.

In cases where all services on the claim are identified in CWF as subject to consolidated billing, the claim is adjusted by the carrier standard system to line item deny all the services on the claim. These fully non-covered claims must be returned to CWF, in order to reflect the denial actions in CWF paid claims history and to update the information in CMS's national claims history file. Carrier and DMERC systems must employ existing processes for the submission of fully non-covered claims.

C. CWF Override Codes.--A CWF override code has been developed for carrier use where, in the course of pursuing a reconsideration, a provider or supplier may bring to the attention of the carrier a situation where services on a claim have been denied, but should actually be allowed to be paid through the carrier. At the carrier's discretion, to allow that claim to process through CWF to payment, enter a "2" in the SNF consolidated billing override field.

D. Coding Files and Updates.--To correspond with the annual and quarterly coding and payment updates, CWF will be provided with files of codes that are not included in consolidated billing and can be paid through the carrier or DMERC. These codes are available to the carriers, providers, and suppliers for informational purposes on the CMS Website at www.cms.hhs.gov/medlearn/snfcode.asp. Changes in designation of codes from excluded to included (or vice versa) in consolidated billing will be considered corrections to align the codes with policy as opposed to changes in policy. Newly established Healthcare Common Procedure Coding System codes will be added to CWF edits to allow carriers to make appropriate payments.

E. Annual Update Process.--

- Barring any delay in the Medicare Physician Fee Schedule, CMS will provide the new code files to CWF by November 1. Should this date change, CWF will be notified through the appropriate mechanism.

- The CWF contractor must compare the new code list for category 75 to the codes in the current edit. Codes that appear on the new list, but not in the current edit, must be added to the edit.

- The CWF contractor must compare the new code list for codes that require the 26 modifier to the codes in the current edit. Codes that appear on the new list, but not in the current edit, must be added to the edit.

- The CWF contractor must compare the new code list for ambulance codes to the codes in the current edit. Codes that appear on the new list, but not in the current edit, must be added to the edit.

- The CWF contractor must compare the new code list for the Part B therapy codes to the codes in the current edit. Codes that appear on the new list, but not in the current edit, must be added to the edit.

- After it has compared all codes on the new edit list to those in the current edits, the CWF contractor must provide CMS with a list of codes by edit that were formerly on the edits, but do not appear on the new code lists.

- CMS will make a determination as to which codes should be deleted from which edits. This mechanism will allow for any changes in professional component/technical component designations to be correctly coded for edits and for deleted codes and codes no longer valid for Medicare purposes as of the end of the calendar year, to continue to pay correctly for prior dates of service.

- CMS will respond to the list provided by the CWF contractor and provide the determination on the codes to the CWF contractor.

- The CWF contractor will delete codes from the edits per the CMS determination.

- Carriers must continue to respond to rejects and unsolicited responses received from CWF per current methodology.

- Carriers must reopen and reprocess any claims brought to their attention for services that prior to this update were mistakenly considered to be subject to consolidated billing and therefore, not separately payable. Carriers need not search claims history to identify these claims.

- Prior to January 1 of each year, new codes files will be posted to the CMS Web site at www.cms.hhs.gov/medlearn/snfcode.asp. Should this date change, carriers will be notified through the appropriate mechanism.

- Coding changes throughout the year may also be made as necessary through a quarterly update process.

- As soon as the new code files are posted to the CMS website, through their Web sites and list serves, carriers must notify physician, non-physician practitioners, and suppliers of the availability of the files.

F. Medicare Coordinated Care Demonstration.--Services for beneficiaries covered under the Medicare Coordinated Care Demonstration will not be subject to consolidated billing. CWF will appropriately edit for these codes so that the carriers will pay them separately.

G. Correct Place of Service (POS) Code for SNF Claims--Per §15036 of the Medicare Carriers Manual, Place of Service (POS) code 31 should be used with services for patients in a Part A covered stay and POS code 32 should be used with services for beneficiaries in a noncovered stay. Carriers should adjust their prepayment procedure edits as appropriate.

H. Ambulance Claims.--When a medically necessary transport from one SNF to another SNF occurs when the beneficiary is discharged from the first SNF and admitted to the second, this transport is included in consolidated billing. The first SNF is responsible for the ambulance service and the cost is included in the Part A rate. It is not separately billable. CWF will reject these services to the carrier. The carrier must deny the service with appeals rights.

I. Messages to be used with Denials for Rejects and Unsolicited Responses.--The following messages should be used when the carrier receives a reject code from CWF indicating that the services are subject to consolidated billing and must be submitted to the SNF for payment.

Remittance Advice

At the service level, report adjustment reason code 109 – Claim not covered by this payer/contractor. You must send the claims to the correct payer/contractor.

At the service level, report remark code N73 - A SNF is responsible for payment of outside providers who furnish these services/supplies to its residents. Only the professional component of physician services can be paid separately.

NOTE: Effective April 1, 2003, remark code N73 will be revised to - A SNF is responsible for payment of outside providers who furnish these services/supplies under arrangement to its residents.

If appropriate, use remark code MA78 – The patient overpaid you. You must issue the patient a refund within 30 days for the difference between our allowed amount total and the amount paid by the patient.

Medicare Summary Notice (MSN)/Explanation of Medicare Benefits (EOMB)

MSN code 13.9 - Medicare Part B does not pay for this item or service since our record show that you were in a SNF on this date. Your provider must bill this service to the SNF.

NOTE: Effective April 1, 2003, MSN 13.9 will be revised to - Medicare Part B does not pay for this item or service since our records show that you were in a skilled nursing facility on this date. The revised Spanish version will be: La Parte B de Medicare no paga por este artículo o servicio porque nuestros expedientes indican que usted estuvo en una institución de enfermería especializada en esta fecha.

Also, if appropriate, use MSN 34.8 – The amount you paid the provider for this claim was more than the required payment. You should be receiving a refund of $.XX from your provider, which is the difference between what you paid and what you should have paid.

Or, use MSN 34.3 – After applying Medicare guidelines and the amount you paid to the provider at the time the services were rendered, our records indicate you are entitled to a refund. Please contact your provider. (NOTE: Use this message only when your system cannot plug the dollar amount in MSN 34.8.)

J. CWF Utilization Edits.--Effective April 1, 2002, CWF implemented the following utilization edits for carrier submitted claims. Carriers implemented automated processes for the resolution of these edits based on the codes returned in the trailers from CWF.

Edits 7258 and 7259 - Carrier Part B Physical Therapy Claim Against an Inpatient SNF 21x and Inpatient Part B 22x Claim

Reject if a carrier Part B claim is received containing physical therapy (type of service of W), occupational therapy, or speech therapy and From/Thru Dates overlap or are within the From/Thru Dates on an SNF inpatient claim (21x) or an inpatient Part B claim (22x).

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 or 22x type of bill contains a cancel date.
- The incoming claim from date equals the SNF 21x or 22x history claim discharge date or incoming through date equals the SNF 21x or 22x history claim admission date.

Edits 7260 and 7261 - 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.
- 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.
- The Part B claim contains ambulance codes per the files supplied to CWF in the annual and quarterly updates with modifiers other than N (SNF) in both the origin and destination on the same claim.
- The Part B claim is a CANCEL ONLY (Action Code 4) claim.
- The Part B claim is denied.
- The Part B service has a Payment Process Indicator other than A (allowed).
- The Part B claim contains only separately payable services per the files supplied to CWF in the annual and quarterly updates.

K. CWF Duplicate Edits.--Effective April 1, 2002, CWF implemented the following duplicate edits for carrier submitted claims.

Edit 7253 - 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 codes per the files supplied to CWF in the annual and quarterly updates and the Date of Service equals the Date of Service on an outpatient Part B SNF (23x) claim with revenue code 54x (ambulance).

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).

Edit 7257 - 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 Part B claim contains only separately payable services per the files supplied to CWF in the annual and quarterly updates.

L. CWF Edit for Clinical Social Workers (CSWs).--Per the Balanced Budget Act, services provided by CSWs to beneficiaries in a Part A SNF stay may not be billed separately to the carrier. Payment for these services is included in the prospective payment rate paid to the SNF by the fiscal intermediary. Though the policy was in effect since April 1, 2001, there were no corresponding edits. With the April 2003 release, CWF implemented a new SNF consolidated billing edit to prevent payment to CSWs for services rendered to beneficiaries in a Part A SNF stay.

Effective April 1, 2003, CWF established the new edit 7269 for services rendered to these beneficiaries with dates of service on or after April 1, 2001, for claims received on or after April 1, 2003. Once CWF determines that a beneficiary is in a Part A stay, prior to applying the edits that review procedure codes to determine if payment should be allowed, CWF will review the performing provider type of the submitting entity. If the performing provider type is 80, CWF will reject the claim to the carrier or return an unsolicited response with new error code 7269. The carrier will then take the same adjustment and recovery action as for other rejects and unsolicited responses.

When carriers receive the new reject code, they must deny the claim and use the following RA and MSN messages.

RA

Report claim adjustment reason code 96 – Non-covered charges; and

Remark code N121 - Medicare Part B does not pay for items or services provided by this type of practitioner for beneficiaries in a Medicare Part A covered skilled nursing facility stay.

MSN

13.10 – Medicare Part B does not pay for items or services provided by this type of practitioner since our records show that you were receiving Medicare Part A benefits in a skilled nursing facility on this date. The Spanish version is: La Parte B de Medicare no paga por artículos o servicios provistos por este tipo de médico ya que nuestros expedientes indican que usted estaba recibiendo beneficios de la Parte A de Medicare en una institución de enfermería especializada en esta fecha.

4210.8 Special Requirements for Claims for Durable Medical Equipment, Prosthetics, Orthotics and Supplies.--

A. Background.--Medicare pays for DMEPOS when it is medically necessary for use in a patient's home. A DME supplier providing the DMEPOS submits a claim for payment to the durable medical equipment regional carrier (DMERC), which processes the claim.

For capped rental items of durable medical equipment (DME) where the DME supplier submits a monthly bill, the date of delivery ("from" date) on the first claim must be the "from" or anniversary date on all subsequent claims for the item. For example, if the first claim for a wheelchair is dated September 15, all subsequent bills must be dated for the 15th of the following months (October 15, November 15, etc.).

The DMEPOS benefit is only meant for items a beneficiary is using in his or her home. For a beneficiary in a Part A stay, a SNF is not defined as a beneficiary's home for DMEPOS (except for Method II home dialysis equipment and supplies and certain customized prosthetics and orthotics), and so Medicare does not make separate payment for DMEPOS when a beneficiary is in a SNF. The SNF is expected to provide all medically necessary DMEPOS during a beneficiary's covered Part A stay. However, in accordance with DMEPOS payment policy, Medicare will make a separate payment for a full month for DMEPOS items, provided the beneficiary was in the home on the "from" date or anniversary date defined above.

If a beneficiary using DMEPOS is at home on the "from" date or anniversary date, Medicare will make payment for the DMEPOS for the entire month, even if the "from" date is the date of discharge from the SNF. If a beneficiary using DMEPOS is in a covered Part A stay in a SNF for a full month, Medicare will not make payment for the DMEPOS for that month.

For capped rental items, if the covered Part A SNF stay overlaps the anniversary date ("from" date on the claim) of the Certificate of Medical Necessity (CMN), and the beneficiary is not in the covered Part A SNF stay for the entire month, the date of discharge becomes the new anniversary date ("from" date on the claim) for subsequent claims. In this situation, the supplier must submit a new claim with the date of discharge as the new anniversary date upon the beneficiary's release from the SNF. Suppliers should annotate the HAO record (field 19 for paper claims) to indicate that the patient was in a SNF, resulting in the need to establish a new anniversary date.

NOTE: The CWF must allow payment for maintenance and servicing of capped rental items, regardless of whether the patient is in a covered Part A stay in the SNF on the date of service of the maintenance and servicing claim.

The CWF must allow payment for DMEPOS items on the date of discharge. CWF must edit based on the "from" date only.

B. Examples.--

Example 1:

A beneficiary rents a wheelchair beginning on January 1. The DMERC determines that the wheelchair is medically necessary and that the beneficiary meets all coverage criteria, and so begins to make payment on the wheelchair. The beneficiary enters a covered Part A stay in a SNF on February 15 and is discharged on April 5.

In this example, Medicare will make payment for the entire month of February, because the patient was in the home for part of the month. However, the DMERC will deny the claim for March, because the patient was in a covered Part A stay in the SNF for the entire month.

Because the anniversary date ("from" date) of the monthly bill was April 1, and the patient was still in the covered Part A stay in a SNF on that date, the DME supplier must not submit another claim until April 5 (the date of discharge). April 5 becomes the new anniversary date ("from" date) for billing purposes, so the supplier would now bill on the 5th of the month rather than the 1st of the month for the remainder of the capped rental period. The supplier should annotate the HAO record (field 19 for paper claims) to indicate that the patient was in a SNF on the first claim with the new anniversary date.

Example 2:

A beneficiary receives oxygen on January 1. On February 28, the patient enters a covered Part A stay in a SNF and is discharged on March 15.

In this example, the DMERC would deny a claim dated March 1. The supplier would submit a new claim dated March 15, which would then become the anniversary date for billing purposes. The supplier should annotate the HAO record (field 19 for paper claims) to indicate that the patient was in a covered Part A stay in a SNF on the first claim with the new anniversary date.

Example 3:

A beneficiary rents a hospital bed beginning on January 1. On March 15, the patient enters a covered Part A stay in a SNF and is discharged on March 25.

In this example, the DMERC will make payment for the entire month of March.

NOTE: The changes in the general policy in this PM apply to all items of DMEPOS paid by the DMERCs. However, changes in "anniversary date" billing requirement only apply to capped rental DME.

C. Activation of the Automated Unsolicited Response.--You are to install an automated unsolicited response for SNF CB, but not to implement the response until CMS instructs you to do so. All carriers, except for the DMERCs, have subsequently been instructed to implement the automated process. The DMERCs must not activate the automated processing of the unsolicited response until further notification is received.

D. DMERC Claims Processing Instructions Effective for Claims Received On or After April 1, 2003.--

o CWF must reject claims for DMEPOS codes when a beneficiary is in a covered Part A stay in SNF on the "from" date of a DMEPOS claim, provided the "from" date is not the date of discharge.

o CWF must not reject claims for DMEPOS HCPCS codes based on the "thru" date, unless the claims meets the following exception: when a patient is in a covered Part A stay in a SNF for the entire month (i.e., both the "from" and "thru" dates on the claim), CWF must reject the claim.

o If the "from" date on the DME claim is the same as the discharge date of the covered Part A SNF stay, CWF must not reject the claim.

o CWF must not send unsolicited responses to the DMERCs when a beneficiary is in a covered Part A stay in a SNF for part of the rental month, but is not in the SNF on the "from" date of the claim.

o In situations where the "from" date of a DME claim falls within a covered Part A SNF stay, but the beneficiary returns home within the same month, the supplier may submit a new claim on the date of discharge from the SNF, and the date of discharge will become the "from" date (anniversary date) for all subsequent claims.

o CWF must allow payment for maintenance and servicing of capped rental items, regardless of whether the patient is in the SNF for a covered Part A stay on the date of service of the maintenance and servicing claim. The "MS" modifier identifies line items for maintenance and servicing.

4210.9 Revisions to CWF Edits to Permit Payment for Certain Diagnostic Services Furnished to Beneficiaries Receiving Treatment for End Stage Renal Disease (ESRD) at an Independent or Provider-Based Dialysis Facility.--

A. Background.-- The SNF CB provision requires a SNF to include on its Part A bill almost all of the services that its residents receive during the course of a Part A covered stay. However, there are several categories of services that the law (§1888(e)(2)(A)(ii) of the Social Security Act) specifically excludes from this provision, and these excluded services remain separately billable under Part B by the outside supplier that furnishes them. One of the excluded categories encompasses those items and services that fall within the scope of the Part B benefit that covers chronic dialysis for beneficiaries with ESRD (§1861(s)(2)(F) of the Act). In addition to covering the ESRD-related dialysis services themselves, the Part B benefit also covers any associated diagnostic tests (see regulations at 42 CFR 410.50(b) - (c) and 410.52(a)(3)).

The SNF CB applies to diagnostic tests that are not ESRD-related. As such, SNF CB applies to diagnostic tests for beneficiaries that do not have ESRD. This would include tests related to "acute dialysis" (that is, dialysis for a beneficiary who is not an ESRD beneficiary), because non-ESRD dialysis services and associated diagnostic tests do not fall within the scope of the Part B dialysis benefit. In addition, SNF CB applies to a diagnostic test for an ESRD beneficiary if the test is unrelated to the beneficiary's ESRD.

The SNF CB does not apply to diagnostic tests that are ESRD dialysis-related. "ESRD-related" means that: (1) the beneficiary must be an ESRD beneficiary; (2) the test must have been ordered by an ESRD facility; and (3) the test must relate directly to the dialysis treatment of the beneficiary's ESRD. In terms of SNF consolidated billing, such tests are considered dialysis services (which are excluded from SNF consolidated billing), rather than diagnostic tests which are subject to SNF consolidated billing.

A supplier or provider may bill the carrier or intermediary, respectively, for an ESRD dialysis-related diagnostic test, provided the test is outside the ESRD-facility composite rate, notwithstanding that the beneficiary is a SNF Part A resident.

A supplier or provider may not bill Medicare separately for a diagnostic test for a SNF Part A resident if the test is either: (1) within the ESRD facility composite rate or (2) not an ESRD dialysis-related diagnostic test.

Effective April 1, 2003, for dates of service on or after April 1, 2001, CWF will not apply the SNF CB edits to line items for diagnostic services where a modifier is placed on the line item to indicate that this service was rendered to an ESRD beneficiary in a SNF Part A stay who is receiving chronic dialysis related services at an Independent or Provider-Based Dialysis Facility. CWF will not return denials for these line items.

B. Claims Processing Instructions.--Beginning April 1, 2003, for dates of service on or after April 1, 2001, CWF will bypass the SNF CB edits for diagnostic services where the modifier "CB" is present for the line item. You must accept the new CB modifier for dates of service on or after April 1, 2001.

The modifier CB - *services ordered by a dialysis facility physician as part of the ESRD beneficiary's dialysis benefit, is not part of the composite rate, and is separately reimbursable,*" is effective April 1, 2003, for dates of service on or after April 1, 2001. Providers and suppliers are not required to report the modifier for every service rendered to an ESRD beneficiary. However, the provider or supplier must be aware that SNF CB editing will be applied if the line item does not contain the modifier. Indeed, the provider or supplier may use the modifier only when it has determined that: (a) the beneficiary has ESRD entitlement, (b) the test is related to the dialysis treatment for ESRD, (c) the test is ordered by a dialysis facility, (d) the test is not included in the dialysis facility's composite rate payment, and (e) the beneficiary is in a Part A stay. A provider or supplier must secure this information from the dialysis facility and use the modifier for only those line items for which all these factors are present.