Medicare
Skilled Nursing Facility Manual

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

Transmittal 376 **Date: MAY 2, 2003**

Refer to CHANGE REQUEST 2589

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
561 - 562	5-87.42 - 5-87.43 (2 pp.)	5-87.42 - 5-87.43 (2 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE:* October 1, 2003
IMPLEMENTATION DATE: October 1, 2003

Section 561, Frequency of Billing, has been amended to include more information specific to the frequency of bill acceptance and will assist providers in billing other insurers more timely. Common Working File (CWF) edits regarding outpatient services and inpatient hospital and Skilled Nursing Facility (SNF) stays are being modified.

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.

These instructions should be implemented within your current operating budget.

561. FREQUENCY OF BILLING

Your intermediary will inform you about the frequency with which it can accept billing records and the frequency with which you may bill on individual cases.

In its requirements, your intermediary considers your systems operation, intermediary systems requirements, and Medicare program and administrative requirements.

Inpatient Billing.--Inpatient services in TEFRA hospitals (i.e., psychiatric hospitals or units, cancer and children's hospitals) and SNFs will be billed:

- o Upon discharge of the beneficiary;
- o When the beneficiary' benefits are exhausted;
- o When the beneficiary's need for care changes; or
- o After 30 days and every 30 days thereafter.

Your intermediary will inform you of the frequency of billing that is acceptable. Each bill must include all diagnoses and procedures applicable to the admission. However, do not include charges that were billed on an earlier bill since the "From" date on the bill must be the day after the "Through" date on the earlier bill. Even if you receive PIP, you may submit interim bills.

These instructions apply to all providers, including those receiving Periodic Interim Payments (PIP). Continue submitting no pay bills until discharge

Outpatient Billing.--Bill repetitive Part B services to a single individual monthly (or at the conclusion of treatment). This avoids Medicare processing costs in holding such bills for monthly review and reduces bill processing costs for relatively small claims. Examples of repetitive Part B services and HHA and hospice services billed under Part A with applicable revenue codes include:

Service	Revenue Code
Therapeutic Radiology	0330 - 0339
Therapeutic Nuclear Medicine	0342
Respiratory Therapy	0410 - 0419
Physical Therapy	0420 - 0429
Occupational Therapy	0430 - 0439
Speech Pathology	0440 - 0449
Cardiac Rehabilitation Services	0943
Psychological Services	091x

Where there is an inpatient stay or outpatient surgery during a period of repetitive outpatient services, you may submit one bill for the entire month if you use an occurrence span code 74 to encompass the inpatient stay or day of outpatient surgery. The Common Working File (CWF) must read occurrences span code 74 and recognize that a beneficiary who is an inpatient or who receives hospital outpatient services subject to OPPS or ambulatory surgery, is on leave of absence from the repetitive outpatient services. This permits you to submit a single bill for the month, and simplifies the review of these bills. This is in addition to the bill for the inpatient stay.

Bill other one-time Part B services upon completion of the service.

562. GUIDELINES FOR SUBMITTING CORRECTED BILLS

A. General.--When an initial bill has been submitted and you or the intermediary discover an error on the bill, submit an adjustment bill if the change involves one of the following:

- o A change in the inpatient cash or Part B deductible of more than $1;
- o A change in the number of inpatient days;
- o A change in the blood deductible;
- o A change in provider number;
- o A change in coinsurance which involves an amount greater than $1.99;
- o A change in the HIPPS code to correct a data input error or;
- o Effective for changes for services June 1, 2000, change in HIPPS code due to an MDS correction. (Such adjustments are required within 120 days of the through date on the initial bill.)

Where there are money adjustments other than a coinsurance amount greater than $1.99, record the difference on a record sufficiently documented to establish an accounting data trail broken out by patient name and HICN, admission, from and thru dates, difference in charge broken out by the ancillary services for the difference, and any unique numbering or filing code necessary for you to associate the adjustment charge with the original billing.

B. Billing Late Charges.--Late charge billing (type of bill xx5) is not acceptable for SNF Part A services. Late charge (xx5 type of bill) is acceptable to report additional unbilled services for SNF inpatient B residents and SNF outpatients. Should a pattern of an excessive volume of late charge bills be determined through audit, you may be required to adjust your billing schedule and procedures by the intermediary. If you fail to include a particular item or service on its initial bill, an adjustment request to include such an item or service is not permitted after the expiration of the time limitation for filing a bill. Late charge(s) bills are subject to the same requirements for timely filing as original bills. However, to the extent that an adjustment request otherwise corrects or supplements information previously submitted on a timely bill about specified services or items furnished to a specified individual, it is subject to the rules governing administrative finality, rather than the time limitation for filing.

C. Procedures.--Follow the procedures for bill completion in §560. Complete all items as applicable for the initial bill except:

FL 37 - Internal Control Number (ICN)/Document Control Number (DCN) of the claim to be adjusted is required for adjustments and late charges. This is in Record Type 31, Positions 155 - 177 of the UB-92 flat file format, version 6. The intermediary reports this to you on the remittance record.

For late charge bills use type of bill 225 or 235, as appropriate, and in FL 42 - 48, report only the services not reported on first bill (revenue code, HCPCS code, units, dates of service). For adjustment requests use type of bill 217, 227, or 237, as appropriate, and in FL 42 - 48, report all services applicable including those correctly reported on the first bill. See instructions for FLs 24 - 30 (Condition Codes) for reporting the reason for the adjustment (Claim Change Reasons). This is reported in RT 41 of the UB-92 flat file version 6. Claim Change Reason Codes applicable to SNFs are: