Program Memorandum
Intermediaries/Carriers

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

Transmittal AB-03-041 **Date: APRIL 4, 2003**

CHANGE REQUEST 1764

This Program Memorandum re-issues Program Memorandum AB-01-159, Change Request 1764, dated November 1, 2001. The only change is the discard date; all other material remains the same.

SUBJECT: Common Working File (CWF) Reject and Utilization Edits and Carrier Resolution for Consolidated Billing for Skilled Nursing Facility (SNF) Residents

This Program Memorandum (PM) provides claims processing instructions for carriers. It supercedes all other carrier PMs issued for SNF consolidated billing. It is only informational for intermediaries and requires no action on their part. A separate PM will be issued for intermediaries.

A. Background.--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.

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 Section 313 of the Benefits Improvement and Protection Act (BIPA) of 2000 subsequently repealed this aspect of consolidated billing altogether, except for physical, occupational, and speech therapies.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

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

Also excluded from SNF PPS consolidated billing 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 consolidated billing that therefore had to be billed directly to the carrier or DMERC by the provider or supplier for payment. As opposed to whole categories of services being excluded, only certain specific services and drugs (identified by HCPCS code) were excluded in each category. These exclusions included ambulance services furnished in conjunction with renal dialysis services, certain specific chemotherapy drugs and their administration services, certain specific radioisotope services, and certain customized prosthetic devices.

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

Effective April 1, 2001, Transmittal B-00-67, Change Request 1256, became 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 requirement was made effective:

- 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.

B. Additional Information

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:

- 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 hospital services; or

- 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.

Types of Facilities Included in Consolidated Billing.--

- A Medicare participating SNF.

Types of Facilities Excluded from Consolidated Billing.--

- 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.

Types of Services Included in Consolidated Billing**.--**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. Exception: a limited number of specifically excluded services.

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. 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. CR 1677, Transmittal AB-01-71, dated May 1, 2001, effective April 1, 2001, clarified that audiologic function tests provided to beneficiaries during a noncovered stay are separately billable. 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.

These HCPCS codes have been published in Transmittals B-00-67 and A-01-45.

For 1998 Only - The transportation costs of electrocardiogram equipment (HCPCS code R0076) are payable but only with respect to electrocardiogram test services 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.

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.

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.

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 round 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.

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.

Carriers are responsible for assuring that payment is made only for ambulance services that meet coverage criteria.

Information for Providers and Suppliers on SNF Contracting with Outside Entities for Ancillary 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.

o Services provided under consolidated billing 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.

C. Claims Processing.--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.

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. The carrier SNF coding files (CSCF) will be made available to the carriers and providers for informational purposes on the CMS Web site at www.CMS.HHS.CSCF.gov.

As defined by the CSCF, services that carriers will continue to pay for separately for beneficiaries in a Part A covered SNF stay (i.e., services not included in consolidated billing), are listed in section B of this PM.

For beneficiaries in a Part A covered stay, all codes not found on the CSCF are subject to consolidated billing and will be rejected by CWF to the carrier to be denied. These services will include therapy services as defined below.

The only services to be consolidated for beneficiaries in a non-Part A covered stay are therapy services. For these beneficiaries, CWF will reject only the therapy codes to the carrier to deny.

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

Place of Service

Per §15036 of the Medicare Carrier 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 code to POS code edits as appropriate.

Health Care Common Procedure Coding System (HCPCS) Codes to Identify Physical, Occupational, and Speech Language Therapy Services that Are Subject to Consolidated Billing.--For consolidated billing purposes, certain therapy services provided to beneficiaries in either a Part A or non-Part A stay, whether considered to have a physician's professional component or not, will always be subject to consolidated billing. These codes will not appear as carrier payable services on the CSCF. CWF will reject these services to the carrier to deny.

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	-------
-------	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	97532	97533	97535
97537	97542	97545	97546	97601
97703	97750	97799	G0169	G0192
G0193	G0194	G0195	G0196	G0197
G0198	G0199	G0200	G0201	V5362
V5363	V5364			

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. These claims will be coded with HCPCS codes A0380, A0390, A0425 through A0436, and A0999 with both characters of the HCPCS modifiers entered as NN, origin and destination SNF. CWF will reject these services to the carrier. The carrier should deny the service with appeals rights.

NOTE: Ambulance fee schedule and coding instructions are found in Transmittals AB-00-88 and AB-00-118.

Messages to be Used with Denials Based On CWF Rejects.--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 should have been 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 new 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: As with any new remark code, notify potential recipients of the new code and its meaning prior to initial use in a remittance advice.

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 / EOMB 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. Your provider must bill this service to the SNF.

Medicare Parte B no paga por este artículo o servicio ya que nuestros expedientes indican que usted estaba en una instalación de enfermería especializada (SNF, por sus siglas en inglés) en esta fecha. Su proveedor debe cobrarle este servicio a la instalación de enfermería especializada. Mensaje del Resumen de Medicare 13.9 - Instalación de Enfermería Especializada

Also, if appropriate, use MSN 34.8/EOMB 16.92 – 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/EOMB 16.93 – 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/EOMB 16.92.)

CWF A/B Crossover Edits.--Effective April 1, 2002, CWF will implement the following utilization edits to carrier submitted claims. Carriers should implement automated processes for the resolution of these edits based on the codes returned in the trailers from CWF.

1. 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 with HCPCS listed above 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.

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.
- 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 HCPCS codes (A0380, A0390, A0425 through A0436, and A0999) 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 services listed in the SPSCF.

3. 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 (A0380, A0390, A0425 through A0436, and A0999) 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).

4. 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:

- o The claim is a CANCEL ONLY (Action Code 4) claim.
- o The claim is denied.
- o HCPCS code is not present on the intermediary claim.
- o The carrier Part B claim payment process indicator is other than A (allowed).
- o For the carrier/DMERC claim only, the Part B claim contains only services listed in the SPSCF as separately payable physician services.

5. 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/DMERC 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 an 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:

- o The claim is a CANCEL ONLY (Action Code 4) claim.
- o The claim is denied.
- o HCPCS code is not present on the intermediary outpatient claim.
- o The Payment Process Indicator is other than A (allowed).
- o For the carrier/DMERC claim only, the Part B claim contains only services listed in the SPSCF as separately payable physician services.

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, the carrier may use the override code to allow that claim to process through CWF to payment. The override code will be specified in the CWF documentation.

D. Provider Notification.--Carriers should notify physicians, non-physician practitioners, and suppliers in their next regularly scheduled bulletin and through their Web sites and any previously scheduled training of the availability of the CSCF on the Web site.

The *effective date* of this PM is April 1, 2002.

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

Funding will be made available through the regular budget process for implementation.

This PM should be discarded after April 1, 2004.

If you have any questions, contact the appropriate regional office.