Program Memorandum Intermediaries/Carriers

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

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This Program Memorandum re-issues Program Memorandum AB-01-158, Change Request 1778, dated November 1, 2001. The only change is the discard date; all other material remains the same.

CHANGE REQUEST 1778

SUBJECT: New Common Working File (CWF) Edits and Standard System Responses on Skilled Nursing Facility (SNF) Claims

The purposes of this Program Memorandum (PM) are:

(1) To describe claim edits for CWF HUOP records against history bills that will be implemented April 1, 2002, and to detect duplicate billing where consolidated billing is involved and provide related intermediary processing requirements;

(2) To provide intermediaries and intermediary standard systems with instructions for edits that must be implemented in standard systems April 1, 2002, for the same purpose; and

(3) To provide information only to carriers.

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. Managed care beneficiaries are identified on CWF with applicable plan ID, entitlement and termination periods on the GHOD screen. The plan ID is a 4-character 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. In addition, condition code '04' on the claim identifies a risk-based HMO enrollee.

A CWF Edits to Detect Inappropriate Claims Related to Consolidated Billing - Background

Effective for services provided on April 1, 2001, on claims received on or after the implementation date, CWF will perform the edits described in section B below. These include edits to identify:

- 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 provided to a SNF Part B resident must be billed under Part B by the SNF for the service to be covered. For other services, other providers or suppliers may bill. These situations are identified by HCPCS code in the edit rules.

- 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.

- Preventive services (e.g., vaccines and screening services) provided to beneficiaries in a covered Part A stay that must be billed by the SNF on a separate Part B bill (TOB 22x).

On the HUOP, CWF will use the line item date(s) of service, HCPCS code(s) and modifier(s) if present. On the HUIP CWF will use admission and discharge (or latest thru) dates. Appropriate edit by pass conditions have been identified and are also described below. Edits on incoming HUIP records against CWF history are being planned and will be implemented later.

CWF edits and contractor resolution procedures are described in section B below. Edits are effective for dates of service April 1, 2001, for claims received on and after implementation. Intermediary standard systems action on CWF rejects will be to reject the line item(s) and move the rejected charges to non-covered. Delete the rejected line from the HUOP record you submit to CWF.

Where rejection applies, appeal rights are not applicable. This is because:

- services for a SNF inpatient that are defined as subject to consolidated billing are also defined as non-covered by Title XVIII unless billed by the SNF, and
- other rejections described here represent duplicate billing for the same service and the program has never intended to make duplicate payment for the same service.

The actions are not considered denials, which afford appeal rights. Instead these are considered returning misdirected claims to the provider so that the proper provider may bill the proper entity.

B CWF Utilization Edits to Detect Claims Related to Consolidated Billing for Services on and after April 1, 2001, for claims received on or after April 1, 2002.

Codes used in CWF edits are described in section C. You will be notified of coding changes as applicable. Also CMS is installing a help file on the CMS web site for online query of SNFs, intermediaries, other providers, practitioners, and suppliers.

Any line item failing an edit will cause CWF to reject the entire claim.

An override code will be made available in case it is necessary for you to override one of the CWF edits. CMS does not anticipate this occurring, but is nevertheless installing such a code for your use in the event you discover a claim that CWF rejected should actually be paid.

1 Outpatient Therapy Claim Against Inpatient SNF 21X Claim Dates of Service

Purpose:

To ensure that Part B therapy services for a SNF inpatient are not separately paid from the SNF bill. The provider is responsible for submitting the charges to and receiving payment from the SNF. The SNF must submit the charges on the SNF claim to the intermediary.

CWF Action:

Reject if an outpatient claim is received with Type of Bill ‘12X’, ‘13X’, ‘14X’, ‘23X’, ‘34X’, ‘74X’, ‘75X’, ‘83X’ or ‘85X’ containing HCPCS codes in II.A.1 (therapies) and line item date of service within the From/Thru Dates on an SNF Inpatient claim (‘21X’ or ‘22X’). The provider number may be the same or different.

Bypass the edit in the following situations:

- The type of bill on the incoming claim is ‘22X’, and the line item date(s) of service is greater than an Occurrence Code ‘A3’, ‘B3’, or ‘C3’ date (Benefits exhausted) on the history claim. The provider number of the ‘22X’ claim is the same as the ‘21X’ history claim.

- The incoming claim is a '22X' type of bill with the same provider number as the '21X' history claim AND the line item date(s) of service on the '22X' is equal to or within the dates associated with one of the following Occurrence span codes on the '21X' SNF history bill:
    - '74' (Non-covered level of care);
    - '76' (Patient Liability);
    - '77' (Provider Liability--Utilization Charged); or
    - '79' (Provider Liability – No Utilization Charged).
- The incoming claim line item date(s) of service equals the SNF '21X' history claim discharge date or admission date.
- The incoming claim type of bill is '22X' with the same provider number as the SNF '21X' history claim and the '21X' history claims has a no-pay code of 'B', 'C', 'N' or 'R'.
- The '21X' history claim contains a cancel date.

Intermediary Action:

Reject the line item(s).

Remittance codes:

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

Use Group Code 'CO': Contractual Obligation.

Use Line Level Remark Code MA101: A SNF is responsible for payment of outside providers who furnish these services/supplies to its residents.

MSN codes:

Use Beneficiary MSN Message 21.7: This service should be included on your inpatient bill.

2. Outpatient Claim Without Therapy Against SNF 21X Inpatient.

Purpose:

An outpatient or Part B claim is rejected because the line item date(s) of service is within the SNF Part A stay. The outpatient or Part B services are included in SNF PPS and consolidated billing, and must be billed by the SNF to the intermediary.

CWF Action:

Reject if an Outpatient claim is received with Type of Bill '12X', '13X', '14X', '22X', '23X', '34X', '74X', '75X', '83X', or '85X' containing line item date(s) of service within the From/Thru Dates on an SNF inpatient claim (21X). The provider number may be the same or different. 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.

Bypass the edit in the following situations:

- The outpatient claim contains any of the HCPCS codes listed in section C 3.

- The incoming claim type of bill is '13X' (Hospital Outpatient) or '85X' (Critical Access Hospital) and contains Revenue code 0450 or any of the HCPCS codes identified in section C 4 except the ambulatory surgical codes in section C 4 that are listed as may not be billed separately.

- A diagnosis code in any position on the incoming claim is for renal disease. These codes are listed in section C 5.

- The outpatient claim contains services for EPO identified by the codes in section C 6.

- The outpatient claim contains ambulance revenue code (54X) and HCPCS modifiers other than 'N' (SNF) in both the origin and destination on the same claim.

- The type of bill on the incoming claim is '22X', and the line item date on the incoming claim is greater than an Occurrence Code 'A3', 'B3', or 'C3' date (Benefits exhausted) on the history claim.

- The only revenue code on the incoming bill is '403' (Screening Mammography) with HCPCS '76092' for services prior to or after 4-1-2001 and for services on or after April 1, 2001, HCPCS codes 'G0202', or 'G0203', and the provider number is the same as the '21X' history bill.

- The only revenue code on the incoming bill is '636' (Pneumococcal, Flu or Hepatitis B vaccine) with one of the following HCPCS codes and the provider number is the same as the '21X' history bill:
    - '90657' Influenza virus vaccine, split virus, 6-35 months dosage, for intramuscular or jet injection use;
    - '90658' Influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use;
    - '90659' Influenza virus vaccine, whole virus, for intramuscular or jet injection use;
    - '90723' Diphtheria, tetanus toxoids, and Acellular pertussis vaccine, Hepatitis B and Poliovirus vaccine, inactivated (DTAP-HEPB-IPV), for intramuscular use
    - '90732' Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for subcutaneous or intramuscular use
    - '90740' Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use.
    - '90743' Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use;
    - '90744' Hepatitis B vaccine, pediatric or pediatric/adolescent dosage, for intramuscular use;
    - '90745' Hepatitis B vaccine, adolescent/high risk infant dosage, for intramuscular use for services prior to January 1, 2001;
    - '90746' Hepatitis B vaccine, adult dosage, for intramuscular use;
    - '90747' Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule) for intramuscular use;
    - '90748' Hepatitis B and Hemophilus Influenza B vaccine (HepB-HIB), for intramuscular use.

  Or revenue code '771' (Administration of vaccine with one of the following HCPCS codes:

    - 'G0008' for administration of the influenza virus vaccine;

- ‘G0009’ for administration of the PPV vaccine; and
- ‘G0010’ for the administration of the hepatitis B vaccine.

For roster billing the claim will contain condition code ‘M1’.

- One of the following Occurrence span codes is present on the ‘21X’ SNF history bill:
  - ‘74’ (Non-covered level of care);
  - ‘76’ (Patient Liability);
  - ‘77’ (Provider Liability--Utilization Charged); or
  - ‘79’ (Provider Liability--No Utilization Charged).

  AND the incoming claim line item date of service is within the occurrence code span dates on the ‘21X’ history bill.

- The incoming claim line item date of service equals the SNF ‘21X’ history claim discharge date or admission date.

- The ‘21X’ history claims has a no-pay code of ‘B’, ‘C’, ‘N’ or ‘R’.

- The ‘21X’ history claim contains a cancel date.

- The incoming claim contains ICD-9-CM code ‘V76.2’, (special screening for malignant neoplasm, cervix) or ‘V15.89’, (other specified personal history presenting hazards to health) and the provider number is the same as the ‘21X’ history bill and one of the following HCPCS codes identifying services for a screening Pap Smear:
  - ‘Q0091’--Screening Papanicolaou smear, obtaining, preparing and conveyance of cervical or vaginal smear to laboratory;
  - ‘P3000’-Screening Papanicolaou smear, cervical or vaginal, up to three smears, by a technician under the physician supervision;
  - ‘G0123’--Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, evaluation by cytotechnologist under physician supervision;
  - ‘G0143’--Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual evaluation and reevaluation by cytotechnologist under physician supervision;
  - ‘G0144’--Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual evaluation and computer-assisted reevaluation by cytotechnologist under physician supervision;
  - ‘G0145’--Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual evaluation and computer-assisted reevaluation using cell selection and review under physician supervision;
  - ‘G0147’--Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision, or
  - ‘G0148’--Screening cytopathology smears, cervical or vaginal, performed by automated system with manual reevaluation.

- The incoming claim contains ICD-9-CM code ‘V76.2’, (special screening for malignant neoplasm, cervix) or ‘V15.89’, (other specified personal history presenting hazards to health or ‘V76.49’ (for a patient who does not have a uterus or cervix) and the provider number is the same as the ‘21X’ history bill and the following HCPCS code identifying services for a screening pelvic examination.
  - ‘G0101’ (cervical or vaginal cancer screening, pelvic and clinical breast examination).

- The incoming claim with the same provider number contains codes to identify colorectal screening services. Colorectal screening services are identified with the following ICD-9-CM diagnosis codes:

    - 'V10.05' Personal history of malignant neoplasm of large intestine;
    - 'V10.06' Personal history of malignant neoplasm of rectum, rectosigmoid junction, and anus;
    - '555.0' Regional enteritis of small intestine;
    - '555.1' Regional enteritis of large intestine;
    - '555.2' Regional enteritis of small intestine with large intestine;
    - '555.9'Regional enteritis of unspecified site;
    - '556.0'Ulcerative (chronic) enterocolitis;
    - '556.1' Ulcerative (chronic) ileocolitis;
    - '556.2' Ulcerative (chronic) proctitis;
    - '556.3' Ulcerative (chronic) proctosigmoiditis;
    - '556.8' Other ulcerative colitis;
    - '556.9' Ulcerative colitis, unspecified (non-specific PDX on the MCE)
    - '558.2' Toxic gastroenteritis and colitis, or
    - '558.9' Other and unspecified non-infectious gastroenteritis and colitis.

    The following HCPCS codes identify claims for colorectal cancer screening:

    - 'G0107'--Colorectal cancer screening; fecal-occult blood test, 1-3 simultaneous determinations;
    - 'G0104'--Colorectal cancer screening; flexible sigmoidoscopy;
    - 'G0105'--Colorectal cancer screening; colonoscopy on individual at high risk;
    - 'G0106'--Colorectal cancer screening; barium enema; as an alternative to 'G0104', screening sigmoidoscopy;
    - 'G0120'--Colorectal cancer screening; barium enema; as an alternative to 'G0105', screening colonoscopy;
    - 'G0121'--Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk (non-covered), or
    - 'G0122'--Colorectal cancer screening; barium enema.

- The incoming claim is for prostate screening services identified with revenue code '30X' and one of the following HCPCS codes. The provider number is the same as the '21X' history bill:

    - 'G0102' (screening digital rectal examination) or
    - 'G0103' (screening prostate specific antigen) (PSA).

- The incoming claim with the same provider number is for glaucoma screening services identified with one of the following HCPCS codes:

    - 'G0117'--Glaucoma screening for high risk patients furnished by a physician or
    - 'G0118'--Glaucoma screening for high risk patients furnished under the direct supervision of a physician.

- The incoming claim is for bone mass screening identified with one of the following HCPCS codes. The provider number is the same as the 21X history bill:

    - '76075' - Dual energy x-ray absorptiometry (DEXA), bone density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine);
    - '76076' - Dual energy x-ray absorptiometry (DEXA), bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel);
    - '76078' - Radiographic absorptiometry (photo densitometry), one or more sites;

- '78350' - Bone density (bone mineral content) study, one or more sites, single photon absorptiometry;
- '76977' - Ultrasound bone density measurement and interpretation, peripheral site(s), any method;
- 'G0130' - Single energy x-ray absorptiometry (SEXA) bone density study, one or more sites, appendicular skeleton (peripheral) (e.g., radius, wrist, heel) (Short descriptor: SINGLE ENERGY X-RAY STUDY);
- 'G0131' - Computerized tomography bone mineral density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine) (Short descriptor: CT SCAN, BONE DENSITY STUDY); and
- 'G0132' - Computerized tomography bone mineral density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel) (Short descriptor: CT SCAN, BONE DENSITY STUDY).

All of the aforementioned codes are bone densitometry measurements except code '76977' which qualifies as a bone sonometry measurement. Any of the above codes, as appropriate, should be used when billing for bone mass measurements.

Intermediary Action:

Reject the line item(s).

Remittance codes:

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

Use Group Code CO: Contractual Obligation.

Use Line Level Remark Code MA101: A SNF is responsible for payment of outside providers who furnish these services/supplies to its residents.

3. Duplicate Edit: Outpatient Part B SNF Ambulance Claim Against a Carrier Part B Ambulance Claim on History

Purpose:

To ensure that a SNF outpatient claim for ambulance service is not paid if a Carrier Part B claim for the same ambulance service on the same day is already paid.

CWF Action:

Reject if an Outpatient Part B SNF ('23X') claim with revenue code '54X' (ambulance) is received and the Date of Service equals the Date of Service on a Carrier Part B claim with ambulance HCPCS codes ('A0021' through 'A0999') and the modifiers 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 history claim payment process indicator is other than 'A' (allowed).

Intermediary Action:

Reject the line item(s).

Remittance codes:

Use Claim Adjustment Reason Code 18: Duplicate claim/service.

Use Line Level Remark Code M86-Service rejected because payment already made for similar procedure.

MSN codes

Beneficiary MSN Message is 7.1: This is a duplicate of a charge already submitted.

4. Duplicate Edit: Intermediary Part B Claim Against An Inpatient Part B SNF (22X) Claim on History

Purpose:

To ensure that services are not paid in duplicate.

CWF Action:

Reject as a duplicate claim if an Intermediary Part B claim ('12X', '13X', '14X', '23X', '34X', '74X', "75X', '83X' or '85X') is received containing line item date(s) of service, HCPCS code and modifier if present, equal to the line item date of service, HCPCS code and modifier, if present, on an Inpatient Part B SNF ('22X') 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.

Intermediary Action:

Reject the line item(s).

Remittance codes:

Use Claim Adjustment Reason Code 18: Duplicate claim/service.

Use Line Level Remark Code M86-Service denied because payment already made for similar procedure.

MSN codes:

Beneficiary MSN Message is 7.1: This is a duplicate of a charge already submitted.

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

Purpose:

To ensure that services excluded from SNF Part A PPS and Part A consolidated billing are not paid in duplicate.

CWF Action:

Reject the line item(s) as duplicate if an Intermediary Outpatient Part B claim (‘12X’, ‘13X’, ‘14X’, ‘23X’, ‘34X’, ‘74X’, ‘75X’, ‘83X’ or ‘85X’) or an Inpatient Part B SNF (‘22X’) 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 a Carrier Part B 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).

Intermediary Action:

Reject the line item(s).

Remittance codes:

Use Claim Adjustment Reason Code 18: Duplicate claim/service.

Use Line Level Remark Code M86-Service denied because payment already made for similar procedure.

MSN codes:

Beneficiary MSN Message is 7.1: This is a duplicate of a charge already submitted.

6. Duplicate Edit: Inpatient Part B SNF Claim Against Outpatient Part B Claim on History

Purpose:

To ensure that services excluded from SNF consolidated billing are not paid in duplicate.

CWF Action:

Reject the line item(s) as duplicate if an Inpatient Part B SNF (‘22X’) is received containing line item dates of Service, HCPCS and modifier codes, if applicable, equal to the line item date(s) of service, HCPCS and modifier codes, if applicable, on an Outpatient Part B claim (‘12X’, ‘13X’, ‘14X’, ‘23X’, ‘34X’, ‘74X’, ‘75X’, ‘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 HUOP claim.

Intermediary Action:

Reject the line item(s).

Remittance codes:

Use Claim Adjustment Reason Code 18: Duplicate claim/service.

Use Line Level Remark Code M86-Service denied because payment already made for similar procedure.

MSN codes:

Beneficiary MSN Message is 7.1: This is a duplicate of a charge already submitted.

C. Tables

1. Therapy Revenue and HCPCS Codes.--

Revenue codes for therapies are '42X' (physical therapy), '43X' (occupational therapy), '44X' (speech therapy).

The applicable HCPCS codes for reporting outpatient rehabilitation services are as follows:

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	95833	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			

** Code 97504 should not be reported with code 97116.

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

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

In addition, the following HCPCS codes identify audiological services:

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								

2. Ambulance Claims.-- If the carrier claim or intermediary outpatient claim includes ambulance services (outpatient revenue code '54X' or carrier claim HCPCS code 'A0021' through 'A0999', reject if both characters of the HCPCS modifier is 'N' (origin and destination is SNF.)) For SNF PPS SNFs show charges for ambulance, like any other transportation, on a covered Part A claim in the revenue center containing the procedure for which the transportation was performed. When the ambulance is used to transfer the beneficiary from one SNF to another SNF, the charges are shown in revenue code 0220, Special Charges.

3. Services Excluded from Consolidated Billing.-- Intermediary and carrier claims with only the following services may be paid when provided by any Medicare provider licensed to provide them. If the claim contains additional services, reject the claims for the carrier or intermediary to obtain separate claims for payable services.

CHEMOTHERAPY ITEMS THAT MAY BE PAID

J9000	J9001	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	J9160	J9170	J9180	J9181	J9182
J9185	J9200	J9201	J9206	J9208	J9211	J9230	J9245
J9265	J9266	J9268	J9270	J9280	J9290	J9291	J9293
J9310	J9320	J9340	J9350	J9355	J9357	J9360	J9370
J9375	J9380	J9390	J9600				

CHEMOTHERAPY ADMINISTRATION SERVICES THAT MAY BE PAID

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	Q0083	Q0084	Q0085					

RADIOISOTOPE SERVICES THAT MAY BE PAID

79030	79035	79100	79200	79300	79400	79420	79440

CUSTOMIZED PROSTHETIC DEVICES THAT MAY BE PAID

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

4. Emergency and Intensive Services Excluded from Consolidated Billing.-- Hospital Outpatient ('13X'), and Critical Access Hospital (CAH) '85X' claims that contain revenue code '45X' (Emergency Room) or any of the following HCPCS codes may be paid. Physician claims for emergency room services are identified with place of service code '23'. The following HCPCS codes may also be paid on the carrier claim. Other services are allowed on the same claim.

5. CT SCANS CODES:

70450	70460	70470	70480	70481	70482	70486	70487	70488
70490	70491	70492	70496	70498	71250	71260	71270	71275
72125	72126	72127	72128	72129	72130	72131	72132	72133
72191	72192	72193	72194	73200	73201	73202	73206	73700
73701	73702	73706	74150	74160	74170	74175	75635	76355
76360	76370	76375	76380	G0131	G0132			

CARDIAC CATHETERIZATION CODES:

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 CODES

70336	70540	70542	70543	70544	70545	70546	70547	70548
70549	70551	70552	70553	71550	71551	71552	71555	72141
72142	72146	72147	72148	72149	72156	72157	72158	72159
72195	72196	72197	72198	73218	73219	73220	73221	73222
73223	73225	73718	73719	73720	73721	73722	73723	73725
74181	74182	74183	74185	75552	75553	75554	75555	75556
76093	76094	76390	76400					

NOTE: Codes 72198, 73225 and 75556 are valid HCPCS codes but are not covered under Medicare.

RADIATION THERAPY CODES

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	77520	77522	77523
77525	77600	77605	77610	77615	77620	77750	77761	77762
77763	77776	77777	77778	77781	77782	77783	77784	77789
77790	77799							

ANGIOGRAPHY CODES

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	75964	75966	75968	75970	75978
75980	75982	75992	75993	75994	75995	75996		

Outpatient surgery codes ranging from 11040 - 69979 EXCEPT those codes below, which should reject because the SNF may provide the service.

THESE CODES MAY NOT BE PAID SEPARATELY.

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

NOTE: Code 36415 is a valid HCPCS code but is not covered under Medicare.

5. Home dialysis suppliers equipment, home dialysis support services, institutional dialysis services and supplies: These services are not included in the SNF Part A PPS rate and are excluded from consolidated billing. They may be paid. These are identified on intermediary claims by type of bill '72X'. Carrier claims that contain the following diagnosis codes may be paid.

40301	40311	40391	40402	40412	40492	5845	5846
5847	5848	5849	585	586	7885	9585	

6. EPO Services: EPO services related to dialysis are not included in the SNF Part A PPS rate and are excluded from consolidated billing. Intermediary EPO claims related to dialysis are identified with the following revenue codes:

- '634' Epoetin (EPO) - Administrations for an injection of less than 10,000 units of EPO was administered.
- '635' Epoetin (EPO) - Administrations for an injection of 10,000 units or more of EPO was administered.

EPO services not related to dialysis are included in consolidated billing.

The *effective date* for this PM is claims with dates of service on and after April 1, 2001 for claims received on and after implementation. Do not search your history for claims to adjust; recovery of duplicate and inappropriate payments will be covered in a separate communication; and process any adjustment requests received on and after the implementation date using these procedures.

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

These instructions should be implemented within your current operating budget.

This PM may be discarded after April 1, 2004.

If you have any questions, contact Cindy Murphy at (410) 786-5733.