CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 229 **Date: JULY 20, 2004**

CHANGE REQUEST 3323

I. SUMMARY OF CHANGES: Additional Clarification of Bill Types 22x and 23x submitted by Skilled Nursing Facilities (SNFs) with Instructions for Involuntarily Moving a Beneficiary Out of the SNF and Ending a Benefit Period.

This clarification replaces instructions previously published in Change Request 2674, Transmittal A-03-040, dated May 9, 2003.

NEW/REVISED MATERIAL – August 19, 2004
CLARIFICATION – EFFECTIVE/IMPLEMENTATION DATE: August 19, 2004

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	6/Table of Contents
R	6/10/Skilled Nursing Facility (SNF) Prospective Payment System (PPS) and Consolidated Billing Overview
R	6/10.1/Consolidated Billing Requirements for SNFs
R	6/20.1.2/Other Excluded Services Beyond the Scope of a SNF Part A Benefit
R	6/20.1.2.1/Outpatient Surgery and Related Procedures -- Inclusions
R	6/20.1.2.2/Emergency Services
R	6/20.2.1/Dialysis and Dialysis Related Services to a Beneficiary With ESRD
R	6/20.2.1.1/ESRD Services
R	6/20.2.1.4/Coding Applicable to EPO Services
N	6/20.2.1.5/Coding for Darbepoetin Alfa
R	6/20.3.1/Ambulance Services
R	6/20.4/Screening and Preventive Services
R	6/20.5/Therapy Services
R	6/40.3.4/Situations that Require a Discharge or Leave of Absence
R	6/40.5/Billing Procedures for Periodic Interim Payment--PIP Method of Payment
R	6/40.7/Ending A Benefit Period
N	6/40.8/Other Billing Situations

R	7/10.2/Billing for Outpatient SNF Services

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 229	Date: July 20, 2004	Change Request 3323

SUBJECT: Additional Clarification of Bill Types 22x and 23x Submitted by Skilled Nursing Facilities (SNFs) With Instructions for Involuntarily Moving a Beneficiary Out of the SNF and Ending a Benefit Period

I. GENERAL INFORMATION

A. Background:

According to §4432(b) of the Balanced Budget Act (BBA) of 1997 (P.L. 105-33), as originally enacted, the SNF consolidated billing legislation stated that beneficiaries were considered "residents" of the SNF for consolidated billing purposes no matter where (certified or non-certified part of the institution) the beneficiary was placed. Subsequent legislation (§313 of the Benefits Improvement and Protection Act of 2000, P.L. 106-554) revised the "resident" definition to include only individuals who were actually placed in the Medicare-certified part of the institution. Because those individuals who are placed in the Medicare non-certified area of the institution are no longer considered SNF "residents," it is appropriate to use bill type 23x (non-resident) rather than 22x (resident). Therefore, when the institution limits its Medicare SNF participation to a distinct part unit (DPU), and moves a beneficiary who no longer meets the Medicare skilled level of care (required for a covered Part A stay) from the Medicare-certified DPU to a Medicare non-certified area of the institution, the beneficiary has technically ceased to reside in the Medicare-certified SNF and, thus, is appropriately billed as a "non-resident" of the SNF using bill type 23x. Incorrectly using the 22x type of bill could inappropriately trigger SNF consolidated billing edits for therapy services that the beneficiary receives in an outpatient setting. In the case where the entire facility qualifies as a Medicare-certified SNF, all Part B therapies must continue to be billed by the SNF on a 22x type of bill.

This instruction replaces Change Request 2674, Transmittal A-03-040 that was previously issued on May 9, 2003. Since that time, CMS and contractors have received numerous provider inquiries regarding transmittal A-03-040, including questions about when a resident can be involuntarily moved out of a Medicare-certified SNF or DPU, and when a benefit period ends. This instruction seeks to clarify those two issues.

Involuntarily Moving a Resident Out of a Medicare-certified SNF or DPU:

The requirements for participation specify the limited circumstances under which a resident can be involuntarily moved out of a Medicare-certified SNF or DPU. These circumstances can include situations in which the resident's health has improved to the point where he or she no longer needs SNF care. However, if a resident has exhausted Part A benefits but nevertheless continues to require SNF care, he or she cannot be moved out of the Medicare-certified SNF or DPU for reasons other than those specified in the regulations. For example, the resident cannot be moved to avoid the consolidated billing requirements, or to establish a new benefit period. The determination to move the beneficiary out of the SNF or DPU must not be made on the

basis of the beneficiary having exhausted his or her benefits, but rather on the beneficiary's lack of further need for SNF care. Once a resident of a Medicare-certified DPU ceases to require SNF care, he or she may then be moved from the DPU to the Medicare non-certified area of the institution. As discussed above, such a move would end the beneficiary's status as a SNF "resident" for consolidated billing purposes.

Ending a Benefit Period:

A benefit period ends 60 days after the beneficiary has ceased to be an inpatient of a hospital and has not received inpatient skilled care in a SNF during the same 60-day period.

When the SNF resident's health has improved to the point where he or she no longer needs or receives the level of skilled care required for Part A coverage, the SNF must bill one of the following two scenarios:

1. For the resident that leaves the Medicare-certified SNF or DPU:

    a. Submit a final discharge bill.
    b. Any services rendered after the discharge and billed by the SNF should be submitted on a 23x.

2. For the resident that remains in the Medicare-certified SNF or DPU after the skilled level of care has ended:

    a. Submit the last skilled care claim with an occurrence code 22 to indicate the date active care ended.
    b. Any services rendered and billed by the SNF after the skilled care ended should be submitted on a 22x; and
    c. All therapies must be billed by the SNF on the 22x.

In conclusion, the lack of a need for skilled care in a SNF is what triggers the start of the 60-day count toward ending a benefit period. However, it is the physical location of the beneficiary within the certified part of the facility that confers “resident” status for the purposes of the SNF Part B consolidated billing rule for therapies. Consequently, it is possible for a beneficiary to no longer need or receive skilled care resulting in ending a benefit period but still be a resident of the SNF or Medicare-certified DPU requiring the SNF to bill for all therapies rendered to the resident.

B. Policy:

Regulations for certification of SNFs at 42 CFR 483.5, specify that for Medicare and Medicaid purposes (including eligibility, coverage, certification, and payment), the “facility” is always the entity that participates in the program.

The requirements for participation at 42 CFR 483.12(a)(2)(i)-(vi) specify the limited circumstances under which a resident can be involuntarily moved out of a Medicare-certified SNF or DPU.

Regulations for ending a benefit period are defined at 42 CFR 409.60(b).

C. Provider Education:

"A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin."

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
3323.1	Intermediaries shall inform affected providers of the information contained in this document through the methods described in section I.C. above.	FI

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/**A**

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: August 19, 2004 **Implementation Date: August 19, 2004** **Pre-Implementation Contact(s):** Wendy Tucker CMS CO 410-786-3004, Wtucker2@cms.hhs.gov or Cindy Murphy CMS CO 410-786-5733, Cmurphy1@cms.hhs.gov **Post-Implementation Contact(s):** Appropriate RO	**These instructions shall be implemented within your current operating budget.**

Medicare Claims Processing Manual

Chapter 6 - SNF Inpatient Part A Billing

Table of Contents

(Rev. 229, 07-20-04)

10 - Skilled Nursing Facility (SNF) Prospective Payment System (PPS) and Consolidated Billing Overview

(Rev. 229, Issued 07-20-04 Effective/Implementation 08-19-04)

SNF-515, PM A-02-016 (CR 1666)

All SNF Part A inpatient services are paid under a prospective payment system (PPS). Under SNF PPS, beneficiaries must meet the regular eligibility requirements for a SNF stay. That is, the beneficiary must have been an inpatient of a hospital for a medically necessary stay of at least three consecutive calendar days. In addition, the beneficiary must have been transferred to a participating SNF within 30 days after discharge from the hospital, unless the patient's condition makes it medically inappropriate to begin an active course of treatment in an SNF within 30 days after hospital discharge, and it is medically predictable at the time of the hospital discharge that the beneficiary will require covered care within a predetermined time period. (See the Medicare Benefit Policy Manual, Chapter 8, "Coverage of Extended Care Services Under Hospital Insurance," §20.2, for further information on the 30-day transfer requirement and exception.) To be covered, the extended care services must be needed for a condition which was treated during the patient's qualifying hospital stay, or for a condition which arose while in the SNF for treatment of a condition for which the beneficiary was previously treated in a hospital.

Also under SNF PPS all Medicare covered Part A services that are considered within the scope or capability of SNFs are considered paid in the PPS rate. In some cases this means that the SNF must obtain some services that it does not provide directly. Neither the SNF nor another provider or practitioner may bill the program for the services under Part B, except for services specifically excluded from *PPS* payment and associated consolidated billing requirements.

Any DME or oxygen furnished to *inpatients in* a *covered* Part A *stay* is included in the SNF PPS rate. The definition of DME in §1861(n) of the Social Security Act (the Act) provides that DME is covered by Part B only when intended for use in the home, which explicitly does not include a SNF. This definition applies to oxygen also. (See the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Service," §110.)

Prosthetics and orthotic devices are included in the Part A PPS rate unless specified as being outside the rate. Those that are considered outside the PPS rate are billed by the qualified outside entity that furnished the service. That entity bills its normal contractor.

Services that are not considered to be furnished within SNF PPS are identified in sections §§20.1 – 20.4. These may be billed separately under Part B. Some services must be billed by the SNF. (This is referred to as "consolidated billing.") Some services must be billed by the rendering provider (SNF or otherwise). These are discussed further in §§20.1 – 20.4.

10.1 - Consolidated Billing Requirement for SNFs

(Rev. 229, Issued 07-20-04 Effective/Implementation 08-19-04)

Section 4432 (b) of the Balanced Budget Act (BBA) requires consolidated billing for SNFs. Under the consolidated billing requirement, the SNF must submit ALL Medicare claims for ALL the services that its residents receive under Part A, **except** for certain excluded services described in §§20.1 – 20.3, **and** for all physical, occupational and speech-language pathology services received by residents under Part B. A SNF resident is defined as a beneficiary who is admitted to a Medicare participating SNF or the participating, Medicare-certified, distinct part unit *(DPU)* of *a larger institution*. When such a beneficiary leaves the facility (or the DPU), the beneficiary's status as a SNF resident for consolidated billing purposes (along with the SNF's responsibility to furnish or make arrangements for needed services) ends. It may be triggered by any one of the following events:

- 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 dies; or
- *The beneficiary is formally discharged (or otherwise departs) from the SNF or DPU, unless the beneficiary is readmitted (or returns) to that or another SNF before midnight of the same day.* A "discharg*e*" from the Medicare-certified DPU includes situations in which the beneficiary is moved from the DPU to a Medicare non-certified area within the same institution.

These requirements apply only to Medicare fee-for-service beneficiaries residing in a participating SNF or DPU.

Claims are submitted to the FI on Form CMS-1450 or its electronic equivalent. All services billed by the SNF (including those furnished under arrangements with an outside supplier) for a resident of a SNF in a covered Part A stay are included in the SNF's Part A bill. If a resident is not in a covered Part A stay (Part A benefits exhausted, posthospital or level of care requirements not met), the SNF is required to bill for all physical, occupational, and/or speech language therapy services provided to a SNF resident under Part B. The consolidated billing provision requires that effective for services and items furnished on or after July 1, 1998, payment is made directly to the SNF.

Thus, SNFs are no longer able to "unbundle" services to an outside supplier that can then submit a separate bill directly to a Part B carrier or DMERC for residents in a Part A stay, or for SNF residents receiving physical, occupational and, or speech language therapy services paid under Part B. Instead, the SNF must furnish the services either directly or under an arrangement with an outside supplier or provider of services in which the SNF (rather than the supplier or provider of services) bills Medicare. Medicare does not pay amounts that are due a provider to any other person under assignment, or power of attorney, or any other direct payment arrangement. As a result, the outside supplier must

look to the SNF (rather than the Medicare carrier or FI or the beneficiary) for payment. The SNF may collect any applicable deductible or coinsurance from the beneficiary.

***NOTE**: The requirements for participation at 42 CFR 483.12(a)(2)(i)-(vi) specify the limited circumstances under which a resident can be involuntarily moved out of a Medicare-certified SNF or DPU. These circumstances can include situations in which the resident's health has improved to the point where he or she no longer needs SNF care. However, if a resident has exhausted Part A benefits but nevertheless continues to require SNF care, he or she cannot be moved out of the Medicare-certified SNF or DPU for reasons other than those specified in the regulations. For example, the resident cannot be moved to avoid the consolidated billing requirements, or to establish a new benefit period. The determination to move the beneficiary out of the SNF or DPU must not be made on the basis of the beneficiary having exhausted his or her benefits, but rather, on the beneficiary's lack of further need for SNF care. Once a resident of a Medicare-certified DPU ceases to require SNF care, he or she may then be moved from the DPU to the Medicare non-certified area of the institution. As discussed above, such a move would end the beneficiary's status as a SNF "resident" for consolidated billing purposes.*

Enforcement of SNF consolidated billing is done through editing in Medicare claims processing systems using lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of SNF PPS. In order to assure proper payment in all settings, Medicare systems must edit for services, provided to SNF beneficiaries, both included and excluded from SNF CB. Transmittals with instructions provide updates to previous lists of the exclusions, and some inclusions, to SNF CB. Such transmittals can be found on the CMS Web site at: www.cms.hhs.gov/manuals/

The list of HCPCS codes enforcing SNF CB may be updated each quarter. For the notice on SNF CB for the quarter beginning January, separate instructions are published for FIs and carriers/DMERCs. Since this is *usually* the only quarter in which new permanent HCPCS codes are produced, this recurring update is referred to as an annual update. Other updates for the remaining quarters of the year will occur as needed prior to the next annual update. In lieu of another update, editing based on the prior list of codes remains in effect. Some non-January quarterly updates may apply to both FIs and carriers/DMERCs, and the applicability of the instruction will be clear in each update. All future updates will be submitted via a Recurring Update Notification form.

- **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 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 and other practitioner'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.

- **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 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.

20.1.2 - Other Excluded Services Beyond the Scope of a SNF Part A Benefit

(Rev. 229, Issued 07-20-04 Effective/Implementation 08-19-04)
SNF-516.3

The following services are not included in Part A PPS payment when furnished in a Medicare participating hospital or CAH and may be paid to the provider rendering them.

This exception does not apply if the service is furnished in an ambulatory surgical center (ASC) or other independent (non-hospital) facility. In transmittals for FI billing providing the annual update list of HCPCS codes affected by SNF consolidated billing, such

services are referred to as " Major Category I" of SNF consolidated billing editing. Note that of the types of services listed, only ambulatory surgeries are listed as inclusions, rather than exclusions, to consolidated billing.

- Certain cardiac catheterizations;
- Certain computerized axial tomography (CT) scans;
- Certain magnetic resonance imaging (MRIs);
- Certain ambulatory surgeries involving the use of a hospital operating room; For Part A inpatients, the professional portion of these services is billed by the rendering practitioner to the carrier. Any hospital outpatient charges are billed to the FI.
- Certain radiation therapies;
- Certain angiographies, and lymphatic and venous procedures;
- Emergency services;
- Ambulance services when related to an excluded service within this list; and
- Ambulance transportation related to dialysis services.

These relatively costly services are beyond the general scope of care in SNFs. Even though it may be medically appropriate for a beneficiary to be cared for in a SNF while receiving radiation therapy, the SNF is not responsible for paying for excluded radiation therapy itself when the beneficiary receives it as a hospital outpatient. Similarly, angiography codes and codes for some lymphatic and venous procedures are considered beyond the general scope of services delivered by SNFs. The hospital or CAH must bill the FI for the services. Excluded services provided to Medicare beneficiaries in swing beds subject to SNF PPS are to be billed on TOB 13x *by the swing bed hospital.*

Services directly related to these services, defined as services billed for the same place of service and with the same line item date of service as the services listed below, are also excluded from SNF CB, with exceptions as listed below.

- Note that anesthesia, drugs incident to radiology and supplies (revenue codes 037x, 0255, 027x and 062x) will be bypassed by enforcement edits when billed with CT Scans, Cardiac Catheterizations, MRIs, Radiation Therapies, or Angiographies or surgeries.
- In general, bypasses also allow CT Scans, Cardiac Catheterization, MRI, Radiation Therapy, Angiography, and Outpatient Surgery HCPCS codes 0001T – 0021T, 0024T – 0026T, or 10021 - 69990 (except HCPCS codes listed in the table below)

to process and pay. This includes all other revenue code lines on the incoming claim that have the same line item date of service (LIDOS).

20.1.2.1 Outpatient Surgery and Related Procedures– INCLUSION

(Rev. 229, Issued 07-20-04 Effective/Implementation 08-19-04)

Inclusions, rather than exclusions, are given in this one case, because of the great number of surgical procedures that are excluded and can only be safely performed in a hospital operating room setting. It is easier to automate edits around the much shorter list of inclusions under this category, representing minor procedures that can be performed in the SNF itself. Additionally, this was the approach originally taken in the regulation to present this information.

- Note that anesthesia, drugs, supplies and lab services (revenues codes 037x, 025x, 027x, 062x and 030x) will be bypassed by enforcement edits when billed with outpatient surgeries excluded from SNF CB. The bypass is implemented for these services when the line item date of service matches the line item date of service for the excluded surgery. For revenue codes not requiring a line item date of service (i.e., pharmacy and supplies), the bypass will be implemented when no line item date of service is present.

See §10.1 above for the link to where transmittals providing current lists of HCPCS codes used for Major Category I SNF consolidated billing editing can be found.

20.1.2.*2* - Emergency Services

(Rev. 229, Issued 07-20-04 Effective/Implementation 08-19-04)

SNF-516.3 These services are identified on claims submitted to FIs by a hospital or CAH using revenue code 045x (Emergency Room - ”x” represents a varying third digit). Related services are also excluded. These are defined as those services having the same line item date of services (LIDOS) as the emergency room visit. Note that in order to get a match on the LIDOS there must be a LIDOS and HCPCS in revenue code 045x. . Revenue codes for related services that do not require a LIDOS (i.e., pharmacy and supplies) will be bypassed when a LIDOS is not present.

20.2.1 – Dialysis and Dialysis Related Services to a Beneficiary With ESRD

(Rev. 229, Issued 07-20-04 Effective/Implementation 08-19-04)

SNF-516

Beneficiaries with ESRD may receive dialysis and dialysis related services from a hospital-based or free-standing RDF, or may receive home dialysis supplies and equipment from a supplier. *The following services are excluded from SNF consolidated billing:*

- Certain dialysis services and supplies, including any related necessary ambulance services;

- Home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies (other than those furnished or arranged for by the SNF itself) are not included in the SNF Part A PPS rate. These services may be billed separately to the FI by the ESRD facility as appropriate; dialysis supplies and equipment may be billed to the DMERC by the supplier; and

- Erythropoietin (EPO) for certain dialysis patients, subject to methods and standards for its safe and effective use (see 42 CFR 405.2163(g) and (h)) may be billed by the RDF to the FI, or by the retail pharmacy to the DMERC;

20.2.1.1 - ESRD Services

(Rev. 229, Issued 07-20-04 Effective/Implementation 08-19-04)

SNF-516.6, PM A-02-118

Home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies (other than those that are furnished or arranged for by the SNF itself) are not included in the Part A PPS payment. They may be billed separately to the FI by the hospital or ESRD facility as appropriate.

Specific coding is used to differentiate dialysis and related services that are excluded from SNF consolidated billing for ESRD beneficiaries in three cases:

1. When the services are provided in a renal dialysis facility (RDF) (including ambulance services *to and from the RDF if medically necessary);*

2. Home dialysis when the SNF constitutes the home of the beneficiary; and

3. When the drug EPO or Aranesp is used for ESRD beneficiaries *in conjunction with dialysis, and given by the RDF*.

Note that SNFs may not be paid for home dialysis supplies.

20.2.1.3 - Coding Applicable to Services Provided in a RDF or SNF as Home

(Rev. 229, Issued 07-20-04 Effective/Implementation 08-19-04)

RDFs use the following revenue codes for such billing on a Form CMS-1450 or ANSI ASC X12N 837 I:

- *0*825 - Hemodialysis OPD/Home Support Services;

- *0*835 - Peritoneal OPD/Home Support Services;

- *0*845 - Continuous Ambulatory Peritoneal Dialysis OPD/Home Support Services; or

- *0*855 - Continuous Cycling Peritoneal Dialysis OPD/Home Support Services.

20.2.1.4 - Coding Applicable to EPO Services

(Rev. 229, Issued 07-20-04 Effective/Implementation 08-19-04)

SNF-543

Epoetin alfa (trade name EPO) is a drug Medicare approved for use by ESRD beneficiaries. FI EPO claims for ESRD beneficiaries are identified with the following revenue codes when services are provided in RDF:

- *0*634 (EPO with less than 10,000 units); and

- *0*635 (EPO with 10,000 or greater units).

Total units given in the period are placed in value code *6*8.

The most recent hematocrit reading is placed in value code 49, or the most recent hemoglobin reading is placed in value code 48.

20.2.1.5 – Coding for Darbepoetin Alfa

(Rev. 229, Issued 07-20-04 Effective/Implementation 08-19-04)

A new drug is now also covered for ESRD beneficiaries for treatment of anemia. The newly covered drug is darbepoetin alfa, and the trade name is Aranesp. Darbepoetin alfa will always be billed in revenue code 0636 and HCPCS code Q4054 for ESRD beneficiaries. When darbepoetin alfa is billed by the RDF, the RDF places the hematocrit reading in value code 49.

20.2.2 – Hospice Care for a Beneficiary's Terminal Illness

(Rev. 229, Issued 07-20-04 Effective/Implementation 08-19-04)

SNF-515.1

Hospice care related to a beneficiary's terminal condition is excluded from SNF PPS and consolidated billing.. Hospice services for terminal conditions are identified with the following types of bill: 81X or 82X. Services unrelated to the beneficiary's terminal condition are designated by the presence of *condition* code 07. Such unrelated services are included in SNF PPS and consolidated billing.

20.3.1. - Ambulance Services

(Rev. 229, Issued 07-20-04 Effective/Implementation 08-19-04)

SNF-516.2

The following ambulance transportation and related ambulance services for residents in a Part A stay are not included in the Part A PPS payment. 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 *and FIs* 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.

The following ambulance services may be billed as Part B services by the supplier in the following situations only.

- The ambulance trip is to the SNF for admission (the second character (destination) of any ambulance HCPCS modifier is N (SNF) other than modifier QN, and the date of service is the same as the SNF 21X admission date.);
- The ambulance trip is from the SNF after discharge, to the beneficiary's home where the beneficiary will receive services from a Medicare participating home health agency under a plan of care (the first character (origin) of any HCPCS ambulance modifier is N (SNF)), and date of ambulance service is the same date as the SNF through date and the SNF patient status is other than 30;
- The ambulance trip is to a hospital based or nonhospital based ESRD facility (either one of any HCPCS ambulance modifier codes is G (Hospital based dialysis facility) or J (Non-hospital based dialysis facility) for the purpose of receiving dialysis and related services excluded from consolidated billing;
- The ambulance trip is from the SNF to a Medicare participating hospital or a CAH for an inpatient admission;
- The ambulance trip after a formal discharge or other departure from the SNF to any destination other than another SNF, and the beneficiary does not return to that or any other SNF by midnight of that same day; and
- Ambulance service that conveys a beneficiary to a hospital or CAH and back to the SNF, for the specific purpose of receiving emergency or other excluded services.

Effective April 1, 2002, payment shall be the amount prescribed in the ambulance fee schedule.

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.

See Chapter 15 for Ambulance Services.

20.4 - Screening and Preventive Services

(Rev. 229, Issued 07-20-04 Effective/Implementation 08-19-04)

SNF-515.7

The Part A SNF benefit is limited to services that are reasonable and necessary to "diagnose or treat" a condition that has already manifested itself and, thus, does not include screening services (which detect the presence of a condition that is still in an asymptomatic stage) or preventive services (which are aimed at avoiding the occurrence of a particular condition altogether). Coverage of screening and preventive services (e.g., screening mammographies, pneumococcal pneumonia vaccine, influenza vaccine, hepatitis vaccine) is a separate Part B inpatient benefit when rendered to beneficiaries in a covered Part A stay and is paid outside of the Part A payment rate. For this reason, screening and preventive services must not be included on the global Part A bill. However, screening and preventive services remain subject to consolidated billing and, thus, must be billed separately by the SNF under Part B. Accordingly, even though the SNF itself must bill for these services, it submits a separate Part B inpatient bill for them rather than including them on its global Part A bill. Screening and preventive services must be billed with a 22X type of bill. Swing Bed providers must use TOB 12x for eligible beneficiaries in a Part A SNF level of care. ***NOTE:*** *For beneficiaries residing in the Medicare non-certified area of the facility, these services should be billed on a 23x type of bill.* In transmittals for FI billing providing the annual update list of HCPCS codes affected by SNF consolidated billing, such services are referred to as " Major Category IV". See §10.1 above for the link to where transmittals providing current lists of HCPCS codes used for Major Category IV can be found.

Formerly, bone mass measurement (screening) was listed as a preventive service excluded from SNF consolidated billing. This was incorrect. Such services are diagnostic, not screening, procedures, and therefore are bundled into SNF PPS payment and subject to consolidated billing.

20.5 – Therapy Services

(Rev. 229, Issued 07-20-04 Effective/Implementation 08-19-04)

Therapy services are edited as inclusions, rather than exclusions, to consolidated billing. *Physical therapy, speech language pathology services and occupational therapy are subject to the SNF Part B consolidated billing requirement and* must be billed by the

SNF alone for its Part B residents *on a 22x type of bill. SNF residents that fall below a Medicare skilled level of care may be moved out of the SNF or certified distinct part unit (DPU) to the Medicare non- certified area of the facility. In doing so, the beneficiary is no longer subject to the SNF consolidated billing rule and therapy services may be billed directly to Medicare by the provider rendering the service or if billed by the SNF should be submitted on a 23x type of bill. If the entire facility qualifies as a Medicare-certified SNF, all Part B therapies must continue to be billed by the SNF on a 22x type of bill. For additional instructions, see Chapter 7, SNF Part B Billing, §10.1.* In transmittals for FI billing providing the annual update list of HCPCS codes affected by SNF consolidated billing, such services are referred to as " Major Category V" of SNF consolidated billing. See §10.1 above for the link to where transmittals providing current lists of HCPCS codes used for Major Category V can be found.

40.3.1 - Date of Admission

(Rev. 229, Issued 07-20-04 Effective/Implementation 08-19-04)

The beneficiary, entitled to Part A benefits, becomes a SNF resident for Part A PPS billing purposes when admitted to a Medicare certified *SNF or DPU*. This could be a first time admission or a readmission following events described in §40.3.2. Services on and after this day are included in the PPS rate and cannot be billed by other providers and suppliers unless excluded as described in this chapter.

40.3.4 - *Situations that Require a Discharge or Leave of Absence*

(Rev. 229, Issued 07-20-04 Effective/Implementation 08-19-04)

SNF-517.6, SNF-515.4 (Transmittal 368)

Medicare systems are set up so that the SNF need not submit a discharge bill when the situation is that the beneficiary (who leaves the SNF and then returns by midnight of the same day) receives outpatient services from a Medicare participating hospital, CAH, or other appropriate provider during his/her absence. Edits allow hospitals and CAHs to bill for these services for *a beneficiary in a* Part A PPS stay. Receipt of outpatient services from another provider does not normally result in a SNF discharge.

Two situations force a discharge from a SNF: 1) the beneficiary's admission as an inpatient to a Medicare participating hospital or CAH, or 2) the beneficiary's transfer to another SNF for inpatient services. A beneficiary cannot be an inpatient in more than one facility at a time. Consequently, the SNF ***must*** *submit a discharge bill if either of these events occur.*

If the patient is readmitted to the SNF, the SNF should submit a new bill (TOB 211 or 212) with a new admission date. See §40.3.2, Patient Readmitted Within 30 days After Discharge, for further instructions.

Bills for excluded services (identified in §20 of this chapter) rendered by participating hospitals, CAHs, or other appropriate providers may be paid to the rendering provider in addition to the Part A PPS payment made to the SNF. Other outpatient services furnished to a resident in a Part A PPS stay by another provider/supplier must be billed by the SNF. Home health or outpatient services provided during a leave of absence do not affect the leave and no discharge bill is required.

Home health services are not payable unless the patient is confined to his home, and under Medicare regulations, a SNF cannot qualify as a home. Where the beneficiary receives services from a home health agency, the home health agency is responsible for billing.

If the beneficiary is formally discharged or otherwise departs for reasons other than described above but then, is readmitted or returns by midnight of the same day, he is not considered discharged. The SNF is responsible for billing for services during the period of absence, unless such services are otherwise excluded from Part A PPS payment or are excluded from Medicare coverage. In this context, a patient "day" begins at 12:01 a.m. and ends the following midnight, so that the phrase "by midnight of the same day" refers to the midnight that immediately follows the actual moment of departure from the SNF, rather than the midnight that immediately precedes it.

NOTE: This instruction only applies to Medicare fee-for-service beneficiaries in a participating SNF.

40.5 - Billing Procedures for Periodic Interim Payment (PIP) Method of Payment

(Rev. 229, Issued 07-20-04 Effective/Implementation 08-19-04)

SNF-5l7.7

SNFs using the PIP method of payment follow the regular billing instructions in Medicare Claim Processing Manual, Chapter 26, "Completing and Processing Form CMS-*1450* Data Set."

See the Medicare Claims Processing Manual, Chapter 1, "General Billing Requirements," §80.4, for requirements SNFs must meet and intermediaries must monitor to continue PIP reimbursement. Refer to the Medicare Claims Processing Manual, Chapter 25, " Completing and Processing the UB-92 (CMS-1450) Data Set," for further information about billing, as it contains UB-92 data elements and the corresponding fields in the electronic record.

40.7 *Ending a Benefit Period*

(Rev. 229, Issued 07-20-04 Effective/Implementation 08-19-04)

A benefit period ends 60 days after the beneficiary has ceased to be an inpatient of a hospital and has not received inpatient skilled care in a SNF during the same 60-day period.

When the SNF resident's health has improved to the point where he or she no longer needs or receives the level of skilled care required for Part A coverage, the SNF must bill one of the two following scenarios:

1. *For the resident that leaves the Medicare-certified SNF or DPU:*
    a. *Submit a final discharge bill, and*
    b. *Any services rendered after the discharge and billed by the SNF should be submitted on a 23x.*
2. *For the resident that remains in the Medicare-certified SNF or DPU after the skilled level of care has ended:*
    a. *Submit the last skilled care claim with an occurrence code 22 to indicate the date active care ended;*
    b. *Any services rendered and billed by the SNF after the skilled care ended should be submitted on a 22x; and*
    c. *All therapies must be billed by the SNF on the 22x.*

For additional instructions on ending a benefit period go to the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 3, §10.4.2.

40.*8* - Other Billing Situations

(Rev. 229, Issued 07-20-04 Effective/Implementation 08-19-04)

A3-3624, A3-3624.B, A3-3630.1, A3-3630.4, A3-3620, HO-411, SNF-517.3, SNF-526.3, SNF-527, SNF-527.1,

A - No Payment Bills

A hospital or SNF is required to submit a bill even though no benefits may be payable. CMS maintains a record of all inpatient services for each beneficiary, whether covered or not. The related information is used for national healthcare planning and also enables CMS to keep track of the beneficiary's benefit period. These bills are known as no-payment bills. A SNF must submit a no-payment bill every month and also when there is a change in the level of care regardless of whether the no-payment days will be paid by Medicaid or a supplemental insurer. When a change in level of care occurs after exhaustion of a beneficiary's covered days of care, the provider must submit the no-payment bill in the next billing cycle.

See the Medicare Claims Processing Manual, Chapter 3, "Inpatient Part A Hospital," §40.4.1, for billing instructions and situations requiring a no-payment bill. See §40.4.2 of the same chapter for FI processing instructions.

Refer to the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-92 (CMS-1450) Data Set" for further information about billing, as it contains UB-92 data elements and the corresponding fields in the electronic record.

Where payment may be made for part of the services, one bill is prepared covering payable **and** nonpayable days and services.

A noncovered bill with condition code 21 indicates a request for a Medicare denial notice. The bill is submitted to obtain a denial notice for Medicaid or another insurer.

Do not send a no-payment discharge bill where the patient has Part B entitlement only.

B - Demand Bills

SNF-526, SNF-526.1, A3-3630.1, SNF-526.2, A3-3630

Where the SNF believes that a covered level of care has ended but the beneficiary disagrees, they report occurrence code 21 (UR Notice Received) or 22 (active care ended) as applicable and condition code 20 indicating the beneficiary believes the services are covered beyond the occurrence date. The SNF reports the days and charges after the occurrence code 21 or 22 date as noncovered.

See the Medicare Claims Processing Manual, Chapter 1, "General Billing Requirements," §60, for additional instruction on advance beneficiary notices and demand bills.

Refer to the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-92 (CMS-1450) Data Set," for further information about billing, as it contains UB-92 data elements and the corresponding fields in the electronic record.

C - Request for Denial Notice for Other Insurer

SNFs complete a noncovered bill and enter condition code 21 to indicate a request for a Medicare denial notice. Refer to Chapter 25, " Completing and Processing the UB-92 (CMS-1450) Data Set," for further information about billing, as it contains UB-92 data elements and the corresponding fields in the electronic record.

D - Another Insurer is Primary to Medicare

See the Medicare Secondary Payer (MSP) Manual, Chapter 3, "MSP Provider Billing Requirements" and Chapter 5, "Contractor Prepayment Processing Requirements," for submitting claims for secondary benefits to Medicare. Refer to the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-92 Data Set," for further information about billing, as it contains UB-92 data elements and the corresponding fields in the electronic record.

E – Special MSN Messages

The Medicare Prescription Drug Improvement and Modernization Act of 2003 requires that Medicare Summary Notices (including SNF claims for post-hospital extended care services provided under Part A) report the number of covered days remaining in the given spell of illness. This requirement became effective July 6, 2004.

10.2 – Billing for Outpatient SNF Services

(Rev. 229, Issued 07-20-04 Effective/Implementation 08-19-04)

SNF-529

Coverage is available for all of the services described in §10.1. However, beneficiaries not in the Medicare-certified Distinct Part Unit (DPU) are not required to have therapy services (physical therapy, occupational therapy, and speech language pathology) billed by the SNF. Therapy services need only be bundled to the SNF for those SNF residents in a Medicare-certified DPU. *For additional information see Chapter 6, SNF Inpatient Part A Billing, §20.5 Therapy Services.*