Medicare

Skilled Nursing FacilityManual

Department of Health and Human Services (DHHS)

HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents - Chapter I	1-1 - 1-2 (2 pp.)	1-1 - 1-2 (2 pp.)
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512 - 513	5-9 - 5-10 (2 pp.)	5-9 - 5-10.4 (6 pp.)
542 - 542	5-26 (1 p.)	5-25.12 - 5-26.57 (51 pp.)

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Section 106, Fraud and Abuse - General, has been **deleted** and moved to the Program Integrity Manual to avoid duplication.

Section 513, Focused Medical Review (FMR), has been **deleted** and moved to the Program Integrity Manual to avoid duplication.

Sections 542 - 544.3, Billing Part B Intermediary Outpatient Physical Therapy Bills, has been **deleted** and moved to the Program Integrity Manual to avoid duplication.

The Program Integrity Manual can be found at the following Internet address: **www.hcfa.gov/pubforms/83_pim/pimtoc.htm**.

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

CHAPTER I
GENERAL INFORMATION ABOUT THE PROGRAM

Section

Administration of Medicare Program

Provider Participation in Medicare

Hospital Insurance

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GENERAL INFORMATION ABOUT THE PROGRAM

Administration of Medicare Program

100. INTRODUCTION

The Health Insurance for the Aged and Disabled Act (Title XVIII of the Social Security Act), known as "Medicare," has made available to nearly every American 65 years of age and older a broad program of health insurance designed to assist the Nation's elderly to meet hospital, medical, and other health costs. Health insurance coverage has been extended to persons under age 65 qualifying as disabled and those having end stage renal disease (ESRD). The program includes two related health insurance programs--hospital insurance (HI) (Part A) and supplementary medical insurance (SMI) (Part B).

The conduct of the program has been delegated by the Secretary of the Department of Health and Human Services (DHHS) to the Administrator of the Health Care Financing Administration (HCFA). Congress has also provided substantial administrative roles to the States and voluntary insurance organizations in recognition of their experience in the health care and insurance fields.

The law does not permit the Federal Government to exercise supervision or control over the practice of medicine, the manner in which medical services are provided, and the administration or operation of medical facilities. The patient is free to choose any qualified institution, agency, or person offering him/her services. The responsibility for treatment and control of care remains with the individual's physician and the hospital or other facility or agency furnishing services. The individual may keep or obtain any other health insurance he/she desires.

102. FINANCING THE PROGRAM

Part A is financed through separate payroll contributions paid by employees, employers, and self-employed persons. The proceeds are deposited to the account of the Federal Hospital Insurance Trust Fund which is used only for hospital insurance benefits and administrative expenses. The cost of providing Part A benefits to persons who are not Social Security or railroad retirement beneficiaries is met by appropriations to the Federal Hospital Insurance Trust Fund from general revenues or through premium payments.

Part B is financed by monthly premiums of those who voluntarily enroll in the program and by the Federal Government which makes contributions. These funds are deposited in a separate account known as the Federal Supplementary Medical Trust Fund. Money from this fund is used only to pay for Part B benefits and administrative expenses.

104. DISCRIMINATION PROHIBITED

Participating providers of services under the hospital insurance program (e.g., hospitals, skilled nursing facilities (SNFs), home health agencies (HHAs), hospices, outpatient physical therapy (OPT), comprehensive outpatient rehabilitation facilities (CORF), occupational therapy, speech pathology providers and ESRD facilities) must comply with the requirements of title VI of the Civil Rights Act of 1964. Under the provisions of that Act, a participating provider is prohibited from making a distinction on the grounds of race, color, or national origin in the treatment of patients, the use of equipment and other facilities, and the assignment of personnel to provide services.

DHHS is responsible for investigating complaints of noncompliance.

106. FRAUD AND ABUSE - GENERAL

Sections 106 - 106.3 have been moved to the Program Integrity Manual which can be found at the following Internet address: www.hcfa.gov/pubforms/83_pim/pimtoc.htm.

108. ASSIGNMENT OF RESPONSIBILITIES - GENERAL

The DHHS has overall responsibility for administering the hospital insurance program and voluntary SMI program. In exercising this responsibility, the Secretary has delegated certain administrative functions to various components of the department. In addition, as provided by the Social Security Act, a major role in the administration of title XVIII has been given to public and private organizations.

108.1 Role of HCFA.--HCFA is responsible for policy formulation. The central and regional offices are responsible for the general management and operation of the program. In brief, HCFA's responsibilities include the following:

- Determining an individual's entitlement to benefits in consultation with the Social Security Administration (SSA);
- Determining the nature and duration of services for which benefits may be paid;
- Establishing, maintaining, and administering agreements with State agencies, providers of services, and intermediaries;
- Formulating major policies regarding conditions of participation for providers (except SNFs) in consultation with the Public Health Service;
- Developing and maintaining statistical research and actuarial programs;
- Managing general finances of the program; and
- Determining reasonable costs and amounts to be paid.

CHAPTER V
BILLING PROCEDURES

Section

Summary

Inpatient Billing

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Retention and Destruction of Health Insurance Records
Insurance Records

Uniform Billing

Billing in Situations Where Medicare is Secondary Payer

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BILLING PROCEDURES

510.2 Scope of the Term "Facility."--The term "facility" is limited for purposes of furnishing services to individuals as inpatients, i.e., hospitals, university medical centers that own and operate hospitals, SNFs, nursing homes, homes for the aged, or other institutions of a similar nature. Physician services furnished outside the physical premises of the facility are considered furnished "in the facility" if furnished in connection with services received by patients in the facility. For example, if you take your inpatients to the private office of a neurologist for necessary tests such as an encephalograph, the services are considered performed in your facility for purposes of honoring a contractual arrangement under which you bill for them.

In some cases, you purchase services for your patients from a hospital "under arrangements," and such services include a physician component. When the physician has entered into a valid contractual arrangement with the hospital in which his/her services are furnished for it to bill for the services, no additional written authorization is needed for you to bill for his/her services. For example, where you arrange to obtain an EKG interpretation from Hospital B, and Hospital B has a valid contractual arrangement with its cardiologist authorizing it to bill for his/her services, you do not need written authorization from the cardiologist to bill Medicare for the cost of the services.

5l0.3 Indirect Contractual Arrangement.--The necessary contractual arrangement between physicians and the facility in which they perform their services may exist indirectly by reason of the terms of their relationship with an employer and the employer's contractual arrangement with the facility.

EXAMPLE: A professional corporation enters into a contractual arrangement with an SNF to provide physician services for it. Under this arrangement, the SNF alone bills and receives payment for the physician services and pays the corporation a percentage of the charges. The corporation, in turn, employs several physicians to provide the services, and under the terms of their employment, is entitled to any fees payable for the services (other than the portion of the fees retained by the SNF). The combination of the two arrangements - between the SNF and the corporation and the corporation and the physicians - would constitute a contractual arrangement between the SNF and the physicians permitting the SNF to bill and receive Part B payment for the physician services. It is not necessary, in this case, that the employees of the corporation enter into a direct contractual arrangement with the SNF.

5l2. ESTABLISHING THAT A SNF QUALIFIES TO RECEIVE PART B PAYMENT ON THE BASIS OF REASSIGNMENT

A SNF wishing to receive Part B payment as a reassignee of one or more physicians must furnish the carrier sufficient information to establish clearly that it qualifies or does not qualify to receive payment for their services. Where there is any doubt that a SNF qualifies as a reassignee, carriers will obtain additional evidence.

In some cases, a SNF may qualify to receive payment for the services of a physician both as the employer of the physician and as the facility in which the services are performed. As soon as it is determined that a SNF can qualify on either basis, no further development is undertaken with respect to that physician or to other physicians having the same status, and reassigned claims submitted by the SNF for services furnished by those physicians are honored. However, where other physicians have, or appear to have different status, further development is required. It is possible in some instances that a determination is made that Part B payment can be made only to the physician himself.

Where the SNF qualifies as a reassignee, it assumes the same liability for any overpayments which it may receive as a reassignee as the physician would have had if the payment had been made to him/her.

513. FOCUSED MEDICAL REVIEW (FMR)

This section has been moved to the Program Integrity Manual which can be found at the following Internet address: www.hcfa.gov/pubforms/83_pim/pimtoc.htm.

Inpatient Billing

517. SPECIAL INPATIENT BILLING INSTRUCTIONS

General.--Furnish a bill at the time of discharge either after his/her benefits are exhausted or on an interim basis.

517.1 Where Charges Which Include Accommodation Charges Are Incurred in Different Accounting Years.--Do not put accommodation charges incurred in different accounting years on the same bill. (See '5l7.3 when billing for ancillary charges for services furnished on the day of discharge or death when it is also the day after the end of the accounting year.) At the end of the accounting year, submit a bill which contains the charges for all services furnished to the patient since the last bill and through the end of that year. Show services furnished in the following accounting year on a separate bill.

The procedure for completing two bills where charges are incurred in different accounting years does not apply to "no-payment" cases. (See '527.) In a "no-payment" case, submit a bill only upon death, discharge, or change in the level of care from a SNF level to a noncovered level of care.

Claims for services provided prior to the grace period (prior to May 1, 1993) must reflect 1992 codes even if received after the end of the grace period (after July 1, 1993). Claims with dates of services prior to May 1, 1993, which reflect 1993 codes, are denied.

Payment for covered laboratory services furnished on or after September 1, 1992, by laboratories that have a waiver is limited to the following eight procedures:

HCPCS Code		Test
1992	1993	
Q0095	81025	Urine pregnancy test; visual color comparison tests;
Q0096	84830	Ovulation test; visual color comparison test for human luteinizing hormone;
Q0097	83026	Hemoglobin; by copper sulfate method, non-automated;
Q0098	32962	Glucose, blood; by glucose monitoring devices cleared by the FDA specifically for home use;
82270	82270	Blood, occult; feces;
Q0100	81002	Urinalysis by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketone, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of constituents; non-automated, without microcopy;
Q0101	85013	Microhematocrit; spun; and
Q0102	85651	Sedimentation rate, erythrocyte; non-automated.

Effective January 19, 1993, a ninth test was added to the waived test list:

Q0116		Hemoglobin by single analyte instruments with self-contained or component features to perform specimen/reagent interaction, providing direct measurement and readout.

F. Under Arrangements.--When you obtain laboratory tests for outpatients under arrangements with independent laboratories or hospital laboratories, be sure that the laboratory performing the service has a CLIA number.

G. Certificate of Registration.--Initially, you are issued a CLIA number when you apply to the CLIA program.

Billing Part B Intermediary
Outpatient Physical Therapy (OPT) Bills

542. BILLING FOR PART B INTERMEDIARY OPT BILLS

Sections 542 - 544.3 have been moved to the Program Integrity Manual which can be found at the following Internet address: www.hcfa.gov/pubforms/83_pim/pimtoc.htm.