

Medicare Claims Processing Manual

Chapter 6 - SNF Inpatient Part A Billing

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(Rev. 215, 06-25-04)

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

(Rev. 1, 10-01-03)

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 PSS payment and associated consolidated billing requirements.

Any DME or oxygen furnished to inpatients under a Part A spell of illness 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. 92, 2-06-04)

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 of an NF. 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 is moved out of the Medicare-certified DPU of the facility (which renders primarily less than skilled care) and placed elsewhere in the facility;
- 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.

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.

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 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.

10.2 - Types of Facilities Subject to the Consolidated Billing Requirement for SNFs

(Rev. 1, 10-01-03)

Consolidated billing applies to:

- Participating SNFs;
- Short term hospitals, long term hospitals, and rehabilitation hospitals certified as swing bed hospitals, except CAHs certified as swing bed hospitals.

But does not apply to:

- A nursing home that is not Medicare-certified, such as:
 - A nursing home that does not participate at all in either the Medicare or Medicaid programs;

- o A non-certified part of a nursing home that also includes a participating distinct part SNF unit; and
- o A nursing home that exclusively participates in the Medicaid program as an NF.

Medicare Coordinated Care Demonstration

Services for beneficiaries covered under the Medicare Coordinated Care Demonstration will not be subject to consolidated billing. Common Working File (CWF) will appropriately edit for these codes so that the carriers will pay them separately.

10.3 - Types of Services Subject to the Consolidated Billing Requirement for SNFs

(Rev. 1, 10-01-03)

As previously discussed, the consolidated billing requirement applies to all services furnished to a SNF resident in a covered Part A stay (other than the excluded service categories described below) and for physical, occupational and, or speech language therapy services provided to residents and paid under Part B. Examples of services that are subject to consolidated billing include:

- Physical, occupational, and speech-language therapy services, regardless of whether they are furnished by (or under the supervision of) a physician or other health care professional (see §1888(e)(2)(A)(ii) of the Act). Physical, occupational, and speech-language therapy services (other than audiology services, which are considered diagnostic tests rather than therapy services) furnished to a SNF resident during a noncovered stay must still be billed by the SNF itself.
- Psychological services furnished by a clinical social worker; and
- Services furnished as an “incident to” the professional services of a physician or other excluded category of health care professional described below.

20 - Services Included in Part A PPS Payment Not Billable Separately by the SNF

(Rev. 92, 2-06-04)

SNF-515

For cost reporting periods beginning on and after July 1, 1998, SNF services paid under Part A include posthospital SNF services for which benefits are provided under Part A, and all items and services which, prior to July 1, 1998, had been paid under Part B but furnished to SNF residents during a Part A covered stay regardless of source, except for

the exclusions listed in the SNF Help File. View the SNF Help file at http://cms.hhs.gov/manuals/104_claims/clm104c06snfhelp.pdf or download a copy of the file at http://cms.hhs.gov/manuals/104_claims/clm104c06snfhelp.zip. This file lists services by HCPCS code and describes their status with respect to whether the service is included in the Part A PPS payment or if the service can be billed separately under Part B. For separately billable services the file also describes whether the SNF is required to bill or whether the rendering provider/supplier must bill. Some services must be billed by the SNF while others must be billed by the rendering provider (SNF or otherwise).

Services paid under Part A cannot be billed under Part B. Any service paid under Part A that is billed separately will not be paid separately, or payment will be recovered if already paid at the time of the SNF billing. The following subsections list the types of services that can be billed under Part B for SNF residents for whom Part A payment is made.

20.1 – Services Beyond the Scope of the Part A SNF Benefit

(Rev. 76, 02-06-04)

The following services are beyond the scope of the SNF Part A benefit and are excluded from payment under Part A SNF PPS and from the requirement for consolidated billing. These services must be paid to the practitioner or provider that renders them and are billed separately by the rendering provider/supplier/practitioner to the carrier or FI. The SNF may not bill excluded services separately under Part B for its inpatients entitled to Part A benefits. HCPCS procedure codes representing these excepted services are updated as frequently as quarterly on the CMS Web site: <http://www.cms.hhs.gov/manuals/> and are updated to the SNF Help File. Physicians, non-physician practitioners, and suppliers billing the carrier should consult the CMS Web site at www.cms.hhs.gov/medlearn/snfcode.asp for lists of separately billable services.

20.1.1 - Physician's Services and Other Professional Services Excluded From Part A PPS Payment and the Consolidated Billing Requirement

(Rev. 1, 10-01-03)

SNF-516.A, SNF-516.1

Except for the therapy services, the professional component of physician services and services of certain nonphysician providers listed below are excluded from Part A PPS payment and the requirement for consolidated billing, and must be billed separately by the practitioner to the carrier.

For this purpose “physician service” means the professional component of the service. The technical component, if any, must be billed by the SNF for its Part A inpatients. The carrier will pay only the professional component to the physician.

- Physician's services other than physical, occupational, and speech-language therapy services furnished to SNF residents;
- Physician assistants, not employed by the SNF, working under a physician's supervision;
- Nurse practitioners and clinical nurse specialists, not employed by the SNF, working in collaboration with a physician;
- Certified nurse-midwives;
- Qualified psychologists; and
- Certified registered nurse anesthetists.

Providers with the following specialty codes assigned by CMS upon enrollment with Medicare are considered physicians for this purpose. Some limitations are imposed by §§1861(q) and (r) of the Act. These providers may bill their carrier directly.

Physician Specialty Codes

01 General Practice	02 General Surgery
03 Allergy/Immunology	04 Otolaryngology
05 Anesthesiology	06 Cardiology
07 Dermatology	08 Family Practice
10 Gastroenterology	11 Internal Medicine
12 Osteopathic Manipulative Therapy	13 Neurology
14 Neurosurgery	16 Obstetrics Gynecology
18 Ophthalmology	19 Oral Surgery (Dentists only)
20 Orthopedic Surgery	22 Pathology
24 Plastic and Reconstructive Surgery	25 Physical Medicine and Rehabilitation
26 Psychiatry	28 Colorectal Surgery (formerly Proctology)
29 Pulmonary Disease	30 Diagnostic Radiology
33 Thoracic Surgery	34 Urology
35 Chiropractic	36 Nuclear Medicine

Physician Specialty Codes

37 Pediatric Medicine	38 Geriatric Medicine
39 Nephrology	40 Hand Surgery
41 Optometry	44 Infectious Disease
46 Endocrinology	48 Podiatry
66 Rheumatology	69 Independent Labs
70 Multi specialty Clinic or Group Practice	76 Peripheral Vascular Disease
77 Vascular Surgery	78 Cardiac Surgery
79 Addiction Medicine	81 Critical Care (Intensivists)
82 Hematology	83 Hematology/Oncology
84 Preventive Medicine	85 Maxillofacial Surgery
86 Neuropsychiatry	90 Medical Oncology
91 Surgical Oncology	92 Radiation Oncology
93 Emergency Medicine	94 Interventional Radiology
98 Gynecological/Oncology	99 Unknown Physician Specialty

Nonphysician Provider Specialty Codes

42 Certified Nurse Midwife	43 Certified Registered Nurse Anesthetist, Anesthesia Assistants (effective 1/1/89)
50 Nurse Practitioner	62 Clinical Psychologist (billing independently)
68 Clinical Psychologist	89 Certified Clinical Nurse Specialist
97 Physician Assistant	

NOTE: Some HCPCS codes are defined as all professional components in the fee schedule. Fee schedule definitions apply for this purpose.

20.1.1.1 - Correct Place of Service (POS) Code for SNF Claims

(Rev. 1, 10-01-03)

Per Chapter 26 of this manual, POS code 31 should be used with services for patients in a Part A covered stay and POS code 32 should be used with services for beneficiaries in a noncovered stay. Carriers should adjust their prepayment procedure edits as appropriate.

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

(Rev. 200, 06-10-04)

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.

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).

Outpatient Surgery and Related Procedures– INCLUSION

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.

20.1.2.1 - Emergency Services

(Rev. 200, 06-10-04)

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 - Services Excluded from Part A PPS Payment and the Consolidated Billing Requirement on the Basis of Beneficiary Characteristics and Election

(Rev. 92, 2-06-04)

SNF-516

These services must be provided to specific beneficiaries, either: (A) End Stage Renal Disease (ESRD) beneficiaries, or (B) beneficiaries who have elected hospice, by specific licensed Medicare providers, and are excluded from SNF PPS and consolidated billing.

SNFs will not be paid for Category II.A. services (dialysis, etc.) when the SNF is the place of service. To receive Medicare payment, these services must be provided in a renal dialysis facility. Hospices must also be the only type of provider billing hospice services.

In transmittals for FI billing that provide the annual update list of HCPCS codes affected by SNF consolidated billing, such services are referred to as “Major Category II” of SNF consolidated billing editing. See §10.1 above for the link to where transmittals providing current lists of HCPCS codes used for edits for these types of services, known as “Major Category II” in SNF consolidated billing editing for FIs.

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

(Rev. 1, 10-01-03)

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.

- 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;
- 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. 92, 2-06-04)

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);
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.

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

20.2.1.2 - Coding Applicable to Services Provided in a Renal Dialysis Facility (RDF)

(Rev. 1, 10-01-03)

SNF-516.6

Institutional dialysis services billed only by a RDF are identified by type of bill 72X. Services for Method 2 ESRD beneficiaries billed by a RDF must be accompanied by the dialysis related diagnosis code 585.

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

(Rev. 92, 2-06-04)

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

- 825 - Hemodialysis OPD/Home Support Services;
 - 835 - Peritoneal OPD/Home Support Services;
 - 845 - Continuous Ambulatory Peritoneal Dialysis OPD/Home Support Services;
- or

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

20.2.1.4 - Coding Applicable to EPO Services

(Rev. 92, 2-06-04)

SNF-543

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

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

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

Total units given in the period are placed in value code 48.

IV. 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 636.

20.2.2 – Hospice Care for a Beneficiary’s Terminal Illness

(Rev. 1, 10-01-03)

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 occurrence code 07. Such unrelated services are included in SNF PPS and consolidated billing.

20.3 – Other Services Excluded from SNF PPS and Consolidated Billing

(Rev. 92, 2-06-04)

SNF-515.1

The following services may be billed separately under Part B by the rendering provider, supplier, or practitioner (other than the SNF that receives the Part A PPS payment) and paid to the entity that furnished the service. These services may be provided by any Medicare provider licensed to provide them, other than the SNF that receives the Part A PPS payment, and are excluded from Part A PPS payment and the requirement for consolidated billing, and are referred to as “Major Category III” for consolidated billing edits applied to claims submitted to FIs.

- An ambulance trip (other than a transfer to another SNF) that transports a beneficiary to the SNF for the initial admission or from the SNF following a final discharge;
- Certain chemotherapy and chemotherapy administration services. The chemotherapy administration codes are included in SNF PPS payment for beneficiaries in a Part A stay when performed alone or with other surgery, but are excluded if they occur with the same line item date of service as an excluded chemotherapy agent. A chemotherapy agent must also be billed when billing these services, and physician orders must exist to support the provision of chemotherapy;
- Certain radioisotope services;

- Certain customized prosthetic devices;
- For services furnished during 1998 only, the transportation costs of electrocardiogram equipment for electrocardiogram test services; and
- All services provided to risk based MCO beneficiaries. These beneficiaries may be identified with a label attached to their Medicare card and/or a separate health insurance card from an MCO indicating all services must be obtained or arranged through the MCO.

HCPCS code ranges for chemotherapy, chemotherapy administration, radioisotopes, and customized prosthetic devices are set in statute. The statute also gives the Secretary authority to make modifications in the particular codes that are designated for exclusion within each of these service categories. See §10.1 above for the link to where transmittals providing current lists of HCPCS codes used for Major Category III SNF consolidated billing editing for FIs can be found.

20.3.1. - Ambulance Services

(Rev. 92, 2-06-04)

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 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.

Note that ambulance trips associated with services provided in renal dialysis facilities (RDFs) are also excluded from SNF consolidated billing. 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. 92, 2-06-04)

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.

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. 92, 2-06-04)

Therapy services are edited as inclusions, rather than exclusions, to consolidated billing. Therapies must be billed by the SNF alone for its Part B residents and non-residents. 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.

30 - Billing SNF PPS Services

(Rev. 1, 10-01-03)

SNF-515.3, PM A-01-056, PM A-02-016 (CR-1666)

SNFs and hospital swing bed providers are required to report inpatient Part A PPS billing data as follows. 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:

- In addition to the required fields identified in the Medicare Claims Processing Manual, Chapter 25, “Completing and Processing the UB-92 (CMS-1450) Data Set,” SNFs must also report occurrence span code “70” to indicate the dates of a qualifying hospital stay of at least three consecutive days which qualifies the beneficiary for SNF services.
- Separate bills are required for each Federal fiscal year for admissions that span the annual update effective date (October 1.)
- Use Type of Bill 21X for SNF inpatient services or 18X for hospital swing bed services.
- Revenue Code, (Record Type (RT) 60, field 5), ANSI X12N 837 I Health Care Claim 2-395-SV201, and Health Care Claim: ANSI X12N 837 I version 4010 SV201 must contain revenue code 0022. This code indicates that this claim is

being paid under the SNF PPS. This revenue code can appear on a claim as often as necessary to indicate different HIPPS Rate Code(s) and assessment periods.

- There must be a line item on the claim for each assessment period represented on the claim with revenue code 0022. This code indicates that this claim is being paid under SNF PPS. This revenue code can appear on a claim as often as necessary to indicate different HIPPS rate code(s) and assessment periods.
- The line item date of service date (RT 60, field 12), ANSI X12N 837 I Health Care Claim, must contain an assessment reference date (ARD) when FL 42 contains revenue code 0022 unless FL 44 contains HIPPS rate code AAA00.
- HCPCS/Rates, (RT 60, field 6), ANSI X12N 837 I Health Care Claim 2-395-SV201-02, and Health Care Claim: Institutional ANSI X12N 837 I version 4010 SV201-02 must contain a 5-digit “HIPPS Code” (AAA00-SSC78). The first three positions of the code contain the RUG III group and the last two positions of the code contain a 2-digit assessment indicator (AI) code. See Tables 1 and 2 below for valid RUG codes and AI codes.
- Service Units, (RT 60, field 9), Medicare A 837 I Health Care Claim version 3051, 2-395-SV205, and Health Care Claim: Institutional 837 I version 4010 2400 SV205 must contain the number of covered days for each HIPPS rate code. The number of units for revenue codes 0022 must equal to the number of covered days minus leave of absence days shown with revenue code 018x.
- Total Charges, (RT 60, field 10), ASC X-12 837 I Health Care Claim version 3051, 2-395-SV203, and Health Care Claim: Institutional ANSI X12N 837 I version 4010 2400 SV203 should be zero total charges when the revenue code is 0022.
- When a HIPPS rate code of RUAxx, RUBxx and/or RUCxx is present, a minimum of two rehabilitation therapy ancillary codes are required (revenue code 042x and/or, 043x and/or, 044x). When a HIPPS rate code of RHAxx, RHBxx, RHCxx, RLAxx, RLBxx, RMAxx, RMBxx, RMCxx, RVAxx, RVBxx and/or RVCxx is present, a minimum of one rehabilitation therapy ancillary revenue code is required (revenue code 042x, 043x, or 044x. Bills that are missing required rehabilitation therapy ancillary revenue codes are to be returned to the SNF for resubmission.
- The accommodation revenue code 018x, leave of absence is reported.

30.1 - Health Insurance Prospective Payment System (HIPPS) Rate Code

(Rev. 1, 10-01-03)

The HIPPS rate code consists of the three-character resource utilization group (RUG) code (see Table 1 below) that is obtained from the “Grouper” software program followed by a 2-digit AI (see Table 2 below) that specifies the type of assessment associated with

the RUG code obtained from the Grouper. SNFs must use the version of the Grouper software program identified by CMS for national PPS as described in the Federal Register for that year. The Grouper translates the data in the Long Term Care Resident Instrument into a case-mix group and assigns the correct RUG code. The AIs were developed by CMS. The Grouper will not automatically assign the 2-digit AI, except in the case of a swing bed MDS that is will result in a special payment situation AI (see below). The HIPPS rate code that appears on the claim must match the assessment that has been transmitted and accepted by the State in which the facility operates. The SNF cannot put a HIPPS rate code on the claim that does not match the assessment.

TABLE 1: RUG CODES

AAA (the default code)

BA1, BA2, BB1, BB2

CA1, CA2, CB1, CB2, CC1, CC2

IA1, IA2, IB1, IB2

PA1, PA2, PB1, PB2, PC1, PC2, PD1, PD2, PE1, PE2

RHA, RHB, RHC, RLA, RLB, RMA, RMB, RMC, RUA, RUB, RUC, RVA, RVB, RVC

SE1, SE2, SE3, SSA, SSB, SSC

TABLE 2 ASSESSMENT INDICATOR CODES (effective July 1, 2002)

Code	Definition
00	Default code
01	5-day Medicare-required assessment/not an initial admission assessment
02	30-day Medicare-required assessment
03	60-day Medicare-required assessment
04	90-day Medicare-required assessment
05	Readmission/Return Medicare-required assessment
07	14-day Medicare-required assessment/not an initial admission assessment
08	Other Medicare-required assessment (OMRA) with an ARD set on day 9, 10, 20, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 93, 94, 95, 96, 97, 98, 99 or 100 of the

Code	Definition
	covered stay.
11	5-day (or readmission/return) Medicare-required assessment AND initial admission assessment
17	14-day Medicare-required assessment AND initial admission assessment. This code is used to signify that the bill is based on an assessment that is satisfying two requirements: the clinical requirement for an Initial Admission Assessment and the Medicare payment requirement for a 14-day assessment
18	OMRA replacing 5-day Medicare-required assessment. This code is used to signify that the bill is based on an OMRA that was performed within the window of a Medicare required 5-day assessment and “replaces” the Medicare required 5-day assessment. This combination of assessment type is extremely rare and accordingly, this code will not likely be used often.
*19	Special payment situation – 5-day assessment (effective July 1, 2002)
28	OMRA replacing 30-day Medicare-required assessment. This code signifies that the HIPPS rate code is based on an OMRA with an ARD set within the window of a Medicare required 30-day assessment and thus “replaces” the Medicare required 30 day assessment.
*29	Special payment situation – 30-day assessment (effective July 1, 2002)
30	Significant Change in Status Assessment (SCSA) with an ARD set on day 9, 10, 20, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 93, 94, 95, 96, 97, 98, 99, or 100 of the covered stay. An SCSA is performed for clinical reasons as defined in the most current version of the Long Term Care Resident Assessment Instrument User’s Manual.
31	SCSA replaces 5-day Medicare-required assessment This code signifies that the HIPPS rate code is based on a SCSA, that was performed for clinical reasons, with an ARD set within the window of a Medicare required 5-day assessment and thus “replaces” the Medicare-required 5-day assessment.
32	SCSA replaces 30-day Medicare-required Assessment. This code signifies that the HIPPS rate code is based on a SCSA with an ARD set within the assessment window for a readmission/return assessment and thus replaces the readmission/return assessment.
33	SCSA replaces 60-day Medicare-required assessment. This code signifies that the HIPPS rate code is based on a SCSA, that was performed for clinical reasons, with an ARD set within the window of a Medicare required 60-day

Code	Definition
	assessment and thus “replaces” the Medicare-required 60-day assessment.
34	SCSA replaces 90-day Medicare-required assessment. This code signifies that the HIPPS rate code is based on a SCSA, that was performed for clinical reasons, with an ARD set within the window of a Medicare required 90-day assessment and thus “replaces” the Medicare-required 90-day assessment.
35	SCSA replaces a readmission/return assessment. This code signifies that the HIPPS rate code is based on a SCSA, that was performed for clinical reasons, with an ARD set within the window of a readmission/return assessment and thus “replaces” the readmission/return assessment.
37	SCSA replaces 14-day Medicare-required assessment. This code signifies that the HIPPS rate code is based on a SCSA, that was performed for clinical reasons, with an ARD set within the window of a Medicare required 14-day assessment and thus “replaces” the Medicare-required 14-day assessment.
38	Effective 10-01-00, OMRA replacing 60-Day Medicare-Required Assessment.. Prior to 10-01-00, AI 38 included both an OMRA and an SCSA with an ARD set on day 9, 10, 20, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 93, 94, 95, 96, 97, 98, 99, or 100 of the covered stay.
*39	Special payment situation – 60-day assessment (effective July 1, 2002)
40	Significant Correction of a Prior Assessment (SCPA) with an ARD set on day 9, 10, 20, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 93, 94, 95, 96, 97, 98, 99, or 100 of the covered stay.
41	SCPA replaces 5-day Medicare required assessment. This code signifies that the HIPPS rate code is based on a SCPA with an ARD set within the assessment window for a 5-day Medicare required assessment and thus “replaces” the Medicare required 5-day assessment.
42	SCPA replaces 30-day Medicare-required assessment. This code signifies that the HIPPS rate code is based on a SCPA with an ARD set within the assessment window for a 30-day Medicare required assessment and thus “replaces” the Medicare required 30-day assessment.
43	SCPA replaces 60-day Medicare-required assessment. This code signifies that the HIPPS rate code is based on a SCPA with an ARD set within the assessment window for a 60-day Medicare required assessment and thus “replaces” the Medicare required 60-day assessment.

Code	Definition
44	SCPA replaces 90-day Medicare-required assessment. This code signifies that the HIPPS rate code is based on a SCPA with an ARD set within the assessment window for a 90-day Medicare required assessment and thus “replaces” the Medicare required 90-day assessment.
45	SCPA replaces a Readmission/Return assessment. This code signifies that the HIPPS rate code is based on a SCPA that was performed within the assessment window of a readmission/return assessment and thus “replaces” the readmission/return assessment.
47	SCPA replaces 14-day Medicare-required assessment. This code signifies that the HIPPS rate code is based on a SCPA with an ARD set within the assessment window for a 14-day Medicare required assessment and thus “replaces” the Medicare required 14-day assessment.
48	OMRA replaces 90-day Medicare-required assessment. This code signifies that the HIPPS rate code is based on an OMRA that was performed within the assessment window of a 90-day Medicare required assessment and thus “replaces” the Medicare required 90-day assessment.
*49	Special payment situation – 90-day assessment (effective July 1, 2002)
54	90-day Medicare assessment that is also a quarterly assessment
78	OMRA replaces 14-day Medicare-required assessment. This code signifies that the HIPPS rate code is based on an OMRA that was performed within the assessment window of a 14-day Medicare required assessment and thus “replaces” the Medicare-required 14-day assessment.
*79	Special payment situation – 14-day assessment (effective July 1, 2002)

*In some situations, beneficiaries may change payer source after admission, but fail to notify the provider in a timely manner, e.g., disenrollment from an HMO, disenrollment from a hospice, change in Medicare payer status from secondary to primary, etc. Problems may also occur in payment ban situations where the SNF may not receive timely notification that a payment ban has been lifted. In these cases, the provider may not have completed the RAI assessments needed for Medicare billing. New AI codes were established for these special payment situations.

AI codes are only used for billing Medicare for covered SNF Part A stays. To the extent possible, every combination of reasons for RAI assessment relevant for payment under Part A PPS has been captured by the HIPPS AI codes. However, to avoid undue complexity and because the information is not relevant for payment, there are some combinations that are not specifically identifiable using the codes. This means that although there are instances in which all of the information contained on the long term care resident assessment instrument is not captured by the HIPPS AI code, it is still an accurate code for billing purposes. From the standpoint of Medicare payment, it does not

matter if Medicare-required assessments are also used to fulfill the clinical requirements for an SCSA or a Quarterly Assessment.

30.2 – Special Billing Requirements Where a Single OMRA, SCSA, or SCPA ARD is Set Within the Window of a Medicare-Required Assessment

(Rev. 1, 10-01-03)

PM-A-01-56, PM-A-01-124 (CR-1655)

For a full explanation of the assessments required that support billing see §2837 of the Medicare Provider Reimbursement Manual. Where an OMRA, SCSA, or SCPA is the only assessment that occurs during the assessment window of a Medicare – required assessment, the SNF must use the HIPPS rate code generated from this assessment in place of the HIPPS code generated from the Medicare-required assessment to bill Medicare. The HIPPS rate code generated from the OMRA, SCSA, or SCPA that “replaces” the Medicare-required assessment must be billed beginning with the ARD found on the replacement assessment only if the ARD was not set on a grace day. Where the ARD for the replacement assessment is set on a grace day, the HIPPS rate code generated from the replacement assessment must be billed beginning on the day the payment rate would have changed for the Medicare-required assessment that was replaced.

EXAMPLE 1

The ARD of an OMRA is set on day 22 of the Part A covered stay. The OMRA is the only assessment performed within the assessment window for the 30-day Medicare-required assessment, therefore, the OMRA replaces the Medicare-required 30-day assessment. The HIPPS rate code derived from the OMRA is billed beginning on day 22 and may continue for up to the number of days in between the ARD on the replacement assessment until the next assessment, assuming the receipt of medically necessary covered services.

EXAMPLE 2

The ARD of an OMRA is set for day 32 of the covered Part A stay. The OMRA is the only assessment performed within the assessment window for the 30-day Medicare-required assessment, therefore, the OMRA replaces the Medicare-required 30-day assessment. The HIPPS rate code derived from the OMRA is billed beginning on day 31, since the ARD for the OMRA replacing the 30-day Medicare-required assessment was set on a grace day.

30.3 – Special Billing Requirements Where There are Multiple Assessments (i.e., OMRA, SCSA, or SCPA) Within the Window of a Medicare-Required Assessment

(Rev. 1, 10-01-03)

While not a common occurrence, there may be situations in which multiple assessments are performed within one Medicare-required assessment window, including the grace days. In these instances, the OMRA, SCSA, or SCPA that occurs first must replace the Medicare-required assessment. Any other assessment performed in the assessment window, including the grace days must be billed as a stand-alone assessment and cannot replace the Medicare-required assessment. The SNF is required to bill the HIPPS rate code derived from the replacement assessment beginning with the ARD on the assessment. The HIPPS rate code derived from the replacement assessment may continue until the ARD on the next assessment, assuming the receipt of medically necessary covered services.

EXAMPLE 1

A SNF sets the ARD for a SCSA on day 22 of the covered stay. The beneficiary is “grouped” into a rehabilitation RUG. Therapy ends on day 24, and the SNF performs an OMRA with an ARD of day 33. The SNF must use the SCSA with the ARD of day 22 of the covered stay to replace the Medicare-required assessment. The OMRA with an ARD that fell on day 33 of the stay cannot replace the Medicare-required assessment since it has already been replaced by the SCSA. Payment to the SNF will change on day 22 (the ARD of the SCSA), since the SCSA must be used to replace the Medicare-required assessment, and then again on day 33 of the covered stay, based on the OMRA. The payment associated with the RUG code derived from the OMRA may continue for up to the number of days in between the ARD on the OMRA and the next assessment, assuming the receipt of medically necessary covered services.

30.4 - Coding PPS Bills for Ancillary Services

(Rev. 1, 10-01-03)

When coding PPS bills for ancillary services associated with a Part A inpatient stay, the traditional revenue codes will continue to be shown, e.g., 0250 - Pharmacy, 042x - Physical Therapy, in conjunction with the appropriate entries in Service Units and Total Charges.

- SNFs are required to report the number of units based on the procedure or service. Specific instructions for reporting units are contained in the specific section for the procedure or service.
- SNFs are required to report the actual charge for each line item, in Total Charges.

30.5 - Adjustment to Health Insurance Prospective Payment System (HIPPS) Codes Resulting From Long Term Care Resident Assessment Instrument (RAI) Corrections

(Rev. 1, 10-01-03)

SNF-515.5, PM A- 00-46, PM A-01-121, CR-1224

The RAI is an assessment tool completed by facility clinical staff that is transmitted electronically to state agencies and then transferred to CMS, and is used to determine a RUG-III code. The 3-digit RUG-III code and the 2-digit AI make up the HIPPS code that appears on the bill, and is used to determine the payment rate for the SNF PPS. Effective for services provided on and after June 1, 2000, SNFs must submit adjustment requests to reflect corrections to the RAI that result in changes to the RUG-III code (i.e., the first three digits of the HIPPS code).

Instructions on the types of errors SNFs may correct within the RAI are available at <http://cms.hhs.gov/medicaid/mds20/default.asp> under Data Specifications. The document is titled "March 2000 Provider Instructions for Making Automated Corrections Using the New MDS Correction Request Form." Please check this page often for timely RAI announcements, corrections, and updates.

Correction to RAI data may affect items that are used in the RUG-III grouper calculations, and could change the RUG-III group for which a beneficiary qualifies. An example of a valid correction would be a change to MDS v 2.0 item M1b, number of stage two ulcers. If the facility reported zero stage two ulcers when there were really three ulcers present, the item should be corrected using this process.

An adjustment request must be submitted if the RAI correction results in a HIPPS code that is different from that already billed and paid. The adjustment request is retroactive to the first date payment was made using the original (but incorrect) HIPPS rate code. An RAI correction is not a new assessment, and can never be used as a replacement for a Medicare-required assessment.

EXAMPLE 1

A Medicare 5-day assessment was completed timely and used to establish the HIPPS rate code for days 1-14 of the Part A covered stay. The bill was paid before the SNF found the error. (The error on that 5-day assessment was identified on day 17 while staff was completing the Medicare 14-day assessment.) The facility corrects the 5-day assessment, and submits an adjustment request for days 1-14 of the Part A stay. Use SNF adjustment condition code D2 in this situation.

EXAMPLE 2

On day 39 of the Part A stay, the SNF identifies an error in a 30-day Medicare-required assessment. Five days of service had already been billed and paid based on the HIPPS

code generated from that 30-day Medicare assessment. The SNF submits an RAI correction to the state that results in a change in the RUG group. The SNF submits an adjustment request to the FI for the five days of service using the corrected HIPPS rate code. Then, the corrected HIPPS rate code is used for billing any remaining covered days in the applicable payment period.

The SNF must document the reason for an RAI correction and certify to the accuracy of the correction. This documentation must be kept in the medical record. Review of this documentation must be incorporated into the FI medical review process.

To meet the clinical RAI requirements, SNFs may be required to perform an SCSA or SCPA in addition to completing the RAI correction. As long as the RUG-III group generated from the RAI correction and the SCSA or SCPA are the same, the SNF can use the corrected assessment to derive the HIPPS rate code in order to bill any remaining covered days in the applicable payment period (e.g., days 31-60 for the 30-day assessment). However, since the SCSAs and the SCPAs require a new observation period and new ARDs, it is possible that the RUG-III group generated by the SCSA or SCPA assessment will be different. In this case, the corrected assessment would be used from the first day of the applicable payment period (e.g., days 31-60 for the 30-day assessment) until the ARD of the SCSA or SCPA assessment. If the ARD for the SCSA or SCPA is within the assessment window, the SCSA or SCPA must also be used as a replacement for the next Medicare-required assessment.

RAI corrections may also be processed to inactivate an RAI record. Some examples of records that should be inactivated include assessment data submitted under the Health Insurance Claim (HIC) number for a different beneficiary, or a record transmitted with the wrong reason for assessment. In most cases, the SNF will also have filed an accurate, timely RAI for the beneficiary, which can be used to derive a HIPPS rate code for billing purposes. If the SNF did not realize the error until a claim had been submitted and paid, the SNF would submit an adjustment request. However, this type of adjustment does not involve a correction of RAI clinical data, and is not subject to the clinical data correction procedures described above. This type of adjustment request would use the regular SNF adjustment condition code, D5. In those rare situations where an RAI is inactivated and there is no valid HIPPS code for that payment period, the SNF must submit an adjustment request at the default rate (AAA00) for the applicable covered days of service. Effective for services provided on and after June 1, 2000, SNFs must submit adjustment requests to reflect corrections to the RAI that result in changes to the RUG-III code (i.e., the first three digits of the HIPPS code).

30.5.1 - Adjustment Requests

(Rev. 1, 10-01-03)

Adjustment request based on corrected assessments must be submitted within 120 days of the service “through” date. The “through” date will be used to calculate the period during which adjustment requests may be submitted based on corrected RAI assessments. The “through” date indicates the last day of the billing period for which the HIPPS code is

billed. Adjustment requests based on corrected assessments must be submitted within 120 days of the “through” date on the bill. An edit is in place to limit the time for submitting this type of adjustment request to 120 days from the service “through” date.

The CMS expects that most HIPPS code corrections will be made during the course of the beneficiary’s Medicare Part A stay. Therefore, providers that routinely submit corrections after the beneficiary’s Part A stay has ended may be subject to focused medical review.

Adjustment requests to change a HIPPS code may not be submitted for any claim that has already been medically reviewed, such claims are identified in the FI’s system by an indicator on the claim record. This applies whether or not the medical review was performed either pre- or post-payment. All adjustment requests submitted are subject to medical review. Information regarding medical review is located in the Medicare Program Integrity Manual.

Billing errors for an incorrect HIPPS code prior to June 1, 2000, cannot be adjusted. However, the requirement that providers may not knowingly over bill the Medicare program remains in effect. SNFs that identify patterns of errors that result in overpayments must report them to the FI, and these overpayments must be recouped. A pattern of errors includes but is not limited to software errors in transmitting RAI files, misunderstandings of RAI instructions that result in consistent miscoding of one or more RAI items used in determining the RUG-III group, etc.

40 - Special Inpatient Billing Instructions

(Rev. 1, 10-01-03)

SNF-517, SNF-561

SNFs bill upon the following:

- Discharge;
- Benefit exhaustion;
- A decrease in level of care to less than skilled care; or
- Monthly (and if necessary, monthly thereafter).

Each bill must include all diagnoses applicable to the admission. However, SNFs do not include charges that were billed on an earlier bill. The “from” date must be the day after the “through” date on the prior bill.

40.1 - Submit Bills in Sequence

(Rev. 1, 10-01-03)

SNF-517.13, A3-3603.2

SNFs must submit bills in sequence for each beneficiary they service. The FI will return to the SNF a continuing stay bill if the prior bill has not been processed. When the FI receives an out-of-sequence claim for a continuous stay, it will search its history for the prior adjudicated claim. If the prior bill has not been finalized, the FI will return to the provider (RTP), the incoming bill, request that the prior bill be submitted first, and the returned bill only be submitted after the SNF receives notice of adjudication of the prior bill. A typical error message follows:

Bills for a continuous stay or admission must be submitted in the same sequence in which services are furnished. If the provider has not already done so, please submit the prior bill. Then, resubmit this bill after you receive the remittance advice for the prior bill.

If the prior bill was submitted, the SNF will hold the returned bill until it receives a remittance advice for the prior bill.

40.2 - Reprocessing Inpatient Bills in Sequence

(Rev. 1, 10-01-03)

SNF-517.14, A3-3603.2

If a SNF, any beneficiary, or secondary insurer are disadvantaged by the CWF's first-in/first-out (FI/FO) processing, the SNF must notify the FI to arrange reprocessing of all affected claims. The FI will verify and cancel any bills posted out-of-sequence and request that any other FI involved also cancel any affected bills. The intermediaries will reprocess all bills in the benefit period in the sequence of the beneficiary's stays to properly allocate days where payment is made in full by Medicare and to identify those days where the beneficiary is required to pay coinsurance.

This is only an issue when the beneficiary experiences multiple admissions (to the same or different facilities) during the benefit period. This situation occurs most often when long-term care hospitals are involved.

This approach is only used when the beneficiary, other insurer, or provider have increased liability as a result of out-of-sequence processing. It is not used if the liability stays the same, e.g., if the deductible is applied on the second stay instead of the first, but there is no issue with regard to the effective date of supplementary coverage.

40.3 - Determining Part A Admission Date, Discharge Date, and Utilization Days

(Rev. 1, 10-01-03)

SNF-515.4, SNF-515.4

40.3.1 - Date of Admission

(Rev. 1, 10-01-03)

The beneficiary, entitled to Part A benefits, becomes a SNF resident for Part A PPS billing purposes when admitted to a Medicare certified bed. 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.

40.3.2 - Patient Readmitted Within 30 Days After Discharge

(Rev. 1, 10-01-03)

SNF-517.5, A3-3630

A patient is deemed not to have been discharged if the time between SNF discharge and readmission to the same or another SNF is within 30 days. (See the Medicare Benefit Policy Manual, Chapter 8, “Coverage of Extended Care Services (SNF) Under Hospital Insurance,” §20.2.) However, if more than 30 days elapse after the patient’s discharge from a participating SNF or after his/her transfer to a nonparticipating part of the institution, the patient must again meet the 3-day hospital stay requirement to become eligible for SNF benefits.

When a discharge bill has been sent and the patient is readmitted to the SNF within 30 days, the SNF must submit another bill, which shows the current admission date and the following additional data.

- The SNF must complete condition code “57” on the claim to indicate the patient previously received Medicare covered SNF care within 30 days of the current SNF admission.
- The SNF must complete occurrence span code “70” to indicate the qualifying stay dates for a hospital stay of at least 3 days which qualifies the patient for payment of the SNF level of care services billed on the claim.

If a discharge bill has not been sent at the time of readmission, the SNF must submit an interim bill with occurrence code “74” to show the from/through dates of the leave of absence (the period the patient was not in the facility) and the number of noncovered days.

40.3.3 - Same Day Transfer

(Rev. 1, 10-01-03)

A3-3610.5, A3-3620, SNF-517.6

The day of admission counts as a utilization day except in the situation where the patient was admitted with the expectation that he remain overnight but was transferred to another participating provider before midnight of the same day. In this instance, the first provider completes the bill as follows:

- Indicate “0” in Covered Days;
- Insert condition code “40” to indicate the patient was transferred from one participating provider to another before midnight on the day of admission; and,
- Admission date, statement “from” and “through” dates are the same.

The provider to which the patient was transferred counts the admission day as a utilization day that includes the day of admission.

Only the second SNF may bill for accommodation and ancillary charges.

This general rule applies to transfers between SNFs. However, under these same circumstances, if the two providers represent an institution composed of a participating hospital and a distinct part participating SNF, the first provider cannot bill for accommodations, but may bill for ancillary charges.

40.3.4 - Day of Discharge, Death, or Leave of Absence

(Rev. 1, 10-01-03)

SNF-517.6, SNF-515.4 (transmittal 368)

The beneficiary is considered discharged from the SNF when any of the following occur:

- The beneficiary is admitted as an inpatient to a Medicare participating hospital or critical access hospital or admitted as a resident to another SNF. Even if the beneficiary returns to the SNF by midnight of the same day, the beneficiary is considered discharged, and the admitting hospital or critical access hospital is responsible for billing. This is because these settings represent situations in which the admitting facility has assumed responsibility for the beneficiary’s comprehensive health care needs.

The SNF should submit a discharge bill, and if the patient is readmitted to the SNF, the SNF should submit a new bill (TOB 211).

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 Part A PPS stay. Receipt of outpatient services from another provider does not normally result in SNF discharge.

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.
- The beneficiary is formally discharged or otherwise departs for reasons other than described in the bullets above. However, if the beneficiary is readmitted or returns by midnight of the same day, he is not considered discharged and 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.

40.3.5 - Determine Utilization on Day of Discharge, Death, or Day Beginning a Leave of Absence

(Rev. 1, 10-01-03)

SNF-517.6.B, A3-3103.4

Generally, the day of discharge, death, or a day on which a patient begins a leave of absence, is not counted as a utilization day. (See the Medicare Benefit Policy Manual, Chapter 3, “Duration of Covered Inpatient Services.”) This is true even where one of these events occurs on a patient’s first day of entitlement or the first day of a provider’s participation in the Medicare program. In addition, a benefit period may begin with a stay in a hospital or SNF, on that day.

The exception to the general rule of not charging a utilization day for the day of discharge, death, or day beginning a leave of absence is where the patient is admitted with the expectation that he will remain overnight but is discharged, dies, or is transferred to a nonparticipating provider or a nonparticipating distinct part of the same provider before midnight of the same day. In these instances, such a day counts as a utilization day. This exception includes the situation where the beneficiary was admitted (with the expectation that he would remain overnight) on either the first day of his entitlement or the provider's first day of participation, and on the same day he was discharged, died, or transferred to a nonparticipating provider.

Payment is not made under PPS unless a covered day can be billed. Also, if no-payment is possible under PPS, billing is not allowed for ancillary services. Ancillary charges for these days have been included in the PPS rates for days that can be billed.

When a patient is discharged on the first day of a provider's participation or the first day of the patient's entitlement, complete the bill as follows:

- Admission date is the actual date of admission;
- From date of service is the date the patient became entitled or date the SNF began participation; and
- The number of noncovered days = 1.

40.3.5.1 - Day of Discharge or Death Is the Day Following the Close of the Accounting Year

(Rev. 1, 10-01-03)

SNF-517.2

Where the day of discharge or death is the day following the close of the cost reporting period, the ancillary charges for services rendered on that day must be included in the bill submitted for services in the prior accounting year, which includes the covered days for the billing period in that year. In such cases, "Statement Covers Period", should show the date of discharge or death as the through date. The "Patient Status" should reflect the date of discharge or death, as appropriate. The SNF uses the same billing method when developing accrued non-Medicare charges. For cost settlement purposes, ancillary charges incurred in the new fiscal year, but billed under the prior fiscal year, are considered charges for the prior fiscal year.

40.3.5.2 - Leave of Absence

(Rev. 1, 10-01-03)

SNF-517.4

A leave of absence for the purposes of this instruction is a situation where the patient is absent, but not discharged, for reasons other than admission to a hospital, other SNF, or distinct part of the same SNF. If the absence exceeds 30 consecutive days, the 3-day prior stay and 30-day transfer requirements, as appropriate, must again be met to establish re-entitlement to SNF benefits.

Leave of absence (LOA) days are shown on the bill with revenue code 018X and LOA days as units. However, charges for leave of absence days are shown as zero on the bill, and the SNF cannot bill the beneficiary for them. Occurrence span code 74 is used to report the leave of absence from and through dates. The electronic data elements are shown in the following chart. Refer to the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-92 (CMS-1450) Data Set," for further information about billing, including UB-92 data elements and the corresponding fields in electronic billing records.

Data Element	UB-92 For Locator	ASC X12N 837 ver. 3051	ASC X12N 837 ver. 4010
Revenue code 018X	FL 42	2-395 SV201	2400 SV201
Revenue code units	FL 46	2-395 SV205	2400 SV205
Revenue code charges	FL 47	2-395 SV203	2400 SV203
Occurrence code 74	FL 32, FL 33, FL 34, and FL 35	2-225.C HI01-02 through HI12-02	2300 HI01-02 through HI12
Occurrence code Date	FL 32, FL 33, FL 34, and FL 35	2-225.C HI01-04 through HI07-04	2300 HI01-04 through HI12
Patient Status	FL22	2-140 CL103	2300 CL103

Where the patient does not return from a leave of absence, regardless of the reason, the SNF must submit a discharge bill showing the date of discharge as the date the individual

actually left. If the patient status was reported as “30” (still patient) on an interim bill and the patient failed to return from a leave of absence within 30 days, including the day leave began, or has been admitted to another institution at any time during the leave of absence, the SNF must submit an adjustment request to correctly indicate the day the patient left as the date of discharge. (A beneficiary cannot be an inpatient in two institutions at the same time.) This closes the open admission on the patient’s utilization record.

EXAMPLE 1

The beneficiary goes on a leave of absence on January 3, expecting to return on January 10. On January 6, the SNF receives word that the patient died on January 5. The SNF submits a discharge bill showing January 3 as the date of discharge.

EXAMPLE 2

The beneficiary goes on a leave of absence on February 6, expecting to return on February 12. However, the beneficiary does not return on February 12 as expected, and the SNF cannot determine whether the beneficiary will return. The SNF submits a discharge bill showing February 6 as the date of discharge as soon as practical, or after 30 days have elapsed from the day the leave began. If an interim bill had been submitted showing the beneficiary in “still patient” status (FL22), as of February 6 or later, the SNF submits an adjustment bill showing February 6 as the discharge date. The advantage of delaying the discharge bill for 30 days is that it will make unnecessary a new admission in the event the beneficiary returns before 30 days have elapsed.

EXAMPLE 3

The beneficiary goes on a leave of absence on March 4, and is expecting to return April 1 but does not. The SNF submits a discharge bill showing March 4 as the date of discharge since the beneficiary did not return within the 30-day period.

40.4 - Accommodation Charges Incurred in Different Accounting Years

(Rev. 1, 10-01-03)

SNF-517.1

The SNF must not put accommodation charges incurred in different accounting years on the same bill. (See [§40.3.5.1](#) 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, the SNF must submit a bill that contains the charges for all services furnished to the patient since the last bill and through the end of that year. The SNF shows services furnished in the following accounting year on a separate bill.

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

(Rev. 1, 10-01-03)

SNF-517.7

SNFs using the PIP method of payment follow the regular billing instructions in Medicare Claim Processing Manual, Chapter 26, “Completing and Processing Form CMS-1500 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.

40.6 - Total and Noncovered Charges

(Rev. 1, 10-01-03)

SNF-517.9

For each cost center for which a separate charge is billed (type of accommodation or ancillary), a revenue code is assigned. The appropriate numeric revenue code is entered in FL 42 to explain each charge in FL 47.

Additionally, there is no fixed “Total” line in the charge area. Instead, revenue code “0001” is always entered last in FL 42. Thus, the adjacent charge entry, in FL 47, is the sum of charges billed. This is also the same line on which noncovered charges, if any, in FL 48, are summed.

The total charge for all services, covered and noncovered, will generally be shown. See [§40.6.1](#) below, for certain exceptions. In the “Noncovered Charges” column (FL48) enter the amount of any noncovered charge except where:

- The FI has notified the SNF that payment can be made under the limitation of liability provisions; and
- A payer primary to Medicare is involved. (See the Medicare Secondary Payer [MSP] Manual, Chapter 3, “MSP Provider Billing Requirements,” and Chapter 4, “Contractor Prepayment Processing Requirements.”)

Where a bill is submitted for a period including both covered and noncovered days (e.g., benefits exhausted during billing period), the SNF must list the charges for noncovered days under noncovered charges. See [§50](#) below for instructions on submitting bills for noncovered days. 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.

40.6.1 - Services in Excess of Covered Services

(Rev. 1, 10-01-03)

SNF-517.10

Where items and services are furnished which are more expensive or in excess of the services covered by the program, the SNF will make the following entries in the Total Charges and Noncovered fields on the bill:

- If the patient did not request such excess or more expensive services, the patient may not be charged for them, and only the services covered by the program are shown in total charges. No entry is made in noncovered charges in this situation. (However, where all patients are routinely billed for such excess or more expensive items, total charges may reflect the excess items or services as discussed in Total and Noncovered Charges, above.);
- If the patient did request such excess or more expensive services, the SNF may charge the patient for them. In this case, the SNF will complete FL 47 to show the line item total charge (any customary charges covered by the program plus the excess charges). The excess charges that will be billed to the patient are shown in FL 48 (Noncovered charges.);
- In the same situation as above, except that the SNF will not bill the patient for the excess services, instead the SNF will show only the customary charges for covered services in FL 47 (Total Charges) and make no entry in FL 48 (Noncovered Charges).

40.6.2 - Showing Discounted Charges

(Rev. 1, 10-01-03)

SNF-517.11

SNFs do not show credit or minus entries on the bill. Where the SNF gives a discount to some patients, they show charges in one of two ways:

1. SNFs show the charges as the full, undiscounted charge if full undiscounted charge data is accumulated for all patients for the purposes of the final cost report; or
2. They show the discounted charges as the only charges, if the SNF, for the purposes of the final cost report, accumulates charges for all patients at the discounted rate.

40.6.3 - Reporting Accommodations on the Claim

(Rev. 1, 10-01-03)

SNF-517.12

See the Medicare Benefit Policy Manual, Chapter 1, “Inpatient Hospital Services,” for an explanation of the rules when other than semi-private accommodations are furnished that apply to SNFs as well as hospitals. The type of accommodation furnished at the time of the SNF census-taking hour determines the applicable revenue code. Where a patient is admitted with the expectation that he will remain overnight, but on the same day is discharged, dies, or is transferred prior to the census, the revenue code is determined by the type of accommodation furnished at the time of the patient’s discharge, death, or transfer.

Payment is based on the PPS rate, not on accommodation levels. See [§40.6.1](#) where the patient requests more expensive accommodations or patient convenience items.

The determination of charges does not affect the determination of inpatient utilization days or when a patient may be considered an inpatient for Medicare purposes as outlined in the Medicare Benefit Policy Manual, Chapter 8, “Coverage of Extended Care (SNF) Services Under Hospital Insurance,” §50 and §60.2. Refer to the Medicare Claims Processing Manual, Chapter 25, “Completing and Processing the UB-92 (CMS-1450) UB-92 Data Set” for further information about billing, as it contains UB-92 data elements and the corresponding fields in the electronic record.

SNFs submit charges for accommodation for the entire period covered by the billing period in FL 47 (Total Charges) and charges for any noncovered days in FL 48 (Noncovered Charges.)

The accommodation days do not include the day of death or discharge, even where the discharge was late. However, where the SNF customarily makes an extra charge for a late discharge, they include this amount in FL 47 (Total Charge) opposite the appropriate accommodation revenue code. The day of discharge is not included in “FL 47 Covered Days” even though an extra charge is included in FL 47 (Total Charges) opposite the accommodation revenue code. Where the late discharge was for the patient’s convenience and not for any medical necessity, SNFs enter the charge for late discharge in FL 48 (Noncovered) as a noncovered charge. Where the late discharge is for a medical reason, the charge is covered. (See the Medicare Benefit Policy Manual, Chapter 8, “Coverage of Extended Care (SNF) Services Under Hospital Insurance,” §60.3.)

The charges for accommodations reflect only the total charges for general routine services as defined in §2202.6 and §2203.1 of the Medicare Provider Reimbursement Manual. All charges, which are charged to every patient for every patient day, are included in the routine accommodation charge.

SNFs bill ancillary charges for day of discharge, death or the day on which a leave of absence begins, under the proper revenue code.

Where the patient is discharged on his first day of entitlement or the first day of the SNF participation in the Medicare program, they submit a billing form with no accommodation charge, but with ancillary charges.

Where some of the days cannot be paid under Part A because benefits were exhausted before discharge, death, or the day on which a leave of absence began, SNFs show the charges for days after benefits were exhausted under noncovered charges, and enter the appropriate occurrence code, e.g., A3, and the date benefits are exhausted. See the Medicare Claims Processing Manual, Chapter 7, "SNF Part B Billing," §10, for billing under Part B in such circumstances.

40.6.4 - Bills With Covered and Noncovered Days

(Rev. 133, 04-02-04)

SNF-525, A3-3620

Any combination of covered and noncovered days may be billed on the same bill. It is important to record a day or charge as covered or noncovered because of the following:

- Beneficiary utilization is recorded based upon days during which the patient received hospital or SNF accommodations, including days paid by Medicare and days for which the provider was held liable for reasons other than medical necessity or custodial care.
- The provider may claim credit on its cost report only for covered accommodations, days and charges for which actual payment is made. Provider liable days and charges are not included on the cost report. Data from the bill payment process are used in preparing the cost report.

SNFs show noncovered charges for denied or noncovered days, which will not be paid. The SNF submits the bill with occurrence span code 76 and completes the from/through dates to report periods where the beneficiary is liable. Occurrence span code 77 is used

to report periods of noncovered care where the SNF is liable. Occurrence code A3 is used to indicate the last date for which benefits are available or the date benefits were exhausted.

The FI will use Occurrence Span Code 79 (a payer only code sent to CWF) to report periods of noncovered care due to lack of medical necessity or custodial care for which the provider is held liable. Periods of beneficiary liability and provider liability may be reported on one bill. Report all noncovered days.

Where the SNF stay begins as noncovered and ends as covered, only one bill is required. Since the bill will include a covered stay, SNFs complete it fully.

See the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-92 (CMS-1450) Data Set" for a complete description of Form CMS-1450, electronic formats UB-92, and ANSI X12N data elements. A crosswalk of the form data elements and related format data elements is found in that chapter. See the Medicare Claims Processing Manual, Chapter 30, "Limitation on Liability," for determining SNF liability.

The provider is always liable unless the appropriate notice is issued. If the SNF issues the appropriate notice, and the beneficiary agrees to make payment either personally or through a private insurer, the days will not be charged towards the 100-day benefit period. Notice requirements for periods of noncoverage are found in Chapter 30, §70.

40.6.5 - Notification of Limitation on Liability Decision

(Rev. 133, 04-02-04)

SNF-517.8

Detailed instructions and application of limitation on liability is found in The Medicare Claims Processing Manual, Chapter 30, "Limitation on Liability." The limitation on liability decision is made by the FI when the medical evidence and admission notice, or the bill is submitted. When coverage is denied, notification will be by telephone, if possible, so written notice can be provided to the patient immediately. When it is determined during the course of a beneficiary's stay in an SNF that the care is not covered but both the beneficiary and the SNF are entitled to limitation on liability, the Medicare program may make payment for the noncovered services for a grace period of one day (24 hours) after the date of notice to the SNF or to the beneficiary, whichever is

earlier. If it is determined that more time is required in order to arrange post-discharge care, up to 1 additional “grace period” day may be paid for.

Limitation of liability may apply to Part A and Part B services furnished by the provider.

40.7 - Other Billing Situations

(Rev. 133, 04-02-04)

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.

1. Use of Noncovered Bills with SNFABNs in Cases of Custodial Care under PPS, or Termination of the Benefit during the Spell.

The use of no payment claims/noncovered bills in association with a SNFABN involving custodial care or termination of a benefit during a spell is a clarification of CMS policy. In cases where the SNF plan of care prescribes only custodial care, or if the inpatient benefit has terminated during a spell, AND the physician, beneficiary and provider are all in agreement the benefit has terminated or does not apply, SNFs can use the following procedures instead of traditional demand billing:

- a. The SNFABN for notification of the beneficiary, selecting Option 1 on that form; and
- b. A condition code 21 no payment claim to bill all subsequent services when no covered charges have accrued for the monthly billing cycle.

NOTE: Providers can never pre-select ABN options for beneficiaries, in accordance with existing ABN policy. In each case, the beneficiary must choose the option they want to select. The ABN option presented relative to the specific billing scenario above, is only an illustration, and not an authorization for preempting a beneficiary's right to choose a specific option.

General instructions for the preparation of no payment claims can be found in §60.1.3, Chapter 1 of the Medicare Claims Processing Manual.

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.

50 - SNF Payment Bans, or Denial of Payment for New Admissions (DPNA)

(Rev. 1, 10-01-03)

PM AB-01-131

Under the Act at §§[1819\(h\)](#) and [1919\(h\)](#) and CMS’ regulations at [42 CFR 488.417](#), CMS may impose a denial of payment for new admissions (DPNA) against a SNF when a facility is not in substantial compliance with requirements of participation. For policy

detail , see the Medicare Benefit Policy Manual, Chapter 8, “Coverage of Extended Care (SNF) Services Under Hospital Insurance,” §§20.3 – 20.3.1.6.

50.1 - Effect on Utilization Days and Benefit Period

(Rev. 1, 10-01-03)

PM AB-01-131

Payment sanctions are applied to days that would otherwise be Part A-payable; i.e., the care is covered but no payment will be made to the provider. Therefore, if the Medicare-participating SNF assumes responsibility for the beneficiary’s costs during the sanction period, it will be considered the same as a program payment, and the days will count towards the 100-day benefit period.

A beneficiary’s care in an SNF met the skilled level of care standards if a Medicare SNF claim for the services provided in the SNF was denied on grounds other than that the services were not at a skilled level of care. SNF days during the sanction period continue a spell of illness if the beneficiary received a skilled level of care.

The 30-day transfer requirement applies in the same manner as it would be for a beneficiary transferring between two SNFs that are not under sanction. A beneficiary may remain at a facility under sanction for a period of time and later transfer to a second SNF. Part A coverage will be available to the second SNF for all remaining days in the benefit period as long as the beneficiary meets the following conditions:

- Had a qualifying hospital stay;
- Was admitted to a Medicare-certified bed in the first (sanctioned) SNF within 30 days of the hospital discharge; and
- Is receiving a covered level of care at the time of transfer.

50.2 - Billing When Ban on Payment Is In Effect

(Rev. 1, 10-01-03)

PM AB-01-131

Beneficiaries admitted before the effective date of the denial of payment and taking temporary leave, whether to receive inpatient hospital care, outpatient services or as therapeutic leave, are not considered new admissions, and are not subject to the denial of payment upon return. This policy applies even if there are multiple hospitalizations and returns to the SNF during the period sanctions are in effect.

When determining if the beneficiary was admitted prior to the imposition of the ban, the actual status of the beneficiary rather than the primary payor is the determining factor. Therefore, there may be situations where the beneficiary is a private pay patient or a dual

eligible who was receiving Medicaid benefits prior to the imposition of the payment ban. If this private pay patient or dual eligible goes to the hospital for needed care, and meets the Medicare Part A criteria upon return to the SNF, the readmission is exempt from the denial of payment sanction. When billing for a readmission that is NOT subject to the payment ban, enter Condition Code 57, Readmission, on the claim.

50.2.1 - Tracking Days to Calculate the Part A Benefit Period

(Rev. 1, 10-01-03)

PM AB-01-131

Payment sanctions are applied to days that would otherwise be Part A-payable; i.e., the care is covered but no payment will be made to the provider. Therefore, if the Medicare-participating SNF assumes responsibility for the beneficiary's costs during the sanction period, it will be considered the same as a program payment, and the days will count towards the 100-day benefit period.

The provider is always liable unless the appropriate Notice of Non-Coverage is issued to the beneficiary or appropriate family member or representative. If the SNF issues the appropriate Notice of Non-Coverage, and the beneficiary agrees to make payment either personally or through a private insurer, the days will not be charged towards the 100-day benefit period.

50.2.2 - Provider Liability Billing Instructions

(Rev. 1, 10-01-03)

PM AB-01-131

In situations where the beneficiary was subject to the payment ban, but the provider failed to issue the proper Notification of Non-Coverage, the provider is liable for all services normally covered under the Medicare Part A benefit. Since the beneficiary is receiving benefits, the days will be considered Part A days and charged against the beneficiary's benefit period. The SNF may collect any applicable copayment amounts.

These days will be charged against the patient's utilization as is currently done with other types of technical denials (i.e., late filing, late denial notices to the patient, etc.). The SNF must file a no-payment bill with the FI for noncovered days using occurrence span code 77. This code indicates that the facility is liable for the services but that the noncovered days and any applicable copayments will be charged to the beneficiary's Part A benefit period. See §60 of Chapter 1 in this manual for detailed instructions on nonpayment billing requirements.

When the SNF is liable for the Part A stay, the SNF is required to provide all necessary covered Part A services, including those services such as therapies and radiology mandated under consolidated billing. For example, if the beneficiary goes to the hospital for a non-emergency chest x-ray, the SNF will be responsible for the outpatient hospital

radiology and any ambulance charges. In this case, the SNF may not charge the beneficiary or family members for any services that, in the absence of a payment sanction, would have been covered under the Part A PPS payment.

50.2.3 - Beneficiary Liability Billing Instructions

(Rev. 1, 10-01-03)

PM AB-01-131

The days will not be charged to the beneficiary's benefit period. The SNF should file a non-payment bill for noncovered Part A services, using occurrence span code 76 that indicates beneficiary liability. When the beneficiary has agreed to accept financial responsibility, no Part A days or copayment amounts will be charged to the beneficiary's benefit period. Services that would have been eligible for Part A benefits in the absence of sanctions cannot be billed as Part B charges. However, the SNF may directly bill the beneficiary, family members or other third party insurers for services provided to that beneficiary.

50.2.4 - Part B Billing

(Rev. 1, 10-01-03)

PM AB-01-131

Facilities subject to a payment ban may continue to bill services for beneficiaries who are not in a Part A stay in the same way as any other SNF. However, services that would have been payable to the SNF as Part A benefits in the absence of a payment sanction must not be billed to either the FI or the carrier as Part B services.

50.3 - Sanctions Lifted: Procedures for Beneficiaries Admitted During the Sanction Period

(Rev. 1, 10-01-03)

PM AB-01-131

For new admissions to certified beds, Medicare payments for eligible beneficiaries should begin on the date the sanction is lifted. The beneficiary must meet technical eligibility requirements (e.g., a 3-day hospital stay, etc.), services must be reasonable and necessary and the beneficiary must be receiving skilled care. The date the sanction is lifted is considered the first day of the Part A stay.

For Part A PPS payment purposes, the period between the actual date of admission and the last day the sanction was in effect should be billed as noncovered days.

(See §50.3.1 below on procedures to track these noncovered days for benefit period and break in spell of illness calculations. RAI requirements are discussed in §30.5.)

50.3.1 - Tracking the Benefit Period

(Rev. 1, 10-01-03)

PM AB-01-131

SNF days during the sanction period will be used to track breaks in the spell of illness if a beneficiary's care in the SNF meets the skilled level of care standards. If the patient is receiving a skilled level of care the benefit period cannot end. Therefore, it should be tracked in CWF.

50.3.2 - Determining Whether Transfer Requirements Have Been Met

(Rev. 1, 10-01-03)

PM AB-01-131

It is very important to safeguard the beneficiary while applying necessary sanctions to the provider. It is certainly possible that a beneficiary may remain at a facility under sanction for a period of time and later transfer to a second SNF. The 30-day transfer requirement will be applied in the same way it would be for a beneficiary transferring between two SNFs that are not under sanction. Part A coverage will be available to the second SNF for all remaining days in the benefit period as long as the beneficiary:

1. Had a qualifying hospital stay
2. Was admitted to a Medicare-certified bed in the first (sanctioned) SNF within 30 days of the hospital discharge, and
3. Is receiving a covered level of care at the time of transfer.

50.4 – Conducting Resident Assessments

(Rev. 1, 10-01-03)

PM AB-01-131

The imposition of sanctions does not waive the SNF's responsibility to perform assessments in accordance with the clinical schedule defined in the SOM. Comprehensive admission assessments are still due within 14 days of admission to the SNF. Facility staff must also maintain the schedule for quarterly and annual assessments, and perform SCSAs and SCPAs when clinically appropriate.

Medicare-required assessments are also necessary for all beneficiaries in the SNF whose stays are not subject to the payment ban. If, during the sanction period, staff do not perform Medicare-required assessments for beneficiaries in covered Part A stays, the Part A days can only be billed at the default HIPPS rate (AAA00).

Part A benefits are NOT available for beneficiaries admitted after the effective date of the payment ban. Therefore, the facility is not required to perform Medicare PPS assessments. Medicare payments can begin no earlier than the date the sanction is lifted. For Medicare PPS assessment scheduling purposes, the date the sanction is lifted should be considered day 1. In this case, if the sanctions are lifted effective June 15, the assessment reference date for the Medicare 5-day assessment must be set between June 15 and June 22 (i.e., the eighth day of the covered stay).

When the facility does not receive timely notification that the payment ban has been lifted, and staff is unaware of the need to start the Medicare-required MDS schedule, the facility may use the most recent clinical assessment, generally the 14-day Initial Admission assessment for SNF PPS payment. The RUG-III group, calculated from the most recent clinical assessment, is used to bill covered Part A days from the date sanctions were lifted to the date the SNF is notified. This assessment will be considered the Medicare 5-day assessment for the purpose of MDS coding. The covered days should be billed using the following 5-digit HIPPS code:

Fields 1-3: The RUG-III group calculated using the most recent clinical assessment.

Fields 4-5: Assessment indicator 01 indicating that the MDS was the Medicare 5-day assessment.

The SNF will then follow the Medicare schedule except that the 14, 30, 60 and 90-day Medicare assessments will be prepared using the date of facility notification as day 1.

In rare situations, the amount of time between the end of the sanction period and the date of facility notification is longer than 14 days. In this case, the facility may use the most recent clinical assessment for multiple Part A PPS payment periods. Separate 0022 revenue code entries will be required for each Part A PPS payment period. The RUG-III group will remain the same, but the assessment indicator will change as follows:

- 07 for 14-day assessment;
- 02 for 30-day assessment;
- 03 for 60-day assessment; and
- 04 for 90-day assessment.

An SNF may choose to perform the Medicare-required assessments during the sanction period, but is not required to do so. Generally, a facility should continue to do the Medicare PPS assessments if SNF staff believe the sanction was in error and may be lifted retroactively. In this case, the SNF would be able to bill Medicare at the correct RUG-III rate.

If the sanctions are not lifted retroactively, the most recent assessment (which can be either a clinical or a Medicare PPS assessment) should be used as the Medicare 5-day

assessment. The SNF will then follow the Medicare schedule except that the 14, 30, 60 and 90-day Medicare assessments will be prepared using the date sanctions were lifted or the date of facility notification as day 1, as appropriate.

The results of Medicare-required assessments, in combination with AIs comprise the HIPPS rate codes used for Part A PPS payment. SNFs use the Grouped results of the RAI (RUG III codes), ARDs, and appropriate AIs as described in §§30 to complete ANSI X12N 837 I transactions. Further instructions for completion of the UB-92 data elements in the 837 I can be found in Chapter 25 of this manual.

50.5 - Physician Certification

(Rev. 1, 10-01-03)

PM AB-01-131

The SNFs under a payment ban are still participating providers, and remain subject to Medicare coverage requirements. Providers are still responsible for evaluating whether beneficiaries meet the Medicare Part A medical necessity and level of care requirements for Medicare Part A coverage, and for obtaining the required physician certifications even though Medicare payment cannot be made for the admission.

The SNFs are required to obtain physician certifications upon notification that a sanction was lifted. The date of notification will be considered day 1 when verifying the timeliness of the physician certification.

When intermediaries process a reconsideration for a claim that was billed as a Part A stay, but rejected due to an incorrect application of the sanction provision, the physician certification is required regardless of the dates of service. Since the provider clearly believed the stay was eligible for Part A payment, all Medicare coverage requirements must have been met.

50.6 - Intermediary Responsibilities

(Rev. 1, 10-01-03)

PM AB-01-131

Intermediaries will receive notices from the CMS Regional Office when sanctions have been imposed or lifted and in some cases when sanctions are proposed. The CMS' primary objective is always to bring the facility into compliance and avoid imposition of sanctions. In many cases, enforcement activity does not go beyond the notice of intent. Intermediaries should initiate action only when notified that sanctions have been imposed.

Upon notification that a sanction is imposed, intermediaries should identify claims affected with service dates on and after the date of the sanction. Overpayments for

claims erroneously paid should be recovered and CWF properly updated to reflect the payment ban action.

Process a no-payment bill submitted as beneficiary liability using occurrence span code 76 or as provider liability using occurrence span code 77. Claims for new admissions should be denied from the date of admission through the last date of the sanction period.

50.7 - Retroactive Removal of Sanctions

(Rev. 1, 10-01-03)

PM AB-01-131

Occasionally, resolution between the State Agency and the SNF is reached after the payment ban has been imposed, and the ban is removed retroactive to its effective date. If bills were denied before notice was received that the ban had been reversed, they should be reprocessed and paid. When reprocessing bills, MDS assessments are needed to support the RUG-III group billed.

Beneficiaries and providers may request intermediaries to reopen and process bills denied as a result of a misunderstanding of the sanction requirements. These reopenings shall be done on a request basis only, and will be limited to service dates on and after January 1, 1999.

60 - Billing Procedures for a Provider With Multiple Provider Numbers or a Change in Provider Number

(Rev. 1, 10-01-03)

SNF-520, A3-3600.5

Where a hospital with sub-providers that meet the provider-based criteria or the distinct part criteria is assigned separate provider numbers for each sub-provider, the SNF is required to use the SNF number for all bills, beginning with the date the new number is effective.

Where there is a change of ownership (CHOW), and the new owner refuses assignment of the existing provider agreement, the old owner submits all claims for periods prior to the CHOW using the old provider number. The new owner submits claims for services rendered after the date of the CHOW using the new provider number.

Also with respect to CHOWs, the SNF submits a bill with the old provider number for the period before the change and another with the new provider number for the period after the change. The date of discharge on the first bill and the date of admission on the second bill are the same, which is the effective date of the new provider number. All subsequent billings are submitted under the new provider number.

70 - Billing for Services After Termination, Expiration, or Cancellation of Provider Agreement, or After Payment is Denied for New Admissions

(Rev. 1, 10-01-03)

SNF-518

All agreements with SNFs are for a specified term of up to 12 full calendar months.

70.1 - General Rules

(Rev. 1, 10-01-03)

SNF-518.1

A SNF whose provider agreement terminates, expires, or is cancelled, or that is denied payment for new admissions as an alternative to termination for noncompliance with one or more conditions of participation, may only be paid for covered Part A inpatient services under the following conditions:

Termination (Voluntary or Involuntary)

- Payment can continue to be made for up to 30 days for covered Part A inpatient services furnished on and after the effective date of termination for beneficiaries who were admitted prior to the termination date.
 - EXAMPLE: Termination date: 9/30/86
 - Beneficiary admitted: before 9/30/86
 - Payment can be made: 9/30/86, up to and including 10/29/86

Expiration (Agreement Has Not Been Renewed)

- Payment can continue to be made for up to 30 days for covered Part A inpatient services furnished after the last day of the specified term of the agreement for beneficiaries who were admitted on or before the last day of the specified term.

EXAMPLE: Agreement expires: 9/30/86 (last date in effect)

- Beneficiary admitted: on or before 9/30/86
- Payment can be made: 10/1/86, up to and including 10/30/86

Cancellation (Cancellation Clause and SNF Has Been Formerly Notified by CMS)

- Payment can continue to be made for up to 30 days for covered Part A inpatient services furnished after the cancellation date for beneficiaries who were admitted on or before the cancellation date.

EXAMPLE: Cancellation date: 9/30/86 (last date in effect)

- Beneficiary admitted: on or before 9/30/86
- Payment can be made: 10/1/86, up to and including 10/30/86

Denial of Payments for New Admissions (DPNA)

- Payment can continue to be made for covered Part A inpatient services furnished on or after the effective date of denial of payments for beneficiaries who were admitted before the effective date of denial of payments.

EXAMPLE: Denial of payment date: 9/30/86

- Beneficiary admitted before: 9/30/86
- Payment can be made: Indefinitely

NOTE: An inpatient, who goes on leave from the SNF before or after the effective date of denial of payments for new admissions is not considered a new admission when returning from leave.

70.2 - Billing for Covered Services

(Rev. 1, 10-01-03)

SNF-518.2

Upon cessation of a SNF's participation in the program, or when a SNF is not receiving payments for new admissions, the RO is supplied with the names and claim numbers of Medicare beneficiaries entitled to have payment made on their behalf for services in accordance with §80.1.

SNFs no longer participating in the program, or those under a denial of payment for new admissions, continue to bill for covered services per §80.1. They continue to submit "no-payment" death, discharge and reduction from SNF level of care bills for Medicare beneficiaries admitted prior to the termination of their agreement, or prior to the denial of payments for new admissions.

70.3 - Part B Billing

(Rev. 1, 10-01-03)

SNF-518.3

Following termination, expiration, or cancellation of its agreement, a SNF is considered to be a “nonparticipating provider.” An inpatient of such a SNF who has Part B coverage, but for whom Part A benefits have been exhausted or are otherwise not available, is entitled to payment only for those services that are covered in a nonparticipating institution. Do not bill such services furnished on or after the effective date of termination, or, in the case of expiration or cancellation of a SNF agreement, on or after the day following the close of such agreement, to the FI.

80 - Billing Related to Physician’s Services

(Rev. 1, 10-01-03)

SNF-502 updated with transmittal 368, SNF-275

Normally physicians are responsible for billing for their own services.

The services of facility-based physicians (e.g., those on a salary or percentage arrangement, lessors of departments, etc., whether or not they bill patients directly) include two distinct elements - the professional component and the provider component.

The professional component of facility-based physicians’ services includes services directly related to the medical care of the individual patient. SNFs cannot bill for the professional components of physician services, these must be billed under a physician provider number to the carrier. The technical and facility based components of physician services delivered to SNF inpatients are bundled into the Part A PPS payment and not paid separately.

A - Podiatry Services

Covered professional services rendered by facility-based podiatrists to individual patients are covered only as physicians’ services under Part B. Note that certain foot care services are excluded under both Part A and Part B. Payments to podiatrists for noncovered services are not allowable Medicare costs regardless of whether the podiatrist’s professional services are covered under Part B.

80.1 - Reassignment Limitations

(Rev. 1, 10-01-03)

SNF-507

Assigned benefits for physician's services may not be paid to anyone other than the physician who furnished the services, except:

- To the employer of the physician who provided the service, if such physician is required as a condition of his employment to turn over his fee for the service to his employer. (See §80.2 below.)
- To a facility in which the service is provided if there is a contractual arrangement between the facility and the physician furnishing the service under which only the facility can bill for the service. (See §80.3 below.)
- To an organization, which furnishes health care through an organized health care delivery system (e.g., a freestanding physician clinic, or prepaid group practice prepayment plan) if there is a contractual arrangement between the organization and the physician furnishing the service under which only the organization can bill for the service.

80.2 - Payment to Employer of Physician

(Rev. 1, 10-01-03)

SNF-508, SNF-510

Subject to the conditions and limitations described below, payment of Part B benefits due a physician under assignment for services furnished in a facility may be made to the facility if the facility and physician have an agreement under which only the facility may bill and receive fees or amounts charged for the services.

Form CMS-855R must be completed to describe the arrangement with the facility. This form and instructions for completing it can be downloaded from the CMS Forms Web page. See the Medicare Program Integrity Manual for processing instructions after completion.

The contractual arrangement between the facility and a physician may apply to all services the physician furnishes in the facility, or merely to a particular category of services that is clearly distinguishable from other categories. The distinction between the categories must be consistent with proper determination of Part B reimbursement and may not be based on whether the patient has Medicare.

While the law permits physicians to reassign to a facility the Part B benefits for the patient care services they perform in the facility, this exception in favor of the facility is intended to apply to an arrangement in which the facility obtains a significant degree of

control or interest in the disposition of the benefits. Under the law, Medicare benefits cannot be paid to a facility under terms that make the facility a mere conduit for payment to another person or entity.

EXAMPLE

Under an agreement between a facility and a partnership of teaching physicians, the facility bills and receives payment in its name for the physician services but is required to turn over to the partnership all fees received, less a small deduction to defray billing expenses. The partnership distributes the monies received among its physician members in accordance with the partnership agreement. Since the SNF functions under the agreement as a mere conduit for payment to the partnership, the agreement is not an acceptable contractual arrangement for purposes of the exception to the prohibition on reassignment.

80.3 - Information Necessary to Permit Payment to a Facility

(Rev. 1, 10-01-03)

SNF-510.1

A facility may ordinarily qualify to receive Part B payment for the services of physicians in the facility by submitting a Form CMS-855R to its FI, certifying that it will bill for their services only as called for by its written contractual arrangements.

For purposes of Medicare benefits payable for the services, this agreement may be terminated by either party upon written notice to the other, but such termination is not binding upon Medicare until two weeks after the contractor receives a revised Form CMS-855R notice of this termination.

80.4 - Services Furnished Within the SNF

(Rev. 1, 10-01-03)

SNF-510.2

The term “facility” is limited for purposes of furnishing services to individuals as inpatients, e.g., 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 SNF if furnished in connection with services received by patients in the SNF. For example, if SNF inpatients are taken to the private office of a neurologist for necessary tests such as an encephalograph, the services are considered performed in the SNF for billing and payment.

80.5 - Billing Under Arrangements

(Rev. 1, 10-01-03)

SNF-510.2

A provider may have others furnish certain covered items and services to their patients through arrangements under which receipt of payment by the provider for the services discharges the liability of the beneficiary or any other person to pay for the service. In permitting providers to furnish services under arrangements, it is not intended that the provider merely serve as a billing mechanism for the other party. Accordingly, for services provided under arrangements to be covered, the provider must exercise professional responsibility over the arranged-for services. See the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, "Definitions," §10.3, for additional discussion on services furnished under arrangement.

The law is silent regarding specific terms of a SNF's payment to the outside provider or supplier and currently does not authorize the Medicare program to impose any requirements in this regard. Thus, the issue of the outside provider or supplier's payment by the SNF is a private, contractual matter that must be resolved through direct negotiations between the parties. However, services provided under consolidated billing arrangements must be provided by Medicare certified providers that are licensed to provide the service involved. In addition, payment may not be made if the provider or supplier is subject to OIG sanctions that would prohibit Medicare payment for the service if the provider or supplier were billing independently.

In some cases, SNFs may purchase services for their patients from a hospital "under arrangements." Such services may 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 SNFs to bill for his/her services. For example, where SNFs 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, SNFs do not need written authorization from the cardiologist to bill Medicare for the cost of the services.

See the Medicare Benefit Policy Manual, Chapter 8, "Coverage of Extended Care (SNF) Services Under Hospital Insurance," §70.4, for additional information on services under arrangements.

80.6 - Indirect Contractual Arrangement

(Rev. 1, 10-01-03)

SNF-510.3

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 - constitutes an indirect contractual arrangement between the SNF and the physicians. For the SNF to bill and receive payment for the physician services furnished in the SNF, the SNF must also enter into a direct contractual arrangement with the physicians for this purpose.

80.7 - Establishing That a SNF Qualifies to Receive Part B Payment on the Basis of Reassignment

(Rev. 1, 10-01-03)

SNF-512

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 that it may receive as a reassignee as the physician would have had if the payment had been made to him/her.

90 - SNF Billing to HMOs

(Rev. 1, 10-01-03)

SNF-500, PM AB-01-132

For billing to HMOs, SNFs follow the requirements of the agreement they have with the HMO. In cases where the patient may have enrolled or disenrolled from an HMO plan during the billing period, the SNF will split the bill and send the HMO portion to it and the remaining portion to the FI.

90.1 - Beneficiary Involuntarily Disenrolled from Terminated Medicare+Choice (M+C) Plans

(Rev. 1, 10-01-03)

PM A-01-122, PM A-02-009

Medicare will cover SNF inpatient services for beneficiaries involuntarily disenrolling from Medicare+Choice (M+C) Plans as a result of an M+C plan termination when the beneficiary has not met the 3-day prior hospital stay requirement. Intermediaries will begin counting 100 days of SNF care with the SNF admission date regardless of whether the beneficiary met the skilled level of care requirements on that date. All other Medicare rules apply, such as the requirement that beneficiaries meet the skilled level of care requirement (for the period for which the original Medicare fee-for-service program is billed) and rules regarding cost sharing apply to these cases. That is, providers may only charge beneficiaries for SNF coinsurance amounts.

SNFs submit the first fee-for-service inpatient claim with condition code “58” to indicate a patient was involuntarily disenrolled from a M+C organization and the 3-day prior stay requirement was not met. Claims with condition code 58 will not require the 3-day prior inpatient hospital stay or that the SNF admission date is within 30 days of the inpatient discharge date identified in occurrence span code 70 “through” date. However, if the SNF admission and from date are the same, CWF will edit to ensure the patient was enrolled with an M+C plan within 30 days prior to admission.

The FI must use CWF files to validate the beneficiary was enrolled in an M+C organization upon admission to the SNF and that the M+C enrollment period ended prior to the “from” date on the claim. The FI does not need to verify that the M+C plan was the one that terminated.

100 – Part A SNF PPS for Hospital Swing Bed Facilities

(Rev. 1, 10-01-03)

PM A-02-016

Section 4432(a) of the Balanced Budget Act (BBA) of 1997 specifies that swing bed facilities must be incorporated into Part A SNF PPS by the end of the statutory transition period. Effective with cost reporting periods beginning on or after July 1, 2002, swing bed bills are not paid on the cost-based method, but rather on the basis of the Part A SNF PPS. These payment rates cover all payment for furnishing covered swing bed extended care services (routine, ancillary, and capital-related costs) other than approved educational activities as defined in 42 CFR 413.85.

Part A SNF PPS applies to short-term hospitals, long-term care hospitals, and rehabilitation hospitals that have Medicare swing bed agreements. CAHs with swing beds are exempt from the Part A SNF PPS, and are not affected by these instructions.

The Part A PPS is phased in based on each swing bed hospital's fiscal year. The transition to Part A PPS is effective with the start of the provider's first cost reporting period that begins on or after July 1, 2002. Consequently, billing for all beneficiaries in a swing bed must be split at the end of the provider's fiscal year. A new bill is created for beneficiaries remaining in the facility at the start of the new fiscal year. The bill must be prepared under the Part A PPS claim guidelines described in this chapter and in Chapter 1, "General Billing Requirements." Payment is made according to the instructions for SNFs under Part A PPS found in the Medicare Provider Reimbursement Manual.

Providers of swing bed services submit Part A inpatient claims using TOB 18X.

The swing bed program does not include an inpatient Part B benefit. For beneficiaries who continue to receive extended care services after the end of a Part A stay (e.g., benefits exhausted, not receiving a skilled level of care, etc.), ancillary services may be billed under the hospital as inpatient Part B services.

If the beneficiary remains a resident in the swing bed facility after the end of the Part A stay, the hospital may submit a claim to the FI for those inpatient services covered by Part B using TOB 12X. The beneficiary would be eligible for the same benefits available to a hospital inpatient in a Part B stay. The hospital provider of SNF level swing bed services must also file a Part A nonpayment bill monthly using the appropriate nonpayment code.

For Part A PPS purposes, intermediaries assign swing bed hospitals to provider type 38 on their Provider-Specific File. Swing bed providers will be paid at 100 percent of the Federal rate. Swing bed claims will be paid using the actual MSA code (based on county codes), and the related rural or urban rate tables. Intermediaries must set the Federal PPS Blend Indicator in the Provider-Specific file to "4." The CMI ADJ CPD field should be blank.

Unless exceptions are noted, instructions applicable to SNFs are also applicable to swing bed providers e.g., demand bills, spell of illness, covered and noncovered days, nonpayment bills, and adjustment bills.

100.1 - Swing Bed Services Not Included in the Part A PPS Rate

(Rev. 1, 10-01-03)

PM A-02-016

Providers of swing bed services are eligible for additional payment for services that are excluded from the SNF Part A consolidated billing requirements. These consolidated billing exclusions are not subject to the hospital bundling requirements specified in §1862(a)(14) of the Act and in 42 CFR 411.15(m). All services not specifically excluded from the SNF PPS consolidated billing requirements must be included in the Part A swing bed bill (TOB 18X).

If a swing bed hospital furnishes a service or supply to a beneficiary receiving SNF-level services, which is excluded from the Part A PPS rate, the swing bed hospital may submit a separate bill to the FI for the SNF PPS-excluded service. This bill must use TOB 13x with all appropriate revenue codes, HCPCS codes, and line item date of service billing information and will be paid as outpatient Part B services under the Outpatient Prospective Payment System (OPPS). A list of services that are excluded from the SNF PPS rate is found in §§20.1 – 20.4 above.

Bills for these SNF PPS consolidated billing “exclusions” must be filed as outpatient Part B services (TOB13X) and will be paid as inpatient Part B services under the Outpatient Prospective Payment System (OPPS). Services included under the SNF PPS may not be billed separately.

Likewise, swing bed hospitals may file bills with the FI for Part B Ancillary services furnished to beneficiaries who are not in a Part A PPS swing bed stay. Such claims are billed as inpatient Part B services, and are paid under the OPPS.

110 – Carrier Claims Processing for Consolidated Billing for Physician and Non-Physician Practitioner Services Rendered to Beneficiaries in a SNF Part A Stay

(Rev. 76, 02-06-04)

For an overview of SNF consolidated billing, including types of facilities and services subject to consolidated billing, see sections 10 and 20.

110.1 - Correct Place of Service (POS) Code for SNF Claims

(Rev. 76, 02-06-04)

Place of Service (POS) code 31 should be used with services for patients in a Part A covered stay and POS code 32 should be used with services for beneficiaries in a noncovered stay. Carriers should adjust their prepayment procedure edits as appropriate.

110.2 - CWF Edits

(Rev. 76, 02-06-04)

The following edits have been implemented in CWF.

110.2.1 – Reject and Unsolicited Response Edits

(Rev. 76, 02-06-04)

A. Reject Edits

When CWF receives a bill from the SNF that shows that a beneficiary became a resident of a SNF, that SNF stay is posted to history. Effective April 2002, for claims processed and adjusted with dates of service on or after April 1, 2001, CWF will apply the reject edits to any claims received after the SNF stay is posted that have dates of service during the periods the beneficiary is shown to have been a resident of the SNF based on that first SNF bill. These claims can be correctly rejected since it will be clear that the beneficiary was in the SNF during those spans that were shown on the SNF claim. This process will repeat when the next SNF bill is received. The process will continue until CWF posts a discharge date, date of death, or the covered number of SNF days has been used.

Based on the CWF line item rejects, carriers must deny assigned and unassigned services they have been billed that should have been consolidated and paid by the SNF and/or billed to the FI. Appeals rights must be offered on all denials. Standard systems must develop, and along with carriers must implement, an automated resolution process whereby when they receive a reject from CWF, they must pay those services correctly billed and only deny those services on the claim incorrectly billed to them.

B. Unsolicited Response Edits

Effective July 1, 2002, CWF implemented the unsolicited response edit based on the same coding files made available for the reject edits. Upon receipt of a Part A SNF claim at CWF, CWF searches paid claims history and compares the period between the SNF from and through dates to the line item service dates of the claims in history. It then identifies any services within the dates of the SNF stay that should have been subject to consolidated billing and should not have been separately paid by the carrier.

The CWF generates an unsolicited response, with a trailer that contains the identifying information regarding the claim subject to consolidated billing and a new trailer containing line item specific information that identifies all the individual services on that claim that fall within the SNF period. The unsolicited response provides all necessary information to identify the claim, including Document Control Number, Health Insurance Claim number, beneficiary name, date of birth, and beneficiary sex. CWF electronically transmits this unsolicited response to the carrier that originally processed the claim with consolidated services. These unsolicited responses are included in the CWF response file. The unsolicited responses in that file for claims to be adjusted for consolidated billing are identified with a unique transaction identifier. The previously paid claim is not canceled and remains on CWF paid claims history, pending subsequent adjustment.

Upon receipt of the unsolicited response, the carrier standard system software reads the line item information in the new trailer for each claim and performs an automated adjustment to each claim. Services subject to consolidated billing must be denied at the line level. The adjusted claims must then be returned to CWF, so that the claim on CWF paid claims history is replaced with the adjusted record. Carriers and DMERCs must return the claims with entry code 5. Both the covered and the non-covered services must be returned to CWF on the adjustment claim.

When CWF adjusts the claim on history, the deductible is updated on the beneficiary's file and the corrected deductible information is returned to the carrier in trailer 11. To recover any monies due back to Medicare resulting from these denials, carriers must follow the criteria in current overpayment recovery for the policy guidelines for furnishing demand letters and granting appeals rights.

In cases where all services on the claim are identified in CWF as subject to consolidated billing, the claim is adjusted by the carrier standard system to line item deny all the services on the claim. These fully non-covered claims must be returned to CWF, in order to reflect the denial actions in CWF paid claims history and to update the information in CMS's national claims history file. Carrier and DMERC systems must employ existing processes for the submission of fully non-covered claims.

C. Messages to be used with Denials for Rejects and Unsolicited Responses

The following messages should be used when the carrier receives a reject code from CWF indicating that the services are subject to consolidated billing and must be submitted to the SNF for payment.

Remittance Advice

At the service level, report adjustment reason code 109 – Claim not covered by this payer/contractor. You must send the claims to the correct payer/contractor.

At the service level, report remark code N73 - A SNF is responsible for payment of outside providers who furnish these services/supplies to its residents. Only the professional component of physician services can be paid separately.

NOTE: Effective April 1, 2003, remark code N73 was revised to - A SNF is responsible for payment of outside providers who furnish these services/supplies under arrangement to its residents.

If appropriate, use remark code MA78 – The patient overpaid you. You must issue the patient a refund within 30 days for the difference between our allowed amount total and the amount paid by the patient.

Medicare Summary Notice (MSN)

MSN code 13.9 - Medicare Part B does not pay for this item or service since our records show that you were in a SNF on this date. Your provider must bill this service to the SNF.

NOTE: Effective April 1, 2003, MSN 13.9 was revised to - Medicare Part B does not pay for this item or service since our records show that you were in a skilled nursing facility on this date. The revised Spanish version is: La Parte B de Medicare no paga por este artículo o servicio porque nuestros expedientes indican que usted estuvo en una institución de enfermería especializada en esta fecha.

Also, if appropriate, use MSN 34.8 – The amount you paid the provider for this claim was more than the required payment. You should be receiving a refund of \$.XX from your provider, which is the difference between what you paid and what you should have paid.

Or, use MSN 34.3 – After applying Medicare guidelines and the amount you paid to the provider at the time the services were rendered, our records indicate you are entitled to a refund. Please contact your provider. (NOTE: Use this message only when your system cannot plug the dollar amount in MSN 34.8.)

110.2.2 - Utilization Edits

(Rev. 76, 02-06-04)

Effective April 1, 2002, CWF implemented the following utilization edits for carrier submitted claims. Carriers implemented automated processes for the resolution of these edits based on the codes returned in the trailers from CWF.

A. Edits 7258 and 7259 - Carrier Part B Physical Therapy Claim Against an Inpatient SNF 21x and Inpatient Part B 22x Claim

Reject if a carrier Part B claim is received containing physical therapy (type of service of W), occupational therapy, or speech therapy and From/Thru Dates overlap or are within the From/Thru Dates on an SNF inpatient claim (21x) or an inpatient Part B claim (22x).

Use separate error codes where (1) dates are within (contractor will reject claim) or (2) where dates overlap (contractor will automate a separate denial message to provider).

Bypass the edit in the following situations:

- The 21x or 22x type of bill contains a cancel date.
- The incoming claim from date equals the SNF 21x or 22x history claim discharge date or incoming through date equals the SNF 21x or 22x history claim admission date.

B. Edits 7260 and 7261 - Carrier Part B Claim Without Therapy Against an Inpatient SNF

Reject if a carrier Part B claim is received with From/Thru Dates overlapping or are within the From/Thru Dates on an SNF Inpatient claim (21x). If the SNF 21x claim on history has patient status 30 and occurrence code 22 (Date Active Care Ended), use occurrence 22 date instead of the through date.

Use separate error codes where (1) dates are within (contractor will reject claim); or (2) where dates overlap (contractor will automate a separate denial message to provider).

Bypass the edit in the following situations:

- The 21x history claim contains a cancel date.
- The incoming Part B claim from date equals the SNF 21x history claim discharge date. The incoming Part B claim through date equals the SNF 21x history claim admission date.
- A diagnosis code in any position on the incoming claim is for renal disease.

- The Part B claim contains ambulance codes per the files supplied to CWF in the annual and quarterly updates with modifiers other than N (SNF) in both the origin and destination on the same claim.
- The Part B claim is a CANCEL ONLY (Action Code 4) claim.
- The Part B claim is denied.
- The Part B service has a Payment Process Indicator other than A (allowed).
- The Part B claim contains only separately payable services per the files supplied to CWF in the annual and quarterly updates.

110.2.3 - Duplicate Edits

(Rev. 76, 02-06-04)

Effective April 1, 2002, CWF implemented the following duplicate edits for carrier submitted claims.

A. Edit 7253 - Carrier Part B Ambulance Claim Against an Outpatient Part B SNF Ambulance Claim on History

Reject if a carrier Part B claim is received with ambulance codes per the files supplied to CWF in the annual and quarterly updates and the Date of Service equals the Date of Service on an outpatient Part B SNF (23x) claim with revenue code 54x (ambulance).

Bypass the edit if either the incoming or history claim contains any of the following situations:

- The claim is a CANCEL ONLY (Action Code 4) claim.
- The claim is denied.
- The incoming claim payment process indicator is other than A (allowed).

B. Edit 7257 - Carrier/DMERC or Intermediary Part B Claim Against An Inpatient B SNF (22x) Claim on History

Reject as a duplicate claim if a carrier/DMERC Part B claim or intermediary Part B claim (12x, 13x, 14x, 23x, 33x, 71x, 73x, 74x, 75x, 76x, 83x or 85x) is received containing date of service, HCPCS code and modifier if present, equal to the date of service, HCPCS code and modifier, if present, on an inpatient Part B SNF (221, 222, 223, 224 or 225) claim.

Bypass the edit if either the incoming or history claim contains any of the following situations:

- 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).
- For the carrier/DMERC claim only, the Part B claim contains only separately payable services per the files supplied to CWF in the annual and quarterly updates.

110.2.4 – Edit for Ambulance Services

(Rev. 76, 02-06-04)

When a medically necessary transport from one SNF to another SNF occurs when the beneficiary is discharged from the first SNF and admitted to the second, this transport is included in consolidated billing. The first SNF is responsible for the ambulance service and the cost is included in the Part A rate. It is not separately billable. CWF will reject these services to the carrier. The carrier must deny the service with appeals rights.

110.2.5 - Edit for Clinical Social Workers (CSWs)

(Rev. 76, 02-06-04)

Per the Balanced Budget Act, services provided by CSWs to beneficiaries in a Part A SNF stay may not be billed separately to the carrier. Payment for these services is included in the prospective payment rate paid to the SNF by the intermediary. Though the policy was in effect since April 1, 2001, there were no corresponding edits. With the April 2003 release, CWF implemented a new SNF consolidated billing edit to prevent payment to CSWs for services rendered to beneficiaries in a Part A SNF stay.

Effective April 1, 2003, CWF established the new edit 7269 for services rendered to these beneficiaries with dates of service on or after April 1, 2001, for claims received on or after April 1, 2003. Once CWF determines that a beneficiary is in a Part A stay, prior to applying the edits that review procedure codes to determine if payment should be allowed, CWF will review the performing provider type of the submitting entity. If the performing provider type is 80, CWF will reject the claim to the carrier or return an unsolicited response with new error code 7269. The carrier will then take the same adjustment and recovery action as for other rejects and unsolicited responses.

When carriers receive the new reject code, they must deny the claim and use the following RA and MSN messages.

RA

Report claim adjustment reason code 96 – Non-covered charges; and

Remark code N121 - Medicare Part B does not pay for items or services provided by this type of practitioner for beneficiaries in a Medicare Part A covered skilled nursing facility stay.

MSN

13.10 – Medicare Part B does not pay for items or services provided by this type of practitioner since our records show that you were receiving Medicare Part A benefits in a skilled nursing facility on this date. The Spanish version is: La Parte B de Medicare no paga por artículos o servicios provistos por este tipo de médico ya que nuestros expedientes indican que usted estaba recibiendo beneficios de la Parte A de Medicare en una institución de enfermería especializada en esta fecha.

110.2.6 - Edit for Therapy Services Separately Payable When Furnished by a Physician

(Rev. 215, 06-25-04)

A number of therapy services are considered separately payable when provided by a physician and shall be paid separately by the Medicare carrier. However, these services are considered therapy when provided by a physical or occupational therapist and are subject to consolidated billing.

Effective for claims with dates of service on or after July 1, 2004, edits will be implemented in the claims processing system to correctly process claims for these services. A complete list of these services can be found on the CMS website at www.cms.gov/medlearn/snfcode.asp.

110.3 - CWF Override Codes

(Rev. 76, 02-06-04)

A CWF override code has been developed for carrier use where, in the course of pursuing a reconsideration, a provider or supplier may bring to the attention of the carrier a situation where services on a claim have been denied, but should actually be allowed to be paid through the carrier. At the carrier's discretion, to allow that claim to process through CWF to payment, enter a "2" in the SNF consolidated billing override field.

110.4 - Coding Files and Updates

(Rev. 76, 02-06-04)

To correspond with the annual and quarterly coding and payment updates, CWF will be provided with files of codes that are not included in consolidated billing and can be paid

through the carrier or DMERC. These codes are available to the carriers, providers, and suppliers for informational purposes on the CMS Web site at www.cms.hhs.gov/medlearn/snfcode.asp. Changes in designation of codes from excluded to included (or vice versa) in consolidated billing will be considered corrections to align the codes with policy as opposed to changes in policy. Newly established Healthcare Common Procedure Coding System codes will be added to CWF edits to allow carriers to make appropriate payments.

110.4.1 - Annual Update Process

(Rev. 76, 02-06-04)

Barring any delay in the Medicare Physician Fee Schedule, CMS will provide the new code files to CWF by November 1. Should this date change, CWF will be notified through the appropriate mechanism.

The CWF contractor must compare the new code list for category 75 to the codes in the current edit. Codes that appear on the new list, but not in the current edit, must be added to the edit.

The CWF contractor must compare the new code list for codes that require the 26 modifier to the codes in the current edit. Codes that appear on the new list, but not in the current edit, must be added to the edit.

The CWF contractor must compare the new code list for ambulance codes to the codes in the current edit. Codes that appear on the new list, but not in the current edit, must be added to the edit.

The CWF contractor must compare the new code list for the Part B therapy codes to the codes in the current edit. Codes that appear on the new list, but not in the current edit, must be added to the edit.

After it has compared all codes on the new edit list to those in the current edits, the CWF contractor must provide CMS with a list of codes by edit that were formerly on the edits, but do not appear on the new code lists.

CMS will make a determination as to which codes should be deleted from which edits. This mechanism will allow for any changes in professional component/technical component designations to be correctly coded for edits and for deleted codes and codes no longer valid for Medicare purposes as of the end of the calendar year, to continue to pay correctly for prior dates of service.

CMS will respond to the list provided by the CWF contractor and provide the determination on the codes to the CWF contractor.

The CWF contractor will delete codes from the edits per the CMS determination.

Carriers must continue to respond to rejects and unsolicited responses received from CWF per current methodology.

Carriers must reopen and reprocess any claims brought to their attention for services that prior to this update were mistakenly considered to be subject to consolidated billing and therefore, not separately payable. Carriers need not search claims history to identify these claims.

Prior to January 1 of each year, new codes files will be posted to the CMS Web site at www.cms.hhs.gov/medlearn/snfcode.asp. Should this date change, carriers will be notified through the appropriate mechanism.

Coding changes throughout the year may also be made as necessary through a quarterly update process.

As soon as the new code files are posted to the CMS Web site, through their Web sites and list serves, carriers must notify physician, non-physician practitioners, and suppliers of the availability of the files.