# Medicare
## Skilled Nursing Facility Manual

**Department of Health and Human Services (DHHS)**
**HEALTH CARE FINANCING ADMINISTRATION (HCFA)**

**Transmittal 368** **Date: MAY 24, 2001**


**REFER TO CHANGE REQUEST 1323**

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This transmittal contains instructions for implementation of provisions in the Balanced Budget Act of 1997 that require payment to SNFs for Part B services under a fee schedule. It also contains instructions about CWF edits being planned for implementation to identify duplicate billings by SNFs and suppliers for Part A and Part B. Consolidated billing for SNF Part B residents and/or outpatients who are not receiving Part A benefits remains in effect only for therapy services.

Currently applicable Part A PPS billing and coverage instructions that have been issued by Program Memoranda to date are also incorporated.

HCPCS codes described in this transmittal are based on codes in effect for 2001. Codes newly effective in 2001 are identified by **bold print**.

**NEW/REVISED MATERIAL--*EFFECTIVE DATE:* April 1, 2001**
***IMPLEMENTATION DATE:* April 1, 2001**

Beginning with services provided on and after April 1, 2001, the intermediary will make payment for SNF Part B services under a fee schedule if there is a Medicare fee schedule established. This applies to 22x and 23x bill types. Related requirements are included in this transmittal. Services that are not paid under a fee schedule will be paid on a reasonable cost basis. The services listed below will not be paid under a fee schedule. Where covered, they continue to be paid on a cost basis. Fee schedules will be established for these services in the future.

Access the HCFA web site for an up to date list of items paid on a cost basis. A list effective with the date of this manual revision is included with the transmittal cover sheet.

SNFs are now required, for Part B services, to report HCPCS codes on the claim record for all services except supplies, and to show the date of service. These are new requirements, and are essential for payment under the applicable fee schedules.

Edits will be implemented in CWF for services provided on and after April 1, 2001, to detect bills with missing data and to detect duplicate billings by SNFs and suppliers. A description of these edits and instructions for contractor resolution are included.

A list of services for which there is no fee schedule follows. This information is not included in the manual. It will be published on the HCFA web site and updated there as needed.

List of Services Not Paid Under Fee Schedule

Note that some codes represent services that may not be covered under Part B for SNF residents or for outpatients.

Medical Supplies
A4570 A4580 A4590

Dialysis Supplies & Equipment
A4650 A4655 A4660 A4663 A4680 A4690 A4700 A4705 A4712 A4714 A4730 A4735 A4740 A4750 A4755 A4760 A4765 A4770 A4771 A4772 A4773 A4774 A4780 A4790 A4820 A4850 A4860 A4870 A4880 A4900 A4901 A4905 A4910 A4912 A4914 A4918 A4919 A4920 A4921 A4927

E1510 E1520 E1530 E1540 E1550 E1560 E1570 E1575 E1580 E1590 E1592 E1594 E1600 E1610 E1615 E1620 E1625 E1630 E1632 E1635 E1636 E1640

Therapeutic Shoes
A5500 A5501 A5502 A5503 A5504 A5505 A5506 A5507, **A5508**

PEN Codes -- PEN codes are billed to the DMERC by the supplier.
B4034 B4035 B4036 B4081 B4082 B4083 B4084 B4085 B4150 B4151 B4152 B4153 B4154 B4155 B4156 B4164 B4168 B4172 B4176 B4178 B4180 B4184 B4186 B4189 B4193 B4197 B4199 B4216 B4220 B4222 B4224 B5000 B5100 B5200 B9000 B9002 B9004 B9006 E0776XA **B9098 B9099**

Blood Products
P9010 P9011 P9012 P9013 P9016 P9017 P9018 P9019 P9020 P9021 P9022 **P9023 P9031 P9032 P9033 P9034 P9035 P9036 P9037 P9038 P9039 P9040 P9041 P9042 P9043 P9044**

**Codes deleted effective December 31, 2000: P9013 and P9018.**

Transfusion Medicine and Other Procedures
86850 86860 86870 86880 86885 86886 86890 86891 86900 86901 86903 86904 86905 86906 86915 86920 86921 86922 86927 86930 86931 86932 86945 86950 86965 86970 86971 86972 86975 86976 86977 86978 86985 89250 89251 89252 89253 89254 89255 89256 89257 89258 89259 89260 89261 89264

Ambulance Services
A0030 A0040 A0050 A0320 A0322 A0324 A0326 A0328 A0330 A0380 A0390 **A0426 A0427 A0428 A0429 A0430 A0431 A0432 A0433 A0434 A0435 A0436**

All Drugs Billed by the SNF on Bill Types 22x and 23x
Current payment and coverage rules apply to all drugs.

Fee schedules are applicable for all other SNF inpatient B and outpatient services. If a fee amount has not been set for a particular service, the service will be priced under individual consideration or gap-filled by the carrier, and the payment will be considered a fee schedule payment.

SNFs continue to bill the intermediary for SNF services, prosthetic, orthotic devices and surgical dressings. SNFs may continue to bill the carrier for physician employee services; and if also approved as a DME supplier, SNFs may bill the DMERC as a supplier of DME services.

**NOTE:** Part B does not cover DME that is furnished for use by residents in SNFs.

In addition to changes described above, some sections have been updated to reflect changes in deductible, coinsurance and benefits that have been issued previously but not yet included in the SNF manual.

Specific changes are:

Section 155, Hospital Insurance - A Brief Description, is changed to eliminate the statement that payment generally is made under reasonable cost.

Section 155.2, Inpatient Hospital Services, is updated for changes in application of coinsurance that were made January 1, 1982

Section 155.3, Posthospital Home Health Services, has been changed to describe Home Health benefit coverage changes as a result of BBA-97.

Section 160.1, Benefits, a new paragraph 19 has been added to include material in section A 160.1 (1981 amendment supplement).

Section 160.3, Annual Part B Deductible and Coinsurance, is updated to include deductible changes after 1982.

Section 220.5, Delayed Certifications and Recertifications, was changed to clarify delayed certifications.

Section 220.6, Disposition of Certification and Recertification Statements, was changed to indicate they must be maintained in the SNF medical record.

Section 270, Coverage of Outpatient Physical Therapy, Occupational Therapy, and Speech Pathology Services, has been updated to state that these services are not covered for SNF residents unless billed by the SNF.

Section 270.1, Services Furnished Under Arrangements With Providers, has been clarified to explain better what "under arrangements" means.

Section 302.4, Signature on the Request for Payment by Someone Other Than the Patient, was updated to delete a discontinued billing form.

Section 306, Time Limits For Requests and Claims For Payment for Services Paid under PPS, Fee Schedule or a Reasonable Cost Basis, has been updated to include PPS and fee schedule payments.

Section 306.1, Usual Time Limit, was changed to update examples using current dates.

Section 306.2, Extension of Time Limit Due to Delay in Transmitting Reply to Notice of Admission, was **deleted** because the admission notice process has been discontinued.

Section 306.3, Extension of Time Limit Where Late Filing is Due to Administrative Error, the examples are updated from 1975 to 2000.

Section 310.2, Part B Services (HCFA-1450 Billings), and Section 315, Time Limit for Filing Part B Claims, have been modified to manualize instructions previously issued about entries to make on the Form HCFA-1450 (UB-92) when filing claims after expiration of the normal time limit and to include claims paid under a fee schedule. Previous language limited application to reasonable cost and reasonable charge.

Section 315.1, Extension of Time Limit Due to Administrative Error, **deletes** the reference to reasonable charge because fee schedules now apply, and corrects spelling errors.

Section 317, Rules Governing Charges to Beneficiaries, has been updated and includes new language.

Section 315.1 Extension of Time Limit Due to Administrative Error, **deleted** the reference to reasonable charge.

Section 414, 3-Day Stay and 30-Day Transfer Requirements, was updated to add the ANSI ASC X-12 837 data reference.

Section 502, Billing Medicare for the Professional Component of SNF-Based Physician's Services is updated to reflect Part A PPS and Part B fee schedules.

Sections 515 - 516.6, SNF PPS Billing, have been added to include pertinent billing instructions for Part A SNF services from program memoranda issued to date.

Section 517.1, Where Charges Which Include Accommodation Charges Are Incurred in Different Accounting Years, is updated to conform to current policies that only a single bill is needed for no payment bills.

Sections 529 - 544, (excluding §539, Ambulance, which has been updated) have been added to describe changes to the SNF Part B billing. This includes material in Program Memoranda issued to date and new instructions.

Sections 556 through 556.4, Retention of Health Insurance Records, **have been relocated from 545 through 545.4.**

Section 595, Duplicate Edits and Resolution, is added to describe CWF and standard system edits related to duplicate billing, and related resolution procedures.

In addition, some material previously located within §§532 - 559 that does not relate exclusively to Part B billing has been relocated so that §§532 - 559 can be used for Part B SNF billing exclusively. as follows:

**Previous §§542 - 544.3 have been deleted and placed in the new Medicare Program Integrity Manual.**

**Previous §§545 - 545.4 have been moved to new §§556 - 556.4.**

**Previous §559 has been updated and moved to §544.**

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

## Hospital Insurance

### 155. HOSPITAL INSURANCE - A BRIEF DESCRIPTION

This is the basic part of the health insurance program. It is designed to help patients defray the expenses incurred by hospitalization and related care. In addition to inpatient hospital benefits, hospital insurance covers posthospital extended care in SNFs and posthospital care furnished by an HHA in the patient's home. In providing these additional benefits, recognition was given to the need for continued treatment after hospitalization and the need to encourage the appropriate use of more economical alternatives to inpatient hospital care. Program payment for services rendered to beneficiaries by providers (i.e., hospitals, SNFs and HHAs) are generally made to the provider based on the Prospective Payment System applicable to that type of provider.

155.1 Posthospital Extended Care Services.--Coverage of extended care services is provided under hospital insurance. The definition of the SNF, requirements for coverage, a description of extended care benefits, and the applicable coinsurance, limitations, and exclusions are fully treated in Chapter II.

155.2 Inpatient Hospital Services.--The items and services covered include: bed and board; nursing and other related services; use of hospital facilities and medical social services ordinarily furnished by the hospital for the care and treatment of inpatients; drugs, biologicals, supplies, appliances, and equipment for use in the hospital, which are ordinarily furnished by the hospital; diagnostic or other therapeutic items or services furnished by the hospital or by others under arrangements made by the hospital; services by interns or residents-in-training under approved teaching programs; and costs of blood after the first 3 pints in a benefit period and all costs of administering the blood including the provider's costs of administering the first 3 pints.

The patient is entitled to payment on his behalf for up to 90 days of inpatient hospital services in each benefit period. He is responsible for a deductible amount in each benefit period and a coinsurance amount equal to one-fourth of the inpatient hospital deductible for each day after the 60th day and through the 90th day of inpatient hospital services during a benefit period. In addition, a beneficiary has a 60-day lifetime reserve available for inpatient hospital services. Unless he elects not to use this reserve, he will be responsible for a coinsurance amount for each day used equal to one-half of the inpatient hospital deductible for the benefit period in which such reserve days are used. (See §249 for chart reflecting the applicable deductible and coinsurance amounts.)

For services furnished before 1982, the year in which the benefit period begins determines not only the deductible amount to be applied during such benefit period, but also the coinsurance amounts for inpatient hospital services and extended care services furnished in the same spell of illness.

For services furnished on or after January 1, 1982, the coinsurance amounts are based on the inpatient hospital deductible applicable for the year in which the services are furnished.

Inpatient tuberculosis hospital services are covered if the services furnished to the individual are services which can reasonably be expected to improve his condition or render it noncommunicable. Inpatient psychiatric hospital services are covered if the services furnished to the patient are furnished when he is receiving intensive treatment, or are necessary for medically-related inpatient diagnostic study. Where an individual is in a qualified psychiatric hospital on the first day for which he is entitled to hospital insurance benefits, the days on which he was an inpatient of such a hospital in the 150-day period immediately before his first day of entitlement must be counted in determining the 150-day lifetime limitation of 190 covered inpatient psychiatric hospital days in a psychiatric hospital. A period spent in a psychiatric hospital from which the beneficiary was discharged prior to entitlement, however, does not count against the 190 days.

Payment may be made for emergency inpatient hospital services furnished by nonparticipating U.S. hospitals when the threat to life or health of the individual necessitates the use of the most accessible hospital. Payment may also be made for emergency inpatient hospital and certain related Part B services in Canada and Mexico where the foreign hospital is more accessible from the site of the emergency than the nearest participating U.S. hospital.

Inpatient hospital services and related Part B services provided to a United States resident in a hospital in Canada or Mexico which is closer or more accessible to his U.S. residence than the nearest participating U.S. hospital may be covered whether or not an emergency existed.

155.3 Posthospital Home Health Services.--To qualify for Medicare coverage of home health care the beneficiary must be confined to the home, under the care of a physician, receiving services under a plan of care established and periodically reviewed by a physician, and be in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology, or have a continuing need for occupational therapy.

Home health benefits may be paid under Part A or under Part B depending upon:

- Whether the beneficiary is entitled only under Part A, Part B, or both;
- Whether the beneficiary has had a 3 consecutive day stay in a hospital or CAH; and
- If entitled under Part A whether home health services were initiated and the first covered home health visit is rendered within 14 days of discharge from a 3 consecutive day stay in a hospital or CAH or within 14 days of discharge from a SNF in which the individual was provided post-hospital extended care services. If the first home health visit is not initiated within 14 days of discharge, then home health services are financed under Part B.
- After an individual exhausts 100 visits of Part A post-institutional home health services, Part B finances the balance of the home health spell of illness.

See the Medicare Home Health Agency Manual for a description of the home health benefit.

§271.4). Coverage of outpatient physical therapy also includes the services of a qualified physical therapist in independent practice when furnished in his/her office or the beneficiary's home; expenses incurred for such services in a calendar year may not exceed $100 for services rendered prior to 1982 and $500 for services rendered on and after January 1, 1982.

11. Pneumococcal vaccine and its administration; hepatitis B vaccine and its administration, and blood clotting factors for hemophiliac patients and their administration.

12. Certain medical supplies used in connection with home dialysis delivery systems;

13. ESRD composite rate for all outpatient maintenance dialysis items and services;

14. Antigens prepared by a physician;

15. Rural health clinic services;

16. Comprehensive outpatient rehabilitative services;

17. Ambulatory surgical facility services furnished in connection with certain surgical procedures;

18. Services furnished in a health maintenance organization by a clinical psychologist, a physician assistant, or nurse practitioner, and services and supplies furnished incident to such services.

Payment may not be made under Part B for services furnished an individual if he is entitled to have payment made for those services under Part A. An individual is considered entitled to have payment made under Part A if the expenses incurred were used to satisfy a Part A deductible or coinsurance amount, or if payment would be made under Part A except for the lack of request for payment or physician certification.

19. For services furnished after June 30, 1981 a dentist qualifies as a "physician" if he/she is a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he/she performs such function and who is acting within the scope of his license when he/she performs such functions. Such services include any otherwise covered service that may legally and alternatively be performed by doctors of medicine, osteopathy and dentistry, e.g., dental examinations to detect infections prior to certain surgical procedures, treatment of oral infections and interpretations of diagnostic x-ray examinations in connection with covered services. The general exclusion of payment for dental services has not been withdrawn, payment for the services of dentists is also limited to those procedures which are not primarily provided for the care, treatment, removal, or replacement of teeth or structures directly supporting teeth. (See §280.12.) The coverage or exclusion of any given dental service is not affected by the professional designation of the "physician" rendering the service; i.e., an excluded dental service remains excluded and a covered dental service is still covered whether furnished by a dentist or a doctor of medicine or osteopathy.

160.2 Basis for Payment.--Payment for services covered by medical insurance and rendered by a participating hospital, skilled nursing facility, HHA, or other provider of services, or under arrangements made by such providers, is based, depending upon the service, on a PPS system applicable to the provider, a fee schedule, or reasonable cost as defined by regulations and manuals.

Payment, based on reasonable charges may be made to or on behalf of individuals covered by medical insurance for services of physicians and other medical and health services furnished under the program. In determining the reasonableness of charges, the carrier takes into consideration the customary charges of the physician (or other person rendering the service) as well as the prevailing charges in the locality generally made for similar services. A charge is not reasonable if it is higher than the charge applicable for a comparable service and under comparable circumstances to the carrier’s own policyholders or subscribers.

160.3 Annual Part B Deductible and Coinsurance.--In each calendar year, a cash deductible must be satisfied before payment can be made under the supplementary medical insurance plan. (See §160.5 for exceptions.)

As of January 1, 1991, the deductible is $100.

From January 1, 1982 through 1990, the deductible is $75.

From 1973 through 1981, the deductible was $60.

From 1966 through 1972, the deductible was $50.

Expenses count toward the deductible on the basis of incurred, rather than paid expenses, and are based on the reasonable charge. Noncovered expenses do not count toward the deductible. Even though an individual is not entitled to Part B benefits for the entire calendar year, i.e., his insurance coverage begins after the first month of a year or he dies before the last month of the year, he is still subject to the full deductible for that year. Medical expenses incurred in the portion of the year preceding entitlement to medical insurance are not credited toward the deductible.

The date of service generally determines when expenses were incurred, but expenses are allocated to the deductible in the order in which the bills are received by the intermediary. Services which are not subject to the deductible cannot be used to satisfy the deductible.

After the deductible has been satisfied, providers will generally be paid the lesser of the reasonable costs or customary charges less 20 percent of the reasonable charge but no more than 80 percent of the reasonable costs, and physicians and other suppliers 80 percent of the reasonable charges, incurred during the balance of the calendar year. The patient is responsible for a coinsurance amount equal to 20 percent of the reasonable charges for the items and services. (See §160.5 for exceptions.)

160.4 Special Carryover Rule for Expenses Incurred Prior to 1981.--Expenses incurred in the last 3 months of a calendar year prior to 1981, which were applied toward the Part B deductible for the year in which they were incurred, may also be credited towards the deductible for the following year.

**NOTE:** This deductible carryover provision was repealed effective with expenses incurred on or after October 1, 1981.

160.5 Exceptions to Part B Deductible and Coinsurance.--

A. The 20 percent coinsurance does not have to be met with respect to the following:

1. Purchased used durable medical equipment (DME) including DME furnished as a home health benefit, if the charge does not exceed 75 percent of the reasonable charge of new equipment.

2. Preadmission diagnostic testing services furnished from December 5, 1980 through July 18, 1984.

CHAPTER II

COVERAGE OF SERVICES

Section

SNF Services Covered Under Part B



Outpatient Physical Therapy, Occupational Therapy, and Speech Pathology Services Covered under Medical Insurance

CHAPTER II

COVERAGE OF SERVICES

Section

Facility-Based Physicians



General Exclusions from Coverage

obtained at the time of admission, or as soon thereafter as is reasonable and practicable. The routine admission procedure followed by a physician would not be sufficient certification of the necessity for posthospital extended care services for purposes of the program.

If ambulance service is furnished by an SNF, and additional certification is required, it may be furnished by any physician who has sufficient knowledge of the patient's case including the physician who requested the ambulance or the physician who examines the patient upon his arrival at the facility. The physician must certify that the ambulance service was medically required.

In addition, physician's certifications are required for the rental and purchase of durable medical equipment (see §264) and outpatient physical therapy and outpatient speech pathology services. (See §271.1.)

220.3 Recertification.--The recertification statement must meet the following standards as to its contents: it must contain an adequate written record of the reasons for continued need for extended care services, the estimated period of time the patient will need to remain in the facility, and any plans, where appropriate, for home care. The recertification statement made by the physician has to meet the content standards, unless, for example, all of the required information is in fact included in progress notes, in which case the physician's statement could indicate that the individual medical record contains the required information and that continued posthospital extended care services are medically necessary. A statement reciting only that continued extended care services are medically necessary is not, in and of itself, sufficient.

A certification may be mailed, faxed or completed when the physician is onsite. However, the physician cannot sign an initial certification and one or more recertifications at the same time.

If the circumstances require it, the first recertification must state that the continued need for a condition requiring such services which arose after the transfer from the hospital and while the patient was still in the facility for treatment of the condition(s) for which he had received inpatient hospital services.

Where the requirements for the second or subsequent recertification are satisfied by review of a stay of extended duration, pursuant to the utilization review (UR) plan, a separate recertification statement is not required. It is sufficient if the records of the UR committee show consideration was given to the recertification content standards. See §251B for requirements regarding certification for presumed coverage cases.

220.4 Timing of Recertifications.--The first recertification must be made no later than the 14th day of inpatient extended care services. An SNF can, at its option, provide for the first recertification to be made earlier, or it can vary the timing of the first recertification within the 14-day period by diagnostic or clinical

categories. Subsequent recertifications must be made at intervals not exceeding 30 days. Such recertifications may be made at shorter intervals as established by the UR committee and the SNF.

At the option of the SNF, review of a stay of extended duration, pursuant to the facility's utilization review plan, may take the place of the second and any subsequent physician recertifications. The SNF should have available in its files a written description of the procedure it adopts with respect to the timing of recertifications. The procedure should specify the intervals at which recertifications are required, and whether review of long-stay cases by the UR committee serves as an alternative to recertification by a physician in the case of the second or subsequent recertifications.

220.5 Delayed Certifications and Recertifications.--SNFs are expected to obtain timely certification and recertification statements. However, delayed certifications and recertifications will be honored where, for example, there has been an oversight or lapse.

In addition to complying with the content requirements, delayed certifications and recertifications must include an explanation for the delay and any medical or other evidence which the SNF considers relevant for purposes of explaining the delay. The facility will determine the format of delayed certification and recertification statements, and the method by which they are obtained. A delayed certification and recertification may appear in one statement; separate signed statements for each certification and recertification would not be required as they would if timely certification and recertification had been made.

220.6 Disposition of Certification and Recertification Statements.--Except for "presumed coverage" cases (see §250), skilled nursing facilities do not have to transmit certification and recertification statements to the intermediary or the Health Care Financing Administration. Instead, they must be maintained in the SNF medical record.

## Extended Care Services Covered Under Hospital Insurance

### 230. COVERED EXTENDED CARE SERVICES

A. Payment for Extended Care Services.--Patients covered under hospital insurance are entitled to have payment made on their behalf for covered extended care services furnished by the facility, by others under arrangements with the facility, or by a hospital with which the facility has a transfer agreement. Effective with the start of the first cost reporting period on or after July 1, 1998, inpatient SNF services are paid under a prospective payment system. (See §211.) If the items or

**EXAMPLE**: Mrs. Jones, who had already met her deductible, purchased a wheelchair on February 1, which she used in her home until her admission to the SNF on April 15. She was discharged from the SNF to her home on June 15 and continued to need the wheelchair. The reasonable charge for the wheelchair was $150 and the reasonable rental charge was $15 per month. The intermediary scheduled 10 monthly payments of $12 each (80 percent of $15) and paid for February, March, and April. Since Mrs. Jones was institutionalized for the entire month of May, the fourth installment was suspended. This installment became the June payment, and payments continued through December rather than November, as originally scheduled.

D. Durable Medical Equipment Purchased Before Beneficiary's Coverage Begins.--The dates on which periodic payments for a covered purchased item are due and allocation of the installments for deductible purposes are determined under the rules in subsection B. However, in determining whether a purchased item is covered, the entire expense of the item is considered to have been incurred on the date the equipment was delivered. Accordingly, where a purchased item of durable medical equipment was delivered to an individual before his/her coverage period began, the entire expense of the item (whether it was paid for in its entirety at the time of purchase or on a deferred or installment basis), are excluded from coverage since payment cannot be made for any expense incurred before an individual's coverage period began.

## Inpatient Part B and Outpatient Physical Therapy, Occupational Therapy, and Speech Pathology Services Covered Under Medical Insurance

### 270. COVERAGE OF INPATIENT PART B AND OUTPATIENT PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH PATHOLOGY SERVICES

Under Part A, physical therapy, occupational therapy, and speech pathology services are included in the SNF PPS rate for cost reporting periods beginning on or after July 1, 1998. For inpatient Part B residents and outpatient services, payment for such services is under a fee schedule. The SNF must bill for physical therapy, occupational therapy, or speech pathology services for Part A residents beginning with its first cost reporting period that starts on or after July 1, 1998, and for Part B for services furnished on or after July 1, 1998. The SNF (rather than an outside provider/supplier such as an approved clinic or rehabilitation agency, or a participating hospital or another SNF or an HHA) bills Medicare and payment is made directly to the SNF. The patient is responsible only for applicable Part A coinsurance or the Part B deductible and coinsurance amounts.

**NOTE:** Part B dates of service for 2 calendar years may not be included on the same bill. Two separate Part B bills are required.

270.1 Services Furnished Under Arrangements With Providers.--You may arrange with others to furnish covered outpatient physical therapy, occupational therapy, or speech pathology services. The SNF (rather than an outside provider/supplier, such as an approved clinic or rehabilitation agency, another SNF, or an HHA) bills Medicare, and payment is made directly to the SNF. When such arrangements are made, receipt of payment by you for the arranged services (as with services provided directly) relieves the beneficiary or any other person of further liability to pay for them. (See §206.)

### 271. CONDITIONS FOR COVERAGE OF OUTPATIENT PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH PATHOLOGY SERVICES

To be covered under the Medicare program, outpatient physical therapy, occupational therapy, or speech pathology services that you furnish a patient must meet all of the conditions listed in §230.3 and the following requirements.

271.1 Physician's Certification and Recertification for Outpatient Physical Therapy, Occupational Therapy, and Speech Pathology Services.--

A. Content of Physician's Certification.--No payment is made for outpatient physical therapy, occupational therapy, or speech pathology services unless a physician certifies that:

- The services are or were furnished while the patient was under the care of a physician (see §271.2);
- A plan for furnishing such services is or was established by the physician, physical therapist, occupational therapist, or speech pathologist and periodically reviewed by the physician (see §271.3); and
- The services are or were required by the patient.

Since the certification is closely associated with the plan of treatment, the same physician who establishes or reviews the plan must certify to the necessity for the services. Obtain certification at the time the plan of treatment is established or as soon thereafter as possible. Physician means a doctor of medicine, osteopathy (including an osteopathic practitioner) or podiatric medicine legally authorized to practice by the State in which he/she performs these services. In addition, physician certifications by doctors of podiatric medicine must be consistent with the scope of the professional services provided by a doctor of podiatric medicine as authorized by applicable State law.

B. Recertification.--When outpatient physical therapy, occupational therapy, or speech pathology services are continued under the same plan of treatment for a period of time, the physician must recertify at intervals of at least once every 30 days that there is a continuing need for such services and estimate how long services will be needed. Obtain the recertification at the time the plan of treatment is reviewed since the same interval (at least once every 30 days) is required for the review of the plan. The physician who reviews the plan of treatment must sign the recertifications. The form and manner of obtaining timely recertification is up to you.

CHAPTER III

PAYMENT PROCEDURES

Section

## Filing for Payment



## Time Limits for PPS, Fee Schedule and Cost Based Payment for Claims



## Time Limits--Part B Claims



## Special Provisions Related to Payment

CHAPTER III

PAYMENT PROCEDURES

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Overpayments



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Limitation on Liability of Beneficiary and SNF
Where Medicare Claims Are Disallowed



Indemnification Procedures Under
Limitation of Liability



Appeals of Payment Determinations

2. To incorporate, by stamp, or otherwise, information to the following effect on any bills sent to Medicare patients: "Do not use this bill for claiming Medicare benefits. A claim has been or will be submitted to Medicare on your behalf." This requirement is necessary to prevent patients from submitting duplicate claims.

The SNF also undertakes to make the patient signature files available for carrier and intermediary inspection on request.

302.4 Signature on the Request for Payment by Someone Other Than the Patient.--If at all practical, the patient should sign the request whether on the billing form or on the provider's record at the time of admission.

In certain circumstances, it would be impracticable for an individual to sign the request for payment himself because when he is admitted to a skilled nursing facility he is unconscious, incompetent, in great pain, or otherwise in such a condition that he should not be asked to transact business. In such a situation, his representative payee (i.e., a person designated by the Social Security Administration to receive monthly benefits on the patient's behalf, a relative, legal guardian, or a representative of an institution (other than the facility) usually responsible for his care, or a representative of a governmental entity providing welfare assistance, if present at time of admission, should be asked and permitted to sign on his behalf.

A. Provider Signs Request.--If, at the time of admission the patient cannot be asked to sign the request for payment and there is no person present exercising responsibility for him, an authorized official of the facility may sign the request. The skilled nursing facility should not routinely sign the request on behalf of any patient. If experience reveals an unusual frequency of such facility signed requests from a particular facility, the matter will be subject to review by the intermediary.

The SNF need not attempt to obtain the patient's signature where the physician sends a specimen (e.g., blood or urine sample) to a laboratory of a participating SNF for analysis, the patient does not go to the SNF, but the tests are billed on an assignment basis through it. The SNF may sign on behalf of the patient and should note in the space provided for the patient's signature "Patient not physically present for tests." This does not apply in cases in which the patient actually goes to the SNF laboratory for tests and the facility fails to obtain the patient's signature while he is there.

B. Patient Dies Before Signing Request for Payment.--If the patient dies before the request for payment is signed, it may be signed by the legal representative of his estate, or by any of the persons or institutions (including an authorized official of the facility) who could have signed it had he been alive and incompetent.

C. Need for Explanation of Signer's Relationship to Patient.--When someone other than the patient signs the request for payment, the signer will submit a brief statement explaining his relationship to the patient and the circumstances which make it impracticable for the patient to sign. The facility will forward this statement with its billing, or retain it in its files if the signature is obtained on the facility's own record.

302.5 Refusal by Patient to Request Payment Under the Program.--A patient on admission to a skilled nursing facility may refuse to request Medicare payment and agree to pay for his services out of his own funds or from other insurance. Such patients may have a philosophical objection to Medicare or may feel that they will receive better care if they pay for services themselves or they are paid for under some other insurance policy. The patient's impression that another insurer will pay

for the services may or may not be correct, as some contracts expressly disclaim liability for services covered under Medicare. Where the patient refuses to request Medicare payment, the provider should obtain his signed statement of refusal whenever possible. If the patient (or his representative) is unwilling to sign, the facility should record that the patient refused to file a request for payment but was unwilling to sign the statement of refusal.

In any event, there is no provision which requires a patient to have covered services he receives paid for under Medicare if he refuses to request payment. Therefore, a provider may bill an insured patient who positively and voluntarily declines to request Medicare payment. However, if such a person subsequently changes his mind (because he finds his other insurance will not pay or for another reason) and requests payment under the health insurance program within the prescribed time limit, the provider must bill the intermediary. The provider should then refund to the patient any amounts he paid in excess of the permissible charges.

Where a patient who has declined to request payment dies, his right to request payment may be exercised by the legal representative of his estate, by any of the persons or institutions mentioned in the second paragraph of § 302.4, by a person or institution which paid part or all of the bill, or in the event a request could not otherwise be obtained, by an authorized official of the facility. This permits payment to the facility for services which would not otherwise be paid for and allows a refund to the estate or to a person or institution which paid the bill on behalf of the deceased.

See §308 for effect on beneficiary and facility of refusal to file.

Time Limits for PPS, Fee Schedule and Cost Based Payment for Claims

306. TIME LIMITS FOR REQUESTS AND CLAIMS FOR PAYMENT FOR SERVICES PAID UNDER PPS, FEE SCHEDULE OR ON A COST BASIS

Program payment may not be made under Part A or Part B for provider services unless the beneficiary or his representative has filed a timely request for payment, and the facility has filed a timely claim. (See §300.) The intermediary has the responsibility for determining if a claim is timely filed.

306.1 Usual Time Limit.--Effective with claims filed after December 31, 1974, the beneficiary request and the provider claim must be filed on or before December 31 of the calendar year following the year in which the services were furnished. Services furnished in the last quarter of the year are considered furnished in the following year; i.e., the time limit is 2 years after the year in which such services were furnished.

**EXAMPLE 1**: A Medicare beneficiary received inpatient services at General SNF in September 1998. The beneficiary signed a request for Medicare payment at the time of admission. The facility billing for the services must file a claim with the intermediary on or before December 31, 1999, the close of the year following the year in which the services were furnished.

**EXAMPLE 2:** A Medicare beneficiary received diagnostic tests as an outpatient of General SNF in November 1998. His request for Medicare payment must be filed with the intermediary by December 31, 2000, the close of the year following the year in which the service was "furnished." Since the services were furnished in the last quarter of 1998, they are deemed to be furnished in 1999.

306.3 Extension of Time Limit Where Late Filing Is Due to Administrative Error.--Where HCFA error (i.e., misrepresentation, delay, mistake, or other action of HCFA or its intermediaries or carriers) causes the failure of the SNF to file a claim for payment within the time limit in §306.l, the time limit will be extended through the last day of the sixth calendar month following the month in which the error is rectified by notification to the SNF or beneficiary, but not beyond December 3l of the third calendar year after the year in which the services were furnished. (For services furnished during October - December of a year, the time limit may be extended no later than the end of the fourth year after that year.)

The administrative error which prevents timely filing of the claim may affect the SNF directly (or indirectly, i.e., by preventing the beneficiary or his representative from filing a timely request for payment.) Situations in which failure to file within the usual time limit in §306.l will be considered to have been caused by administrative error include but are not limited to the following:

l. The failure resulted because the individual's entitlement to HI or SMI was not established until long after the month for which it was effective (e.g., a beneficiary is awarded 2 years of retroactive coverage).

2. The failure resulted from HCFA's failure to notify the individual that his entitlement to HI or SMI had been approved, or in giving him (or his representative or the SNF) cause to believe that he is not entitled to HI or SMI.

3. The failure resulted from misinformation from HCFA or the intermediary or carrier, e.g., that certain services were not covered under HI or SMI, although in fact they were covered.

4. The failure resulted from excessive delay by HCFA, the intermediary, or the carrier in furnishing information necessary for the filing of the claim.

5. The failure resulted from advice by HCFA or an authorized agent for HCFA that precluded the filing of a claim until the SNF receives certain information from the intermediary (e.g., an SNF following manual instructions does not file a billing for outpatient services where the services are expected to be paid for by worker's compensation; but the facility learns after the expiration of the time limit of the ultimate denial of workers' compensation liability).

The intermediary will submit to HCFA for advice any claim in which delay in establishing HI or SMI entitlement or notifying an individual of HI or SMI entitlement prevents the filing of a claim until more than 3 years after the year in which the services were furnished (4 years after the year, in the case of services furnished in the last quarter of the year).

**EXAMPLE l**: Information submitted in connection with a claim for services during the period May 1998 - September 1998, filed in March 2000, shows that the beneficiary's application for HI was initially denied. He was first notified on January l5, 2000, that he had HI effective May 1998. Under these circumstances, the intermediary may pay appropriate HI benefits for the services provided during May - September 1998. Although the usual time limit expired December 3l, 1999, the error in this case--delay in establishing HI entitlement--was not corrected until January l5, 2000, thus extending the time limit to July 3l, 2000.

**EXAMPLE 2**: An individual requested enrollment in SMI in March 1998, the month before he attained age 65. He received covered outpatient services in July 1998, but did not request payment because he had not received notice of his SMI entitlement. Such notice was mailed to him on October 3, 1999. Although the regular time limit for the services in July 1998 expired on December 3l, 1999, the claim will be considered promptly and timely filed if it is filed on or before April 30, 2000, (within the 6-month period following the month in which the notice was sent).

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## 308. EFFECT ON BENEFICIARY AND PROVIDER OF LATE FILING OR BENEFICIARY'S REFUSAL TO FILE

A. Skilled Nursing Facility Is Responsible for Not Filing Timely.--Where the beneficiary request was filed timely (or would have been filed timely had the SNF taken action to obtain a request from the patient whom the facility knew or had reason to believe might be a beneficiary) but the facility is responsible for not filing a timely claim, the SNF may not charge the beneficiary for the services except for such deductible and/or coinsurance amounts as would have been appropriate if Medicare payment had been made. The beneficiary is charged utilization days. (See §528.)

B. Patient Refuses to Request Medicare Payment or SNF Is Unaware of His Eligibility.--The facility may charge the beneficiary for covered services where no timely request for payment is filed by or on behalf of the beneficiary because;

1. The beneficiary refused to file. (Utilization days will be charged, and if Part B services are rendered the Part B deductible will be credited to his SSA record.)

2. The patient failed to bring his entitlement or possible entitlement to the attention of the SNF and the SNF had no other reason to believe the patient had Medicare. If the patient later brings his entitlement to Part A or Part B (whichever is required for payment for the services) to the facility's attention after the time limit and the bill is not filed timely, utilization days will not be charged, and if Part B services are rendered the Part B deductible will not be credited.

## 310. FILING CLAIM WHERE USUAL TIME LIMIT HAS EXPIRED

Where it comes to the attention of a facility that health services which are or may be covered were furnished to a beneficiary but that the usual time limit in §306.l on filing a claim for such services has expired, the facility should take the following action:

310.1 Part A Skilled Nursing Facility Services.--Where the SNF accepts responsibility for late filing, it should file a no-payment bill. (See §§527ff.) Where the facility believes the beneficiary is responsible for a late filing, it should also file a no-payment bill and attach a statement explaining the circumstances which led to the late filing and giving the reasons for believing that the beneficiary (or other person acting for him) is responsible for the late filing and, if practicable, attach the statement of the beneficiary as to his view of these circumstances.

Where the SNF believes HCFA or its agents are responsible for the late filing, it should file a regular payment bill and attach a statement explaining its view of the circumstances which led to the late filing and, if practicable, the written explanation of the beneficiary as to such circumstances.

310.2 Part B Services (HCFA-l450 Billings).--Where the facility accepts the responsibility for the late filing, it should submit an HCFA-l450 which contains the legend "late filed claim--provider fault" in the remarks section (Form Locator FL 84) to differentiate it from a regular HCFA-l450. For the UB-92 remarks, use Record Type 91. For the ANSI ASC X-12 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1 remarks, use 2-190.A NTE02. For the Health Care claim: Institutional ANSI ASC X-12 837 version 4010 remarks, use BILLING NOTE NTE02. Provider liability is shown by using Occurrence Span Code 77. The intermediary will determine whether a span code 77 or 79 is appropriate.

Where the SNF believes the beneficiary is responsible for late filing, it should file a no-payment bill, attach a statement explaining the circumstances which led to late filing and setting forth reasons for belief that the beneficiary (or person acting for him) is responsible for the late filing and, if practicable, attach the statement of the beneficiary as to his view of the circumstances. Where the SNF believes HCFA or its agent is responsible for the late filing, it should proceed as in §3l0.l.

310.3 Appeals.--Where the beneficiary does not agree with the determination that the claim was not filed timely or with the assignment to him of the responsibility for the late filing, the usual appeal rights are available to him, i.e., reconsideration, hearing (if the amount in controversy equals $l00 or more), etc. (See §383.) Where the provider is protesting the denial of payment or the assignment of responsibility for the late filing, no formal channels of appeal are available. However, the intermediary may, at the request of the provider, informally review its initial determination.

Time Limits - Part B Claims

315. TIME LIMIT FOR FILING PART B CLAIMS

For Medicare payment to be made for a claim for physician or other Part B services, the claim must be filed no later than the end of the calendar year following the year in which the service was furnished, except for services furnished in the last 3 months of a year, where the time limit is December 3l of the second year following the year in which the services were rendered. This time limit was effective with claims filed after March l968. (See §§300.l and 300.2 for effect of Federal nonworkdays and rules applicable to claims received in the mail.)

315.1 Extension of Time Limit Due to Administrative Error.--Where administrative error (that is, misrepresentation, delays, mistake, or other action of HCFA or its intermediaries or carriers) causes the failure of a beneficiary or the provider, physician, or supplier to file a claim for payment within the time limit specified in § 3l5, the time limit will be extended through the close of the 6th calendar month following the month in which the error is rectified.

Consideration of possible extension of the time limit on Part B claims will be initiated by the intermediary only if there is a basis for belief that the claimant (the enrollee or his representative or assignee) has been prevented from timely filing by an administrative error; for example, he states that official misinformation caused the late filing, or the social security office calls to the contractor's attention a situation in which such error has caused late filing. (See §306.3 for examples of administrative error.)

315.2 Time Limit Where a Skilled Nursing Facility Has Billed Improperly for Professional Component.--In some cases, an SNF may have incorrectly billed for a Part B professional component as a provider expense. For example, a physician's services were erroneously considered entirely administrative in nature and the error was not discovered until the final cost settlement. Where the claim which included the physician services was filed within the time limit, it establishes protective filing for a subsequent perfection of a Part B claim. Such claims are considered filed as of the date the incorrect billing was submitted to the intermediary provided the usual claims information (e.g., Form HCFA - 1500) is submitted within 6 months after the month in which the notice was sent that payment for the patient care services was disallowed.

The perfected claim may be filed by the physician on the basis of assignment, by you (when your facility has a contractual arrangement to bill and receive payment for the physician’s services), or by the patient on the basis of an itemized bill.

An SNF claim filed within the Part B time limit does not establish a filing date for the related professional component when such component was recognized and not included in the provider bill, e.g., no claim was filed for the professional component as a nonprovider expense because the physician and SNF could not agree on the exact amount of the component charge or who would bill for it.

315.3 Responsibility When Claim Not Filed Timely.--When the time limit has expired on services payable on a reasonable charge basis, there is no requirement that a billing be filed. However, where a person (or organization) accepts assignment within the time limit but fails to submit a timely claim, he/she is barred by the terms of the assignment from collecting from the patient or others amounts in excess of the deductible and coinsurance for the services involved.

## Special Provisions Related to Payment

### 317. RULES GOVERNING CHARGES TO BENEFICIARIES

A. General.--Under your provider agreement, you may charge a beneficiary only applicable deductible and coinsurance amounts and for noncovered services. Additional restrictions, implied by your provider agreement, on what you may collect or seek to collect from a beneficiary (or any party acting on the beneficiary's behalf) are set forth below. You must refund amounts incorrectly collected.

B. Requests and Requirements for Deposits and Other Payments.--You may not require, request, or accept a deposit or other payment from a Medicare beneficiary as a condition for admission, continued care, or other provision of services, except as follows:

- You may request and accept payment for a Part A deductible and coinsurance amount on or after the day to which it applies and payment for a Part B deductible and coinsurance amount at the time of or after the provision of the service to which it applies. You may not request or accept advance payment of Medicare deductible and coinsurance amounts.

- You may require, request, or accept a deposit or other payment for services if it is clear that the services are not covered by Medicare. See subsection C for the effect of a beneficiary request for submission of a demand bill. See subsection D for charges for personal comfort and convenience services.

C. Effect of Submission of Demand Bill by SNF.--If you believe that a beneficiary requires only a noncovered level of care beginning with admission or at some point thereafter, give the beneficiary proper notice to that effect and advise the beneficiary before the services are furnished that, in your opinion, Medicare will not pay for the services and the beneficiary will be personally and fully responsible for payment. (Section 1879(a)(1) of the Act) If the beneficiary disagrees and asks you to submit a bill to the intermediary, you must submit a demand bill for an initial determination. You may not require, request, or accept a deposit or other payment from the beneficiary for the services until the intermediary makes an initial determination that the services are not covered by Medicare.

**EXCEPTION**: You may request and accept payment for a potential Part A coinsurance amount no earlier than the day to which the coinsurance applies if the services are found to be covered.

If you believe that the services are noncovered or excluded for reasons other than the level of care required to be furnished (e.g., the 3-day prior hospitalization requirement is not met, the beneficiary is not admitted to the SNF within 30 days (or longer period, if appropriate) of discharge from the hospital, or SNF benefits are exhausted), you must still submit a demand bill upon request. You may require, request, and accept a deposit or other payment from the beneficiary while the intermediary determination is pending.

D. Charges for Personal Comfort and Convenience Services.--You may charge a beneficiary for noncovered excluded personal comfort and convenience services (e.g., rental of a television set or a telephone) if the beneficiary requests these services with knowledge of the charges. Also, you may require an advance deposit from the beneficiary for the noncovered services requested by the

beneficiary if this is your practice with non-Medicare patients. You may not, however, require a beneficiary to request such noncovered services as a condition for admission or continued care.

E. Other Restrictions and Requirements.--Medicare regulations include several other special limitations that are covered by or based on the provider agreement:

- You may not evict or threaten to evict a beneficiary for inability to pay a deductible or coinsurance amount applying under Medicare;

- You may not charge a beneficiary for your agreement to admit or readmit him/her as of some specified future date for inpatient services which are or may be covered under Medicare (as distinguished from charging a beneficiary for holding a bed for him/her at his/her request as is permissible); and

- You may not charge a beneficiary who is receiving inpatient care which is or may be covered by Medicare for failure to remain in your facility for a certain period of time or for failure to give you advance notice of departure.

If you require the execution of an admission contract by the beneficiary (or by another person acting on behalf of the beneficiary), the terms of the contract must be consistent with this section.

F. Compliance.--Improper charges to beneficiaries under the above restrictions and requirements constitute violations of the provider agreement under §1866(a)(1) of the Act. Noncompliance with these restrictions and requirements may, depending on the nature and extent of the violations, subject you to termination of your provider agreement.

Under §1819(d)(4)(A) of the Act, you violate the conditions of participation if you fail to operate and provide services in compliance with all applicable Federal, State and local laws and regulations, including the Federal statutory requirements and regulations which are the basis of the above restrictions and requirements. Section 1819(h) of the Act authorizes a number of alternative remedies to be imposed on you in lieu of termination of your provider agreement if you fail to comply with Federal participation requirements. In the case of SNFs §1819(h)(2)(B)(i) and (ii) gives the HCFA regional office (RO) as an alternative to termination of the provider agreement the authority to deny Medicare payments for new admissions and/or fine the SNF up to $10,000 a day as long as the violations continue or are not corrected. If the initial RO finding of violations indicates extreme abuse, the RO will be able to impose sanctions without first asking for a commitment by you to desist from those violations.

The State agency, usually the State health department, which surveys SNFs for compliance with the conditions of participation, also monitors SNFs for compliance with the requirements and restrictions and reports its findings to the RO.

The date of discharge from the prior-stay hospital must have occurred on or after the first day of the month in which the beneficiary became entitled to Medicare.

Hospital days to which waiver of liability was applied cannot be used to satisfy the 3-day hospital stay requirement for SNF services.

The prior-stay hospital will usually send you a patient transfer form in accordance with your transfer agreement. When you have a transfer form on file showing the hospital's admission and discharge dates, or a written record of a telephone conversation with the transferring hospital containing this information, record these dates in Item 33 of the Form HCFA-1450 or in the Institutional ANSI ASC X-12 837.

# CHAPTER V

# BILLING PROCEDURES

Section

## Summary



## Inpatient Billing

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Retention and Destruction of Health Insurance Records



Uniform Billing

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Billing in Situations Where Medicare is Secondary Payer



Time Limitation for Medical Information Requests



Standard System and CWF Edits and Error Resolution Procedures



Provider Submission of Electronic Media Claims Data (EMC)

The interest period begins on the day after payment is due and ends on the day of payment.

| EXAMPLES: | Clean Paper Claim | Clean Electronic Claim |
|---|---|---|
| Date Received | November 1, 1993 | November 1, 1993 |
| Payment Due | November 28, 1993 | November 15, 1993 |
| Payment Made | December 3, 1993 | December 2, 1993 |
| Interest Begins | December 2, 1993 | December 2, 1993 |
| Days for Which Interest Due | 2 | 1 |
| Amount of Payment | $100 | $100 |
| Interest Rate | 5.625% | 5.625% |

Use the following formula:

o For the clean paper claim--$100 X .05625 x 2 divided by 365 = $.0308 or $.03 when rounded to the nearest penny.

o For the clean electronic claim--$100 X .05625 x 1 divided by 365 = $.0154 or $.02 when rounded to the nearest penny.

When interest payments are applicable, your intermediary indicates for the individual claim the amount of interest on their remittance record to you.

D. Definition of "Clean Claim".--A "clean" claim is one that does not require your intermediary to investigate or develop external to their Medicare operation on a prepayment basis.

Examples of clean claims are those that:

o Pass all edits (intermediary and Common Working File (CWF)) and are processed electronically;

o Do not require external development by your intermediary and are not approved for payment by CWF within 7 days of your intermediary's original claim submittal for reasons beyond your intermediary's or your control;

o Are investigated within your intermediary's claims, medical review, or payment office without the need to contact you, the beneficiary, or other outside source;

o Are subject to medical review but complete medical evidence is attached by you or forwarded simultaneously with EMC records in accordance with your intermediary's instructions. If medical evidence must be requested, see first item under subsection D; or

o Are developed on a postpayment basis.

E. Other Claims.--Claims that do not meet the definition of "clean" claims are considered "other" claims. Other claims require investigation or development external to your intermediary's Medicare operation on a prepayment basis. Other claims are those that are not approved by CWF which your intermediary identifies as requiring outside development. Examples are claims on which your intermediary:

- Requests additional information from you or another external source. This includes routine data omitted from the bill, medical information, or information to resolve discrepancies;

- Requests information or assistance from another contractor. This includes requests for charge data from the carrier or any other request for information from the carrier;

- Develops MSP information;

- Requests information necessary for a coverage determination;

- Performs sequential processing when an earlier claim is in development; and

- Performs outside development as result of a CWF edit.

For purposes of counting the 7 day period described above, all intermediaries (including CWF) start their count on the day after their original query or bill submittal.

## 502. BILLING MEDICARE FOR THE PROFESSIONAL COMPONENT OF SNF-BASED PHYSICIAN'S SERVICES

Section 275 defines "facility-based physicians," "professional component," and "facility component."

Part B benefits for the professional component of physician or other nonprovider services are payable on a fee schedule basis.

Use the Form HCFA-1500, Health Insurance Claim Form, to bill the carrier for physician services.

## 503. REDUCTION IN PAYMENT DUE TO P.L. 99-177

A. General.--Public Law 99-177, the Balanced Budget and Emergency Deficit Control Act of 1985 (Gramm-Rudman-Hollings), provides for an automatic deficit reduction procedure to be established for Federal FYs 1986 through 1991.

Each payment amount is reduced by a specified percentage which cannot exceed 1 percent for FY 1986 and 2 percent for each subsequent year in which sequestration takes place. The reduction percentages are proportionately decreased in any year in which the excess deficit is small enough to permit a smaller reduction.

The intermediary reduces all Medicare program payments after applying deductible, coinsurance, and any applicable MSP adjustment. It reduces each claim or interim payment (including PIP).

B. Definitions.--

Date of Service: The intermediary applies the reduction for all SNF services based upon the through date on the bill. You may bill earlier services separately to avoid the reduction.

Reduction Amount: The applicable reduction percentages by FY are:

o Federal FY 1986 - 1 percent for all services (Part A and Part B) for the period March 1, 1986 through September 30, 1986.

o Federal FY 1987 - There is no sequestration order for this period.

Federal FY 1988 - 2.324 percent as follows:

-- November 21, 1987 through March 31, 1988, for all Part A inpatient hospital services and all items and services (other than physicians' services) under Part B.

-- November 21, 1987 through December 31, 1987, all other Part A services.

o Federal FY 1989 - There is no sequestration order for this period.

Federal FY 1990 -

-- 2.092 percent from October 17, 1989 through December 31, 1989, for items and services under Part A.

-- 2.092 percent from October 17, 1989 through March 31, 1990, for items and services under Part B.

-- 1.4 percent from April 1, 1990 through September 30, 1990, for items and services under Part B.

- Federal FY 1991 -

  -- There is no sequestration for Part A.

  -- 2.00 percent from November 1, 1990 through December 31, 1990, for items and services under Part B.

The amount of the reduction is determined by October 15 for each year. You will be informed by your intermediary of the specific percentage by which bills are reduced after the final determination of the amount is made.

C. Changes Required in Bill Payment Procedures for Sequestration--You may bill separately for all services prior to the effective date to avoid the reduction of the entire bill. Split any bills spanning the effective date of the reduction.

The intermediary reduces all bills with dates of service or through dates on or after the effective date. It will not develop bills which may contain earlier services, and will not accept adjustment bills to correct earlier bills spanning the effective date.

You can expect reduction on final payments and interim payments (cost-based interim payments), and PIP payments and PPS pass-through payments. When payment is for laboratory services, the intermediary makes the reduction after it decides whether the charge or fee schedule is lower.

The intermediary adjusts payment amounts, not payment rates. It applies the reduction to the amount that would have been paid before P.L. 99-177, i.e., after reduction for deductible, coinsurance and MSP. This provides a slightly higher payment to you than applying the percentage reduction before deductible, coinsurance and MSP.

You may not collect the reduction amount from beneficiaries.

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

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

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

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

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

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

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

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

513. FOCUSED MEDICAL REVIEW (FMR)

This section has been moved to the Program Integrity Manual which can be found at the following Internet address: www.hcfa.gov/pubforms/83_pim/pim83toc.htm.

## Billing Under SNF PPS

515. SNF PPS BILLING

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 3 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 exception in §212.3B applies. 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.

515.1 Coverage and Patient Classification.--SNF services included in PPS are posthospital SNF services for which benefits are provided under Part A (the hospital insurance program) and all items and services which, prior to July 1, 1998, had been paid under Part B (the supplementary medical insurance program) but furnished to SNF residents during a Part A covered stay (other than the excluded services listed below). These services (other than the exclusions) are considered included in the PPS rate and therefore may not be billed separately by any other provider.

Services excluded from SNF PPS that must be billed separately by the rendering provider/supplier are:

- Physician's services,
- Physician assistant services,
- Nurse practitioner,
- Clinical nurse specialist services,
- Certified mid-wife services,
- Qualified psychologist services,
- Certified registered nurse anesthetist services,
- Certain dialysis-related services including covered ambulance transportation to obtain the dialysis services,
- Erythropoietin (EPO) for certain dialysis patients,
- Hospice care related to a terminal condition,
- Ambulance trips that convey a beneficiary to the SNF for admission or from the SNF following discharge,

- Certain services involving chemotherapy and its administration,
- Radioisotope services,
- Certain customized prosthetic devices,

The transportation costs of electrocardiogram equipment (HCPCS code R0076), but only with respect to those for electrocardiogram test services furnished during 1998.

In addition, certain services are excluded from the SNF PPS only when furnished on an outpatient basis by a hospital or a CAH:

- Cardiac catheterization services,
- Computerized axial tomography (CT scans),
- Magnetic resonance imaging (MRIs),
- Radiation therapy,
- Ambulatory surgery involving the use of a hospital operating room,
- Emergency services,
- Angiography services,
- Lymphatic and venous procedures,
- Ambulance services that convey a beneficiary to a facility to receive any of the previously mentioned excluded outpatient hospital services,

The SNF PPS incorporates adjustments to account for facility case mix, using the system for classifying residents based on resource utilization known as Resource Utilization Groups, Version III (RUG-III). Facilities will utilize information from the most recent version of the Resident Assessment Instrument (RAI), to classify residents into the RUG-III groups. The MDS contains a core set of screening, clinical, and functional status elements, including common definitions and coding categories, that form the basis of a comprehensive assessment. The assessments are required by law and are to be performed based on a predetermined schedule for purposes of Medicare payment (see Medicare Assessment Schedule chart below). The software programs used by providers to assign patients to appropriate RUG-III groups based on the MDS 2.0, called groupers, are available from many software vendors. A grouper can also be accessed directly by providers from HCFA's Internet web site at: http://www.hcfa.gov/medicaid/mds20/raven.htm. Other software and data related to SNF PPS can also be accessed on HCFA's web site at: www.hcfa.gov/medicaid/mds20/mdssoftw.htm.

For Medicare billing purposes, there is a payment code associated with each of the 44 RUG-III groups, and each assessment applies to specific days within a resident's SNF stay. SNFs that fail to perform assessments timely are paid a default payment for the days of a patient's care for which they are not in compliance with this schedule. Facilities will send each beneficiary's MDS assessment to the State and claims for Medicare payment to the intermediary on a 30-day cycle.

When the initial Medicare-required, 5-day assessment results in a beneficiary being correctly assigned to one of the highest 26 of the 44 RUG-III groups, this effectively creates a presumption of coverage for the beneficiary from admission up to, and including, the assessment reference date for that assessment. The coverage that arises from this presumption remains in effect for as long thereafter as it continues to be supported by the actual facts of the beneficiary's condition and care needs. However, this administrative presumption does not apply to any of the subsequent assessments.

For a beneficiary assigned to one of these upper 26 groups, the required initial certification essentially serves to verify the correctness of the beneficiary's assignment to that particular RUG-III group. RUG-III hierarchy categories that qualify for the administrative presumption of coverage in connection with the initial Medicare-required, 5-day assessment (assuming services provided are reasonable and necessary) include:

1. Rehabilitation;

2 Extensive care;

3. Special care; or

4. Clinically complex

For a beneficiary who is assigned to any of the lower 18 of the 44 RUG-III groups on the initial, Medicare-required, 5-day assessment (or for any beneficiary on a subsequent assessment), the beneficiary is not automatically classified as either meeting or not meeting the SNF level of care definition. Instead, the beneficiary must receive an individual level of care determination using existing administrative criteria and procedures.

MEDICARE ASSESSMENT SCHEDULE

| Medicare MDS Assessment Type | Assessment Window (including authorized grace days) | Maximum Number of Days Authorized for Coverage and Payment | Applicable Medicare Payment Days |
|---|---|---|---|
| 5 day | Days 1 - 8* | 14 | 1 through 14 |
| 14 day | Days 11 - 14 | 16 | 15 through 30 |
| 30 day | Days 21 - 29 | 30 | 31 through 60 |
| 60 day | Days 50 - 59 | 30 | 61 through 90 |
| 90 day | Days 80 - 89 | 10 | 91 through 1000 |

*If a patient expires or transfers to another facility before the 5 day assessment is completed, the facility must still prepare an MDS as completely as possible for the RUG-III classification and Medicare payment purposes. Otherwise the days will be paid at the default rate.

515.2 Payment Provisions.--Section 1888(e) of the BBA of 1997 provides the basis for the establishment of the per diem Federal payment rates applied under PPS to SNFs that received their first payment from Medicare on or after October 1, 1995. A transition period applied for those SNFs who first accepted payment under the Medicare program prior to October 1, 1995. The BBA sets forth the formula for establishing the rates as well as the data on which they are based. In addition, this section prescribes adjustments to such rates based on geographic variation and case-mix and the methodology for updating the rates in future years. For the initial period of the PPS beginning on July 1, 1998, and ending on September 30, 1999, all payment rates and associated rules were published in the ***Federal Register*** on May 12, 1998, (63 FR 26252). For each succeeding fiscal year, the rates are to be published in the ***Federal Register*** before August 1 of the year preceding the affected fiscal year.

At the inception of the SNF PPS, providers that were enrolled in the Multi-State Case Mix and Quality Demonstration had the option of remaining in the demonstration until the end of their current fiscal year. Providers with fiscal years that ended on June 30, 1998, converted to PPS payment on the first day of their fiscal year beginning with the cost reporting year July 1, 1998, with all providers having transitioned by June 30, 1999.

The Federal rate incorporates adjustments to account for facility case mix using Resource Utilization Groups Version III (RUG-III), the patient classification system used under the national PPS. RUG-III, is a 44-group patient classification system that provides the basis for the case-mix payment indices (or relative payment weights) used both for standardization of the Federal rates and subsequently to establish case-mix adjustments to the rates for patients with different service use.

A case-mix adjusted payment system measures the intensity of care (e.g., hours of nursing or therapy time needed per day) and services required (i.e., requirement of a ventilator) for each resident and then translates it into a specific payment level. Information from the most recent version of the RAI, version 2.0, is used by SNFs to classify residents into one of 44 RUGS-III groups. SNFs complete these assessments according to an assessment schedule specifically designed for Medicare payment, that is on the 5th, 14th, 30th, 60th, and 90th days after admission to the SNF. For Medicare billing purposes, there is a Health Insurance PPS rate code (HIPPS) associated with each of the 44 RUG-III groups, and each assessment applies to specific days within a resident's SNF stay. SNFs that fail to perform assessments timely are paid a default payment for the days of a patient's care for which they are not in compliance with this schedule.

515.3 Billing SNF PPS Services.--SNFs are required to report inpatient Part A PPS billing data as follows.

Separate bills are required for each Federal fiscal year for admissions that span the annual update effective date (October 1).

Report revenue code, 0022, and a HIPPS Rate Code on the same line to identify the RUG-III group the beneficiary was classified into as of the assessment reference date. These data are required in addition to standard UB-92 data elements.

Use Type of Bill 21x. See record formats for the UB-92 flat file, the ANSI ASC X-12 837 Health Care Claim, and the Health Care Claim: Institutional ANSI ASC X-12 837 version 4010. These record formats require an assessment (service) date on the IP Ancillary Services Data record type for SNF Type of Bill 21x.

- Revenue Code, FL 42, (Record Type (RT) 60, field 5), ANSI ASC X-12 837 Health Care Claim 2-395-SV201, and Health Care Claim: Institutional ANSI ASC X-12 837 version 4010 SV201 must contain revenue code 0022. This code indicates that this claim is being paid under the PPS. This revenue code can appear on a claim as often as necessary to indicate different HIPPS Rate Code(s) or assessment periods.

- HCPCS/Rates, FL 44, (RT 60, field 6), ANSI ASC X-12 837 Health Care Claim 2-395-SV201-02, and Health Care Claim: Institutional ANSI ASC X-12 837 version 4010 SV201-02 must contain a five digit "HIPPS Code" (AAA00-SSC78). The first three positions of the code contain the MDS RUG-III group and the last two positions of the code contain a two assessment indicator code. See Tables 1 and 2 below for valid RUG codes and assessment indicator code.

- The Service Date (Assessment Reference Date), FL 45, (RT 60, field 13), ANSI ASC X-12 837 Health Care Claim 2-475-DPT03, and Health Care Claim: Institutional ANSI ASC X-12 837 version 4010 ASSESSMENT DATE DTP must contain an assessment reference date when FL 42 contains revenue code 0022.

- Service Units, FL 46, (RT 60, field 9), ANSI ASC X-12 837 Health Care Claim 2-395-SV205, and Health Care Claim: Institutional ANSI ASC X-12 837 version 4010 SV205 must contain the number of covered days for each HIPPS rate code and, if applicable, the number of visits for each rehabilitation therapy code.

- Total Charges, FL 47, (RT 60, field 10), ANSI ASC X-12 837 Health Care Claim 2-395-SV203, and Health Care Claim: Institutional ANSI ASC X-12 837 version 4010 SV203 should contain zero total charges when the revenue code is 0022.

- For accommodation revenue codes (010x-021x), total charges must equal the rate times the units. The SNF PRICER will calculate and return the rate for each line item with revenue code 0022. The claims processing standard system will multiply the rate by the number of units to get the payment amount and then sum the payment amounts for all lines with revenue code 0022 and

make the appropriate payment. Payments will not be made based on the total charges shown in Revenue Code 0001.

- When a HIPPS rate code of RUAxx, RUBxx and/or RUCxx is present, a minimum of two rehabilitation therapy ancillary codes are required (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 (042x, 043x or 044x). Bills that are missing required rehabilitation therapy ancillary revenue codes are to be returned to the SNF for resubmission.

- The number of units on lines with revenue codes 0022 must be equal to the number of covered days on the claim minus any leave of absence days billed with revenue code 018x.

**TABLE 1 - HIPPS RATE CODES**

The HIPPS rate codes consist of the RUG-III code obtained from the MDS Grouper followed by a two digit assessment indicator (see Table 2). Both components of the HIPPS rate code must be present for a claim to be paid.

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 - HIPPS ASSESSMENT INDICATOR CODES** (effective October 1, 2000)

| 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. There may or may not, be a clinical reason for assessment. |
| 07 | 14-day Medicare-required assessment/not an initial admission assessment |
| 08 | Off-cycle Other Medicare-required assessment (OMRA) |
| 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 MDS that is satisfying two requirements: the clinical requirement for an Initial Admission Assessment and the Medicare payment requirement for a 14-day assessment |

| Code | Definition |
|---|---|
| 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. |
| 28 | OMRA replacing 30-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 30-day assessment and 'replaces' the Medicare required 30 day assessment. |
| 30 | Off-cycle Significant Change in Status Assessment (SCSA). This code is used to signify that the bill is based on a SCSA performed for clinical reasons as required by OBRA 1987. As defined in the Long Term Care Resident Assessment Instrument User's Manual, MDS 2.0, a SCSA is appropriate if there is a consistent pattern of change, with either 2 or more areas of decline or two or more areas of improvement in the beneficiary's clinical status. |
| 31 | SCSA replacing 5-day Medicare-required assessment. This code is used to signify that the bill is based on a SCSA that was performed for clinical reasons within the window of a Medicare required 5-day assessment and 'replaces' the Medicare-required 5-day assessment. |
| 32 | SCSA replacing 30-day Medicare-required assessment. This code is used to signify that the bill is based on a SCSA that was performed within the assessment window for a readmission/return assessment and will 'replace' the readmission/return assessment. |
| 33 | SCSA replacing 60-day Medicare-required assessment |
| 34 | SCSA replacing 90-day Medicare-required assessment |
| 35 | SCSA replacing a Readmission/Return Medicare-required assessment |
| 37 | SCSA replacing 14-day Medicare-required assessment |
| 38 | Effective 10-01-2000, OMRA replacing 60-day Medicare-required assessment. Prior to 10-01-2000, '38' included both that the bill was based on either a SCSA only or on a SCSA that was also used to satisfy the requirement for an OMRA. See '30' for off-cycle SCSA. |
| 40 | Off-cycle Significant Correction of a Prior Assessment (SCPA) (outside assessment window). This code is used to signify that the bill is based on a SCPA that was performed for clinical reasons. |
| 41 | SCPA replacing a 5-day Medicare-required assessment |
| 42 | SCPA replacing 30-day Medicare-required assessment |
| 43 | SCPA replacing 60-day Medicare-required assessment |
| 44 | SCPA replacing 90-day Medicare-required assessment |
| 45 | SCPA replacing a Readmission/Return assessment. This code is used to signify that the bill is based on a SCPA that was performed within the assessment window of a readmission/return assessment and 'replaces' the readmission/return assessment. |
| 47 | SCPA replacing 14-day Medicare-required assessment |

| Code | Definition |
|---|---|
| 48 | OMRA replacing 90-day Medicare-required assessment. This code is used to signify that the bill is based on an OMRA that was performed within the assessment window of a 90-day Medicare required assessment and 'replaces' the Medicare required 90-day assessment. |
| 54 | 90-day Medicare assessment that is also a quarterly assessment |
| 78 | OMRA replacing 14-day Medicare-required assessment. This code is used to signify that the bill is based on an OMRA that was performed within the assessment window of a 14-day Medicare required assessment and 'replaces' the Medicare-required 14-day assessment. |

A significant change in status assessment (SCSA) is completed when triggered by the guidelines in the current version of the Resident Assessment Instrument User's Manual, Minimum Data Set, Version 2.0.

Another Medicare required assessment (OMRA) is completed only when a beneficiary discontinues all occupational, physical, and/or speech therapy.

A Significant Correction of Prior Assessment (SCPA), is performed when a major error has occurred, defined as an error that resulted in an assessment that did not reflect the resident's status, so that a care plan derived from it would not address the resident's needs.

There are three types of assessments: Medicare required assessments, off-cycle assessments, and a Significant Correction of a Prior Assessment. The Medicare required assessments are those scheduled for the 5$^{th}$, 14$^{th}$, 30$^{th}$, 60$^{th}$, and 90$^{th}$ days of the Medicare Part A covered stay. **Off-Cycle** assessments include the OMRA and the SCSA. In addition, the SCPA is now designated as an off-cycle assessment and thus, it must be used to "replace" a Medicare-required assessment when the timing and type of assessment being corrected warrant the use of this assessment type, and the assessment reference date of the SCPA falls at the time that a Medicare-required assessment is due to be performed.

SCPAs are only performed to correct major errors in comprehensive assessments, that is, MDS assessments that include care planning and Resident Assessment Protocols. An SCPA may never be performed to correct a regularly scheduled Medicare assessment (5-day, 14-day, 30-day, etc.) since none of those are comprehensive MDS assessments.

**EXAMPLE 1**: A facility realized that the Initial Admission Assessment performed regarding a Medicare beneficiary contained clinical information that was erroneous and did not accurately reflect that beneficiary's needs or his care plan. The facility realizes that it must do a new assessment, an SCPA to have an accurate MDS for this beneficiary. The date chosen for the assessment reference date for the SCPA was one of the days in the assessment window for the 30-day Medicare assessment. In this situation, the SCPA replaces the 30-day assessment. The rate of payment changes on the ARD of SCPA.

Assessment indicator codes are only used for billing Medicare for covered SNF Part A stays. To the extent possible, every combination of reasons for MDS assessment relevant for Medicare payment has been captured by the HIPPS assessment indicator 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 MDS is not captured by the HIPPS assessment indicator code, it is still an accurate code for billing purposes. For example, '08' indicates that the bill is based on an MDS assessment performed to fulfill the Medicare requirement for an OMRA 8-10 days after the discontinuation of all rehabilitation therapy. From the standpoint of Medicare payment, it does not matter if the MDS (the required OMRA) was also used to fulfill the clinical requirement for an SCSA or a Quarterly. For this reason, the assessment indicator code '08' is used for billing several different combinations of reasons for assessment, as can be seen in Table 2. The important information for the payer is that the facility performed the required MDS in a timely manner and that the payment rate changes as of the assessment reference date (ARD) of the assessment. Please note that several assessment indicator codes (i.e., '05', '01', '11', and '07'), like '08', are used in multiple situations, but always to convey the most important information from a billing standpoint. See Tables 2 and 3 for a display of combinations of reasons for assessment and the appropriate assessment indicator code to use for billing.

## TABLE 2 - HIPPS ASSESSMENT INDICATOR CODES

| Reason for Assessment | Medicare 5-Day | | | Medicare 30-Day | | | Medicare 60-Day | | |
|---|---|---|---|---|---|---|---|---|---|
| | AA8a | AA8b | **HIPPS** | AA8a | AA8b | **HIPPS** | AA8a | AA8b | **HIPPS** |
| Initial Admissions | 01 | 1 | **11** | -- | -- | -- | -- | -- | -- |
| Annual | 02 | 1 | **01** | 02 | 2 | **02** | 02 | 3 | **03** |
| Significant Change in Status-SCSAs | 03 | 1 | **31** | 03 | 2 | **32** | 03 | 3 | **33** |
| Significant Correction of Prior Fulls | 04 | 1 | **41** | 04 | 2 | **42** | 4 | 3 | **43** |
| Quarterly | 05 | 1 | **01** | 05 | 2 | **02** | 05 | 3 | **03** |
| Significant Correction of Prior Quarterly | 10 | 1 | **41** | 10 | 2 | **42** | 10 | 3 | **43** |
| None of the Above | 00 | 1 | **01** | 00 | 2 | **02** | 00 | 3 | **03** |

## TABLE 2 - HIPPS ASSESSMENT INDICATOR CODES (Continued with 90 days)

| Reason for Assessment | Medicare 90-Day | | | Readmission/Return | | | Medicare 14-Day | | |
|---|---|---|---|---|---|---|---|---|---|
| | AA8a | AA8b | **HIPPS** | AA8a | AA8b | **HIPPS** | AA8a | AA8b | **HIPPS** |
| Initial Admissions | -- | -- | -- | 01 | 5 | **11** | 01 | 7 | **17** |
| Annual | 02 | 4 | **04** | 02 | 5 | **05** | 02 | 7 | **07** |
| Significant Change in Status-SCSAs | 03 | 4 | **34** | 03 | 5 | **35** | 03 | 7 | **37** |
| Significant Correction of Prior Fulls | 04 | 4 | **44** | 04 | 5 | **45** | 04 | 7 | **47** |
| Quarterly | 05 | 4 | **54** | 05 | 5 | **05** | 05 | 7 | **07** |
| Significant Correction of Prior Quarterly | 10 | 4 | **44** | 10 | 5 | **45** | 10 | 7 | **47** |
| None of the Above | 00 | 4 | **04** | 00 | 5 | **05** | 00 | 7 | **07** |

**TABLE 2 - HIPPS ASSESSMENT INDICATOR CODES (Continued with OMRAs)**

| Reason for Assessment | Other Medicare Required OMRA | | |
|---|---|---|---|
| | AA8a | AA8b | **HIPPS** |
| Initial Admissions | 01 | 8 | **08** |
| Annual | 02 | 8 | **08** |
| Significant Change in Status-SCSAs | 03 | 8 | **08** |
| Significant Correction of Prior Fulls | 04 | 8 | **08** |
| Quarterly | 05 | 8 | **08** |
| Significant Correction of Prior Quarterly | 10 | 8 | **08** |
| None of the Above | 00 | 8 | **08** |

**TABLE 3 - HIPPS Assessment Indicator Codes for billing when there are two Medicare reasons for assessment; two codes in MDS item AA8b or no reason for assessment to be coded in AA8b.**

| Reason for Assessment | Medicare 5-Day | Medicare 14-Day | Medicare 30-Day | Medicare 60-Day | Medicare 90-Day | Readmission Return Assessment | SCSA | SCPA |
|---|---|---|---|---|---|---|---|---|
| Other State required Assessment* | 01 | 07 | 02 | 03 | 04 | 05 | 30 | 40 |
| OMRA | 18 | 78 | 28 | 38 | 48 | 18 | 08 | 08 |
| No reason for assessment in AA8b | N/A | N/A | N/A | N/A | N/A | N/A | 30 | 40 |

***This item in Section AA8b of the MDS is not used in every State and has no implications for Medicare billing. It is shown here only in the interest of providing clear and complete information.

A. Billing Based on Off-Cycle MDS Assessments.--If an off-cycle assessment is performed within the assessment window of a Medicare-required assessment, it must replace the Medicare required assessment. Payment will change effective with the ARD of the off-cycle assessment that replaces the Medicare required assessment and will continue until the next Medicare required assessment or off-cycle assessment, whichever occurs first. This policy is applied when there is a single off-cycle assessment that is performed within the Medicare required assessment window. However, when the ARD of the "replacement" (or off-cycle) assessment is on one of the grace days, the payment rate changes on the day it would have changed based on the regularly schedule assessment.

**EXAMPLE 1**: If the ARD of an OMRA is set on day 22 of the Part A covered stay, which is within the assessment window for setting the ARD for the 30-day Medicare required assessment, it must replace the 30 day Medicare required assessment. Payment will change on day 22, the ARD of the OMRA, and will continue until the next Medicare required assessment or off-cycle assessment, whichever occurs first.

**EXAMPLE 2:** If the ARD of an OMRA is set for day 32 of the stay and the OMRA is replacing the Medicare 30-day assessment, then the payment will change as of day 31, as if it were a regularly scheduled 30-day assessment. The payment rate changes retrospectively in this case because otherwise, there is no appropriate rate to bill for day 31. Payment based on the 14-day assessment may only go through day 30.

While not a common occurrence, there may be situations in which multiple assessments are performed within one Medicare required assessment window. In these instances, the off-cycle assessment with an ARD closest to, and before, the date on which the Medicare required assessment is due (i.e., day 5, day 14, day 30, day 60 or day 90) is the assessment that must replace the Medicare required assessment. Any other assessment performed in the assessment window must be billed as a stand-alone assessment and cannot replace the Medicare required assessment.

If there is one off-cycle assessment within the assessment window and another off-cycle assessment performed with an ARD on a grace day, the assessment with the grace day ARD must be billed separately as an off-cycle assessment and cannot replace the Medicare required assessment. The assessment with the ARD closest to, and before, the date on which the assessment was due must replace the assessment. In this case, there was an off-cycle assessment with an ARD before the assessment due date, therefore, that assessment is the replacement assessment. The assessment with an ARD in the grace period must be billed separately. There is no longer a Medicare assessment to be replaced. The required Medicare assessment was already replaced by the assessment that was performed within the assessment window and before the due date.

**EXAMPLE 3**: A SNF sets the ARD for a SCSA on day 22 of the covered stay. The beneficiary "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. This assessment must be used as the replacement assessment because its ARD is within the assessment window for the Medicare required assessment and is before the date on which the Medicare required assessment is due. The OMRA with an ARD that fell on day 33 of the stay cannot replace the Medicare required assessment since it already has 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 will continue until the next Medicare required assessment or off-cycle assessment, whichever occurs first.

B. System Edits.--Standard system edits verify the following situations:

- To insure that revenue code 0022 is not reported on any bill type other than 21x;
- To insure that a valid HIPPS rate code is always present on revenue code 0022;
- To insure that all revenue code 0022 lines have units > 0;
- To insure that revenue code total charges line 0001 must equal the sum of the individual total charges lines;
- To insure that the length of stay in the statement covers period, from and through dates equals the total days for accommodations revenue codes 010x-021x, including revenue code 018x (leave of absence); and

o To insure that the sum of revenue codes 010x-021x units minus revenue code 018x, leave of absence units, is equal to the sum of PPS revenue code 0022 units.

B. Billing Ancillary Services Under SNF PPS.--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.

o 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.

o SNFs are required to report the actual charge for each line item, in Total Charges.

o The accommodation revenue code 018x, (RT 50, field 5), ANSI ASC X-12 837 Health Care Claim 2-395-SV201, and Health Care Claim: Institutional ANSI ASC X-12 837 version 4010 SV201 (leave of absence) will continue to be used in the current manner including the appropriate UB92 occurrence span code, 74 (RT 40, field 28-33) and date range.

C. Demand Bills.--Demand bills are submitted as usual, indicating the beneficiary requested the noncovered claim be submitted by the SNF to the intermediary for consideration and approval. The HIPPS Rate Codes and the 0022 revenue code for SNF PPS must be present on the demand bill.

515.4 Determining Part A Admission and Discharge Dates.--Note that the following instructions apply to determining Part A admission and discharge dates for billing Medicare.

A Date of Admission--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 section B. 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 §531.

B Date of Discharge.--The beneficiary is considered discharged from the SNF when any of the following occur:

o The beneficiary is admitted as an inpatient to a Medicare participating hospital or CAH or admitted as 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 CAH 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 type 21x.

o A beneficiary (who leaves the SNF and then returns by midnight of the same day) receives outpatient services from a Medicare participating hospital or CAH during the absence, but only with respect to certain services identified in §531. Other outpatient services furnished to a SNF PPS inpatient by the hospital or CAH must be billed by the SNF.

Medicare systems are set up so that the SNF need not submit a discharge bill where this situation applies. Edits allow hospitals and CAHs to bill for these services for a SNF PPS inpatient. Receipt of outpatient services from another provider does not normally result in SNF discharge.

o The beneficiary receives services under a plan of care from a Medicare participating HHA. Where the beneficiary receives services from an HHA, the HHA is responsible for billing. 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.

o The beneficiary is formally discharged or otherwise departs for reasons other than described in the preceding 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 SNF PPS 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.

515.5. Adjustment to HIPPS Codes Resulting From MDS Corrections.--The MDS is an assessment tool completed by facility clinical staff that is transmitted electronically to state agencies and then transferred to HCFA, and is used to determine a Resource Utilization Group (RUG-III) code. The 3-digit RUG-III code and the 2-digit assessment indicator make up the Health Insurance Prospective Payment System (HIPPS) code that appears on the bill, and is used to determine the payment rate for the skilled nursing facility (SNF) Prospective Payment System (PPS). Effective for services provided on and after June 1, 2000, SNFs must submit adjustment bills to reflect corrections to the MDS data that result in changes to the RUG-III code (i.e., the first three digits of the HIPPS code).

When the SNF PPS was implemented in July 1998, there were limited options for facilities to correct an incorrect response in the MDS record that was used to calculate the RUG-III group, even when that error resulted in an incorrect payment rate. Correction of MDS 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 adjustment bill would be submitted if the MDS correction results in a RUG-III code that is different from that already billed. The adjustment bill is retroactive to the first date payment was made using the original (but incorrect) RUG-III code.

**EXAMPLE 1:** A Medicare 5-day assessment was completed timely and used to establish the RUG-III rate for days 1-14 of the Part A stay. The bill was paid before the provider found the error. (The error on that 5-day assessment was identified on day 17 while staff were completing the Medicare 14-day assessment.) The facility corrects the 5-day assessment, and submits an adjustment bill for days 1-14 of the Part A stay.

**EXAMPLE 2:** On day 39 of the Part A stay, the facility identifies an error in a 30-day Medicare MDS. Five days of service had already been billed and paid based on the HIPPS code generated from that 30-day Medicare assessment.

The facility submits an MDS correction that results in a change in the RUG-III group. The SNF submits an adjustment bill for the 5 days of service using the corrected RUG-III group. Then, the corrected RUG-III code is used for billing any remaining covered days in the applicable payment period.

Unlike the significant correction of a prior assessment, MDS corrections are not new assessments and cannot be used as replacements for any Medicare-required assessment. SNFs must document the reason for the MDS correction, and certify the accuracy of the correction. This documentation must be kept in the medical record.

A. Effective Date for Adjustment Billing.--Beginning June 1, 2000, when an MDS modification or inactivation results in a change in the RUG-III group and HIPPS code used on a previously paid claim, the SNF must submit an adjustment bill. This policy only refers to Medicare skilled services that were provided in the SNF on June 1, 2000, or later. Therefore, HIPPS codes based on service dates (FL 45 on the bill) beginning prior to June 1, 2000, may not be adjusted based on a correction to the relevant MDS. If this type of adjustment bill (condition code D4) is submitted for service dates prior to June 1, 2000, it will be returned to the provider (RTP). The report message is, "An adjustment bill based on a corrected MDS cannot be processed for service dates prior to June 1, 2000."

After the initial period of this new adjustment bill policy, the beginning date of service, the "from" date, will have little significance. The "through" date will be used to calculate the period during which adjustment bills may be submitted based on corrected MDS assessments. The "through" date indicates the last day of the billing period for which the HIPPS code is billed. Adjustment bills based on corrected MDS 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 bill to 120 days from the service "through" date.

We expect that most MDS corrections will be made during the course of the beneficiary's Medicare Part A stay. Therefore, providers that routinely submit MDS corrections after the beneficiary's Part A stay has ended may be subject to focused medical review.

**Adjustment bills to change a HIPPS code may not be submitted for any claim that has already been medically reviewed.** This applies whether or not the medical review was performed either pre- or post-payment. All adjustment bills submitted may be subject to medical review. Information regarding medical review is located in the Program Integrity Manual found at the following internet address: www.hcfa.gov/pubforms/83_pim/pim83toc.htm.

Isolated billing errors on a single MDS 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 intermediary, and these overpayments must be recouped. A pattern of errors includes but is not limited to software errors in transmitting MDS files, misunderstandings of MDS instructions that result in consistent miscoding of one or more MDS items used in determining the RUG-III group, etc.

B. Billing Instructions.--Adjustment bills adhere to the same billing instructions as non inpatient adjustment bills with the following changes:

Paper Claims:

1. FL 4. Type of Bill is 217 (replacement debit).

2. FL 37. Internal Control Number (ICN)/ Document Control Number (DCN) Required. All providers requesting an adjustment to a previously processed claim must insert the ICN/DCN of the claim to be adjusted. Payer A's ICN/DCN must be shown on line "A" in FL 37. Similarly, the ICN/DCN for Payer's B and C must be shown on lines B and C respectively, in FL 37.

3. FLs 24, 25, 26, 27, 28, 29, and 30: Condition Code D4, Change of Grouper Code, will be used.

4. The adjustment claim will reflect the corrected RUG-III group by changing the HIPPS code associated with that assessment.

Electronic Claims Using the UB-92 National Format (Version 060):

1. Type of bill 217 is placed in Record type 40, Field No. 4.

2. Submit the ICN/DCN of the original bill in Record Type 31, Field No. 14.

3. Condition Codes will be entered in Record Type 41, Field No. 4-10. Other condition codes may be necessary on the claim and can be repeated 10 times.

4. The adjustment claim will reflect the corrected RUG-III group by changing the HIPPS code associated with that assessment.

Billing Instructions - Electronic Claims Using the ANSI ASC X-12 837 (Version 3051):

1. Type of bill is placed in 2-130-CLM05-01 and 2-130-CLM05-03.

2. Submit the ICN/DCN of the original bill in 2-180.A-REF02 and 2-355.AC-REF02.

3. The Condition Code (D4) will be placed in 2-225.E-HI01-02. Other condition codes may be necessary on the claim and can be repeated up to 9 times.

4. The adjustment claim will reflect the corrected RUG-III group by changing the HIPPS code associated with that assessment.

515.6 Services Included in the Part A PPS Rate and Billed by the SNF.--All Medicare-covered services rendered a SNF resident during a Part A PPS stay are included in the SNF PPS payment except for the exclusions listed in §§516ff below. These services (services not described in §516ff) are considered included in the SNF Part A PPS payment and must be billed by the SNF on the inpatient bill. Services for a SNF resident who is entitled to Part A benefits are not covered under Part B.

Therapy services are included in the PPS rate. If payment cannot be made under Part A but can be made under Part B, therapy services must be billed by the SNF. See §532 for Part B therapy billing instructions.

515.7 Preventive Services and Screenings.--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., pneumococcal pneumonia vaccine, influenza vaccine, hepatitis vaccine) is a separate Part B benefit. They are excluded from Part A PPS and are covered under Part B in addition to the PPS rate. They must not be included on the SNF PPS bill. However, they 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 would submit a separate Part B bill for them rather than including them on its global Part A bill.

## 516. SERVICES NOT INCLUDED IN THE PART A PPS RATE AND NOT BILLED BY THE SNF

The following services are beyond the scope of the SNF Part A benefit and excluded from SNF PPS. The SNF may not bill excluded services separately under Part B for its inpatients entitled to Part A benefits. They are billed separately by the rendering provider/supplier to Part B. The services and related codes are described in §516.1 through 516.6 below.

A. Providers.--Services from the following providers are billed by the rendering provider and paid separately, i.e., are not included in the PPS rate.

- Physician's services other than physical, occupational, and speech-language therapy services furnished to SNF residents. These services are billed separately to the Part B carrier. Respiratory therapy services are included in the PPS rate except for physician's component. Section 4432 (b)(4) of the BBA requires bills for these particular services to include the SNF's Medicare provider number. Therefore the physician will need to know your Medicare provider number;

- 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;

- Certified registered nurse anesthetists;

B. Services.--The following services are billed separately under Part B by the rendering provider (e.g., exempted under Part A PPS), and may be paid to the provider/supplier that furnished the service.

- Dialysis services and supplies, including any related necessary ambulance services;

- 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));

- Hospice care related to a beneficiary's terminal condition;

- An ambulance trip (other than a trip to or from another SNF) that transports a beneficiary to the SNF for the initial admission or from the SNF following a final discharge.

- The following services are not included in SNF PPS when furnished in a Medicare participating hospital or CAH. (See §516.3.) This exception does not apply if the service is furnished in an ASC. Specific HCPCS and/or revenues codes describing these services are in the billing chapter, §§531ff.

  - Cardiac catheterization;
  - Computerized axial tomography (CT) scans;
  - Magnetic resonance imaging (MRIs);
  - Ambulatory surgery involving the use of an operating room;
  - Radiation therapy;
  - Angiography;
  - Lymphatic and venous procedures;
  - Emergency services;
  - Ambulance services when related to an excluded service within this list; and
  - Ambulance transportation related to dialysis services

- The following services when provided by any Medicare provider licensed to provide them are excluded from PPS. Specific HCPCS describing these services are in the billing chapter, §§531ff.

  - Certain chemotherapy and chemotherapy administration services
  - Radioisotope services
  - Certain customized prosthetic devices

- For services furnished during 1998 only, the transportation costs of electrocardiogram equipment for electrocardiogram test services.

- 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.

516.1 Physician's Services and Other Professional Services Excluded from SNF Part A PPS.--Except for the therapy services, professional component of physician services and the services of certain non-physician providers listed below are excluded from the SNF Part A PPS rate and must be billed separately by the physician to the carrier.

For this purpose "physicians 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 technical component of services rendered to Part B SNF patients is paid at the fee schedule rate. The carrier will pay only the professional component to the physician.

Providers with the following specialty codes assigned by HCFA upon enrollment with Medicare are considered physicians for this purpose. Some limitations are imposed by §§1861 (q) and (r) of the Social Security Act.

Physician 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
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

Non - Physician Provider Specialty Codes.--These non physician providers may bill separately.

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 component in the fee schedule. Fee schedule definitions apply for this purpose.

516.2 Ambulance Services.--The following ambulance transportation and related ambulance services for residents in a Part A stay are not included in the PPS rate. They may be billed as Part B services by the supplier in only the following situations.

o 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.)

o The ambulance trip is from the SNF to home (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 (FL 22) is other than 30.)

o The ambulance trip is to a hospital based or non-hospital based ESRD facility (either one of any HCPCS ambulance modifier codes is G (Hospital based dialysis facility) or J (Non-hospital based dialysis facility).

o Ambulance associated with the following inpatient hospital service exclusions payment is under the ambulance fee schedule (see §516.3):

-- Cardiac catheterization;
-- Computerized axial tomography (CT) scans;
-- Magnetic resonance imaging (MRIs);
-- Ambulatory surgery involving the use of an operating room;
-- Emergency services;
-- Angiography;
-- Lymphatic and Venous Procedures; and
-- Radiology therapy.

516.3 Outpatient/Emergency Services in a Medicare Participating Hospital or Critical Access Hospital (CAH).--The following services are exempted from Part A PPS and consolidated billing when furnished in a Medicare participating hospital or CAH.

o Cardiac catheterization;
o Computerized axial tomography (CT) scans;
o Magnetic resonance imaging (MRIs);
o Ambulatory surgery involving the use of an operating room;
o Radiation therapy;
o Angiography services;
o Lymphatic and venous procedures;
o Emergency services; and
o Ambulance services when related to the excluded services listed above (see §516.2).

These are relatively costly services which are beyond the 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 radiation therapy that a beneficiary receives as a hospital outpatient. Similarly, angiography codes and codes for lymphatic and venous procedures are considered beyond the scope of services delivered by SNFs.

The hospital or CAH must bill the intermediary for the services. Emergency services are defined by the presence of revenue code 045x on the claim.

Other services are defined by the following HCPCS codes. Any other services (defined by other HCPCS codes) must be bundled back to the SNF and the hospital must look to the SNF for payment.

Outpatient CT scans:

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

Outpatient Cardiac Catheterization:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 93501 | 93503 | 93505 | 93508 | 93510 | 93511 | 93514 | 93524 | 93526 |
| 93527 | 93528 | 93529 | 93530 | 93531 | 93532 | 93533 | 93536 | 93539 |
| 93540 | 93541 | 93542 | 93543 | 93544 | 93545 | 93555 | 93556 | 93561 |
| 93562 | 93571 | 93572 | | | | | | |

Outpatient MRI:

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

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

Outpatient Radiation Therapy:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 77261 | 77262 | 77263 | 77280 | 77285 | 77290 | 77295 | 77299 | 77300 |
| 77305 | 77310 | 77315 | 77321 | 77326 | 77327 | 77328 | 77331 | 77332 |
| 77333 | 77334 | 77336 | 77370 | 77399 | 77401 | 77402 | 77403 | 77404 |
| 77406 | 77407 | 77408 | 77409 | 77411 | 77412 | 77413 | 77414 | 77416 |
| 77417 | 77427 | 77431 | 77432 | 77470 | 77499 | **77520** | **77522** | **77523** |
| **77525** | 77600 | 77605 | 77610 | 77615 | 77620 | 77750 | 77761 | 77762 |
| 77763 | 77776 | 77777 | 77778 | 77781 | 77782 | 77783 | 77784 | 77789 |
| 77790 | 77799 | | | | | | | |

Outpatient Angiography:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 75600 | 75605 | 75625 | 75630 | 75650 | 75658 | 75660 | 75662 | 75665 |
| 75671 | 75676 | 75680 | 75685 | 75705 | 75710 | 75716 | 75722 | 75724 |
| 75726 | 75731 | 75733 | 75736 | 75741 | 75743 | 75746 | 75756 | 75774 |
| 75790 | 75801 | 75803 | 75805 | 75807 | 75809 | 75810 | 75820 | 75822 |
| 75825 | 75827 | 75831 | 75833 | 75840 | 75842 | 75860 | 75870 | 75872 |
| 75880 | 75885 | 75887 | 75889 | 75891 | 75893 | 75894 | 75898 | 75900 |
| 75940 | 75960 | 75961 | 75962 | 75964 | 75966 | 75968 | 75970 | 75978 |
| 75980 | 75982 | 75992 | 75993 | 75994 | 75995 | 75996 | | |

Outpatient Surgery

All codes from 10040 - 69979 with the following exceptions. Codes that are within the list of exceptions may not be billed by the hospital as they fall within the range of minor procedures that the SNF may provide. These exceptions are:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 10040 | 10060 | 10080 | 10120 | 11040 | 11041 | 11042 | 11043 | 11044 |
| 11055 | 11056 | 11057 | 11200 | 11300 | 11305 | 11400 | 11719 | 11720 |
| 11721 | 11740 | 11900 | 11901 | 11920 | 11921 | 11922 | 11950 | 11951 |
| 11952 | 11954 | 11975 | 11976 | 11977 | 15780 | 15781 | 15782 | 15783 |
| 15786 | 15787 | 15788 | 15789 | 15792 | 15793 | 15810 | 15811 | 16000 |
| 16020 | 17000 | 17003 | 17004 | 17110 | 17111 | 17250 | 17340 | 17360 |
| 17380 | 17999 | 20000 | 20974 | 21084 | 21085 | 21497 | 26010 | 29058 |

Outpatient Surgery continued

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 29065 | 29075 | 29085 | 29105 | 29125 | 29126 | 29130 | 29131 | 29200 |
| 29220 | 29240 | 29260 | 29280 | 29345 | 29355 | 29358 | 29365 | 29405 |
| 29425 | 29435 | 29440 | 29445 | 29450 | 29505 | 29515 | 29540 | 29550 |
| 29580 | 29590 | 29700 | 29705 | 29710 | 29715 | 29720 | 29730 | 29740 |
| 29750 | 29799 | 30300 | 30901 | 31720 | 31725 | 31730 | 36000 | 36140 |
| 36400 | 36405 | 36406 | **36415** | 36430 | 36468 | 36469 | 36470 | 36471 |
| 36489 | 36600 | 36620 | 36680 | 44500 | 51772 | 51784 | 51785 | 51792 |
| 51795 | 51797 | 53601 | 53660 | 53661 | 53670 | 53675 | 54150 | 54235 |
| 54240 | 54250 | 55870 | 57160 | 57170 | 58300 | 58301 | 58321 | 58323 |
| 59020 | 59025 | 59425 | 59426 | 59430 | 62367 | 62368 | 64550 | 65205 |
| 69000 | 69090 | 69200 | 69210 | 95970 | 95971 | 95972 | 95973 | 95974 |
| 95975 | | | | | | | | |

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

516.4 Chemotherapy, Chemotherapy Administration, and Radioisotope Services.--The following chemotherapy and radioisotope items are not included in the Part A PPS rate and are excluded from consolidated billing whether they are furnished in a hospital or non-hospital setting. The rendering provider must bill these services.

Chemotherapy

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| J9000 | **J9001** | J9015 | J9020 | J9040 | J9045 | J9050 | J9060 |
| J9062 | J9065 | J9070 | J9080 | J9090 | J9091 | J9092 | J9093 |
| J9094 | J9095 | J9096 | J9097 | J9100 | J9110 | J9120 | J9130 |
| J9140 | J9150 | J9151 | **J9160** | J9170 | **J9180** | J9181 | J9182 |
| J9185 | J9200 | J9201 | J9206 | J9208 | J9211 | J9230 | J9245 |
| J9265 | J9266 | J9268 | J9270 | J9280 | J9290 | J9291 | J9293 |
| J9310 | J9320 | J9340 | J9350 | **J9355** | **J9357** | J9360 | J9370 |
| J9375 | J9380 | J9390 | J9600 | | | | |

Chemotherapy Administration Services that are Excluded from PPS

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 36260 | 36261 | 36262 | 36489 | 36530 | 36531 | 36532 | 36533 | 36534 |
| 36535 | 36640 | 36823 | 96405 | 96406 | 96408 | 96410 | 96412 | 96414 |
| 96420 | 96422 | 96423 | 96425 | 96440 | 96445 | 96450 | 96520 | 96530 |
| 96542 | Q0083 | Q0084 | Q0085 | | | | | |

Radioisotope Services that are Excluded from PPS

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 79030 | 79035 | 79100 | 79200 | 79300 | 79400 | 79420 | 79440 |

516.5 Certain Customized Prosthetic Devices.--The following customized prosthetic devices are not considered included in the Part A PPS rate and are excluded from consolidated billing. They must be billed by the supplier furnishing the service.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| L5050 | L5060 | L5100 | L5105 | L5150 | L5160 | L5200 | L5210 | L5220 | L5230 |
| L5250 | L5270 | L5280 | L5300 | L5310 | L5320 | L5330 | L5340 | L5500 | L5505 |
| L5510 | L5520 | L5530 | L5535 | L5540 | L5560 | L5570 | L5580 | L5585 | L5590 |
| L5595 | L5600 | L5610 | L5611 | L5613 | L5614 | L5616 | L5617 | L5618 | L5620 |
| L5622 | L5624 | L5626 | L5628 | L5629 | L5630 | L5631 | L5632 | L5634 | L5636 |
| L5637 | L5638 | L5639 | L5640 | L5642 | L5643 | L5644 | L5645 | L5646 | L5647 |
| L5648 | L5649 | L5650 | L5651 | L5652 | L5653 | L5654 | L5655 | L5656 | L5658 |
| L5660 | L5661 | L5662 | L5663 | L5664 | L5665 | L5666 | L5667 | L5668 | L5669 |
| L5670 | L5672 | L5674 | L5675 | L5676 | L5677 | L5678 | L5680 | L5682 | L5684 |
| L5686 | L5688 | L5690 | L5692 | L5694 | L5695 | L5696 | L5697 | L5698 | L5699 |
| L5700 | L5701 | L5702 | L5704 | L5705 | L5706 | L5707 | L5710 | L5711 | L5712 |
| L5714 | L5716 | L5718 | L5722 | L5724 | L5726 | L5728 | L5780 | L5785 | L5790 |
| L5795 | L5810 | L5811 | L5812 | L5814 | L5816 | L5818 | L5822 | L5824 | L5826 |
| L5828 | L5830 | L5840 | L5845 | L5846 | L5850 | L5855 | L5910 | L5920 | L5925 |
| L5930 | L5940 | L5950 | L5960 | L5962 | L5964 | L5966 | L5968 | L5970 | L5972 |
| L5974 | L5975 | L5976 | L5978 | L5979 | L5980 | L5981 | L5982 | L5984 | L5985 |
| L5986 | L5988 | L6050 | L6055 | L6100 | L6110 | L6120 | L6130 | L6200 | L6205 |
| L6250 | L6300 | L6310 | L6320 | L6350 | L6360 | L6370 | L6400 | L6450 | L6500 |
| L6550 | L6570 | L6580 | L6582 | L6584 | L6586 | L6588 | L6590 | L6600 | L6605 |
| L6610 | L6615 | L6616 | L6620 | L6623 | L6625 | L6628 | L6629 | L6630 | L6632 |
| L6635 | L6637 | L6640 | L6641 | L6642 | L6645 | L6650 | L6655 | L6660 | L6665 |
| L6670 | L6672 | L6675 | L6676 | L6680 | L6682 | L6684 | L6686 | L6687 | L6688 |
| L6689 | L6690 | L6691 | L6692 | L6693 | L6700 | L6705 | L6710 | L6715 | L6720 |
| L6725 | L6730 | L6735 | L6740 | L6745 | L6750 | L6755 | L6765 | L6770 | L6775 |
| L6780 | L6790 | L6795 | L6800 | L6805 | L6806 | L6807 | L6808 | L6809 | L6810 |
| L6825 | L6830 | L6835 | L6840 | L6845 | L6850 | L6855 | L6860 | L6865 | L6867 |
| L6868 | L6870 | L6872 | L6873 | L6875 | L6880 | L6920 | L6925 | L6930 | L6935 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| L6940 | L6945 | L6950 | L6955 | L6960 | L6965 | L6970 | L6975 | L7010 | L7015 |
| L7020 | L7025 | L7030 | L7035 | L7040 | L7045 | L7170 | L7180 | L7185 | L7186 |
| L7190 | L7191 | L7260 | L7261 | L7266 | L7272 | L7274 | L7362 | L7364 | L7366 |

516.6 ESRD Services.--Home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies are not included in the SNF Part A PPS rate. They may be billed separately to the intermediary by the hospital or ESRD facility as appropriate. The are identified by type of bill 72x.

Some dialysis related services for method 2 beneficiaries are billed by a hospital using type of bill 13x. The following revenue codes accompanied by a dialysis related diagnosis code listed below identify those services:

Revenue Codes:

- 025x – Pharmacy
- 027x – Medical/Surgical Supplies
- 030x – Laboratory
- 031x – Laboratory Pathological
- 032x – Radiology – Diagnostic
- 038x – Blood
- 039x – Blood Storage and Processing
- 073x – EKG/ECG (Electrocardiogram)

Diagnosis Codes:

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

The Part A PPS exclusion is applicable to services within the composite rate and to services paid for ESRD in addition to the composite rate.

**NOTE:** For method 2 beneficiaries who receive services or supplies from a "provider" that normally bills the carrier, the carrier will continue to be billed.

## Inpatient Billing

### 517. SPECIAL INPATIENT BILLING INSTRUCTIONS

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

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

The procedure for completing two bills where charges are incurred in different accounting years does not apply to "no-payment" cases. (See §527.) In a "no-payment" case, you need only submit a bill upon death, discharge, or change in the level of care from a SNF level to a noncovered level of care. If more frequent billing is necessary in order to bill another payer, you may bill every 30 days.

Submit a Form HCFA-1450 in the following situations where utilization is charged to the patient, even though no program payment can be made:

o The patient or his representatives refuses to request that payment be made on his behalf. (See §302.5.);

o The physician refuses to make an otherwise required certification for a reason other than lack of medical necessity. (See §220.);

o The time limitation on filling for covered services expires before you file a claim for payment and you are responsible for the late filing. (See §§310ff.) A bill must be submitted to record utilization and applicable deductibles;

o You fail to submit needed information ; and

o The intermediary has notified you that a limitation of liability decision finds you at fault.

In these cases, complete all items, except those set aside for intermediary use, on the bill the same as on a payment bill.

If the patient or his representative refuses to sign a request for payment, submit a bill upon discharge or death so that utilization days will be charged. You may bill the patient for services.

If a physician refuses to sign a certification, even though he agrees that extended care services are required, no program payment can be made, but submit a bill upon discharge or death so that utilization days can be charged. However, the patient cannot be billed for any covered services, since your agreement with the Secretary precludes it.

If the needed information is not submitted, or if an adverse limitation of liability decision was made, finding only you at fault under the limitation of liability provisions, submit a bill upon discharge or death so that utilization days may be charged. Do not bill the patient for Medicare services.

## Billing for Medical and Other Health Services

### 529. BILLING FOR MEDICAL AND OTHER HEALTH SERVICES - GENERAL

Use Form HCFA-1450, UB-92 flat file, or ANSI ASC X-12 837 to bill for the covered Part B services (see §260A) furnished to inpatients whose benefit days are exhausted, or who are not entitled to have payment made for these services under Part A (e.g., 3-day prior stay requirement is not met). Use it also to bill for covered Part B services rendered to outpatients (§260B) and for ambulance services. Bill under Part B, outpatient physical therapy, speech therapy, and, occupational therapy services furnished to inpatients where the beneficiary has exhausted his benefits under Part A or is otherwise not eligible for them.

When the intermediary denies a Part A bill because the stay is not at a covered level of care and no Part A program payment is possible, some or all services may be medically necessary and can be covered as ancillary services under Part B. A SNF must bill the intermediary unless the service is an exception identified in §§516ff that must be billed by the provider/supplier rendering the service. Sections 529 through 544 provide specific billing instructions for services that may be billed by the SNF.

If accommodation services are not medically necessary and program payment is not possible under waiver, and if the ancillary services are determined to be not medically necessary, do not complete a bill since no payment can be made. In this situation, if the ancillary services are determined to be medically necessary, the intermediary will ask you to complete a Part B bill.

No bill is required when:

- The patient is not enrolled under Part B;
- It is obvious that only noncovered services have been furnished;
- Payment was made or will be made by the Public Health Service, VA, or other governmental entity;
- Workers' compensation has paid or will pay the bill; or
- Payment was made by liability, no-fault insurance, group health plan, or a large group health plan.

529.1 Determining How Much to Charge Before Billing Is Submitted.--You may be able to determine from your own records, from a transferring hospital, or from the patient the extent to which the Part B cash deductible is met. You may charge the patient for the unmet deductible and coinsurance. Submit a bill even if no payment can be made because the unmet Part B cash deductible exceeds the covered charges. In addition, a bill is required when you become aware that no bill has been submitted for covered services even though the time limitation for filing has expired.

529.2 Charges for Services Provided in Different Accounting Years.--Do not put charges for services provided in different accounting years on the same bill. At the end of your accounting year, submit a bill which contains the charges for all services furnished to the patient since the last bill through the end of the year. Include bills in which the deductible covers full charges. Put services furnished in the succeeding accounting year on a separate bill. Complete all items on the subsequent bill.

529.3 General Payment Rules and Application of Part B Deductible and Coinsurance.--Section 1888(e)(9) of the Social Security Act requires that the payment amount for Part B SNF services shall be the amount prescribed in the otherwise applicable fee schedule. Thus, where a fee schedule exists for the type of service, the fee amount will be paid. Where despite the fee schedule the particular service is priced based on individual consideration or gap-filled by the carrier the fee amount will be determined by individual consideration or gap filled amount. Some specific services continue to be paid on a cost basis. These are specifically identified in §531. Where payment is made under a fee schedule, the beneficiary's deductible and coinsurance are based on the approved amount. Where payment is made on a cost basis, deductible and coinsurance are based on charges for the service.

## 530. DESCRIPTION OF HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

HCPCS is required for reporting SNF services paid by Medicare fee schedules.

HCPCS is based upon the American Medical Association's (AMA) Physicians' Current Procedural Terminology, Fourth Edition (CPT-4). It includes three levels of codes and modifiers. HCFA monitors the system to ensure uniformity. Level I contains only the AMA's CPT-4 codes. This level consists of all numeric codes. The second level contains the codes for physician and nonphysician services which are not included in CPT-4, e.g., ambulance, DME, orthotics and prosthetics. These are alpha-numeric codes maintained jointly by HCFA, the Blue Cross and Blue Shield Association (BCBSA), and the Health Insurance Association of America (HIAA). Level III (local assignment) contains the codes for services needed by individual contractors or State agencies to process Medicare and Medicaid claims. They are used for services which are not contained in either other level. The local codes are also alpha-numeric, but are restricted to the series beginning with W, X, Y, and Z.

Level I (CPT-4) codes/modifiers can be purchased in hardcopy form or a tape/cartridge from:

American Medical Association
P.O. Box 7046
Dover, DE 19903-7046
Telephone 1-800-621-8335

Level II (non-CPT-4) codes/modifiers can be purchased in hardcopy form from:

Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954
Telephone (202) 512-1800
Fax: (202) 512-2250

Level II codes/modifiers are also available on computer tape from the National Technical Information Services (NTIS). Their address is:

National Technical Information Service
5285 Port Royal Road
Springfield, VA 22161
Sales Desk: (703) 487-4650,
Subscriptions: (703) 487-4630,
TDD (hearing impaired only): (703) 487-4639,
RUSH Service (available for an additional fee):
1-800-553-NTIS, Fax: (703) 321-8547,
and E-Mail: orders@ntis.fedworld.gov

HCPCS information is also published on the HCFA Web Page at http://www.hcfa.gov
Select the Plans and Providers page.

530.1 Use and Maintenance of CPT-4 in HCPCS.--The text contains over seven thousand service codes, plus titles and modifiers. The AMA and HCFA have entered into an agreement that permits the use of CPT-4 codes in HCPCS and describes the manner in which they may be used. See Program Memorandum AB-00-126.

530.2 Addition, Deletion, and Change of Local Codes.--There may be procedures for which you bill, but are unable to determine a code. Contact your intermediary for advice. Furnish the intermediary with a full narrative description of the procedure, its projected volume, and the charge.

Your intermediary will review the request to determine that the required documentation is provided, and whether a current code exists. If no current code is found, the intermediary will forward the submitted documentation for consideration of a local code assignment to HCFA. The request will be placed on the HCFA HCPCS Workgroup agenda for review and a final decision regarding the establishment of a new local code. If a new code is approved, it will be added to the HCPCS database.

HCPCS is updated quarterly to reflect changes in the practice of medicine and provision of health care. The major update occurs for claims with dates of service beginning each January 1, although additional updates occur quarterly. HCFA provides a file containing the updated HCPCS codes to contractors and Medicaid State agencies 90 days in advance of the implementation of the major annual update.

530.3 Considerations in Use of HCPCS for Medicare Billing.--Use the CPT-4 portion of HCPCS and/or level II as directed by the manual sections applicable to the Part B service that you are billing. Currently, HCPCS codes are not applicable on SNF Part A inpatient claims.

For Part B claims, there are separate codes for the technical component, professional component, and/or complete procedure. Use the code that describes the procedure you provided.

There may be specific rules for use of HCPCS codes for specific types of services (e.g., SNF's must bill global services for therapies). These will be described in the manual sections for the applicable service.

## 532. BILLING PART B THERAPY SERVICES

Section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33) which added §1834(k) (5) to the Social Security Act, (the Act) requires that all claims for outpatient rehabilitation, certain audiology services and comprehensive outpatient rehabilitation facility (CORF) services be reported using a uniform coding system. The Health Care Financing Administration Common Procedure Coding System (HCPCS) is the coding system used for the reporting of these services. This coding requirement was effective for all claims for the above mentioned services submitted on or after April 1, 1998. The Medicare Physician Fee Schedule (MPFS) is the payment system for these services, effective January 1, 1999.

HCPCS includes CPT-4 codes. Providers report HCPCS codes in FL 44, HCPCS/rates. Hospitals and SNFs providing outpatient rehabilitation and certain audiology services to their inpatients, who are entitled to benefits under Part A, but who have exhausted benefits for inpatient services during a spell of illness, or to their inpatients who are not entitled to benefits under Part A, are required to report HCPCS codes.

The appropriate bill types are 22x or 23x, depending upon whether the patient is a Part B resident or an outpatient. Use 22x for residents, and 23x for beneficiaries that live outside the facility. If you utilize the UB-92 flat file to bill use record type 40, field 4, to report bill type. For electronic billing on the ANSI ASC X-12 837 Health Care Claim, and the Health Care Claim: Institutional ANSI ASC X-12 837 version 4010, use 2-130-CLM05-01 and 2-130-CLM05-03.

It is not necessary to match HCPCS codes to revenue codes because many therapy services, physical therapy modalities, or therapy procedures as described by HCPCS codes, may be delivered by both physical and occupational therapists. Other services may be delivered by either occupational therapists or speech-language pathologists. Therefore, providers report outpatient rehabilitation HCPCS in conjunction with the appropriate outpatient rehabilitation revenue code based on the type of therapist who delivered the service, or, if the service is not delivered by a therapist, then the type of therapy under the Plan of Care for which the service is delivered.

A. Applicable Revenue Codes.--The applicable revenue codes for reporting outpatient rehabilitation services are 420, 430, and 440.

HCPCS codes are to be reported when billing for audiological services under revenue code 470.

B. Applicable HCPCS Codes.--The applicable HCPCS codes for reporting outpatient rehabilitation services are as follows:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 11040 | 11041 | 11042 | 11043 | 11044 | 29065 | 29075 | 29085 | 29105 |
| 29125 | 29126 | 29130 | 29131 | 29200 | 29220 | 29240 | 29260 | 29280 |
| 29345 | 29365 | 29405 | 29445 | 29505 | 29515 | 29520 | 29530 | 29540 |
| 29550 | 29580 | 29590 | 64550 | 90901 | 90911 | 92506 | 92507 | 92508 |
| 92510 | 92525 | 92526 | 92597 | 92598 | 95831 | 95832 | 95833 | 95834 |
| 95851 | 95852 | 96105 | 96110 | 96111 | 96115 | 97001 | 97002 | 97003 |
| 97004 | 97010***** | | 97012 | 97014 | 97016 | 97018 | 97020 | 97022 |
| 97024 | 97026 | 97028 | 97032 | 97033 | 97034 | 97035 | 97036 | 97039 |
| 97110 | 97112 | 97113 | 97116 | 97124 | 97139 | 97140 | 97150 | 97504** |
| 97520 | 97530 | 97535 | 97537 | 97542 | 97545 | 97546 | 97703 | 97750 |
| 97770*** | | 97799 | G0169 | V5362 | V5363 | V5364 | | |

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

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

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

The above list of codes contains commonly utilized codes for outpatient rehabilitation services. Intermediaries may consider other codes for payment as outpatient rehabilitation services to the extent that such codes are determined to be medically reasonable and necessary and those that could be performed within the scope of practice of the therapist or provider providing the service.

The following audiological services are not considered therapy services, and may be billed by the SNF under arrangements or by a rendering provider, e.g., hospital outpatient department billing the intermediary or practitioner/supplier billing the carrier. Payment to a SNF for these tests is made by fee schedule. SNFs may bill only the technical component and must use the TC modifier for the codes identified by *. The remainder of these codes are defined as technical component only.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 92552 | 92553 | 92555 | 92556 | 92557 | 92561 | 92562 | 92563 | 92564 |
| 92565 | 92567 | 92568 | 92569 | 92571 | 92572 | 92573 | 92575 | 92576 |
| 92577 | 92579 | 92582 | 92583 | 92584 | 92587* | 92588* | 92589 | 92596 |
| V5299 | | | | | | | | |

C. Reporting of Service Units.--Effective with claims submitted on or after April 1, 1998, providers are required to report the number of units for outpatient rehabilitation and certain audiology services in FL 46 Service Units based on the procedure or service, e.g., on the HCPCS code reported instead of the revenue code. Units are to be reported based on the number of times the procedure, as described in the HCPCS code definition, is performed. When reporting service units for HCPCS codes where the procedure is not defined by a specific timeframe report "1" in FL 46. Visits should not be reported as units for these services. Since providers may perform a number of procedures or services during a single visit, the number of units may exceed the number of visits.

**EXAMPLE**: A beneficiary received occupational therapy (HCPCS code 97530 which is defined in 15 minute intervals) for a total of 60 minutes. The provider would then report revenue code 043x in FL 42, HCPCS code 97530 in FL 44, and four units in FL 46.

Several CPT codes used for therapy modalities, procedures, and tests and measurements specify that the direct (one on one) time spent in patient contact is 15 minutes. Providers report procedure codes for services delivered on **any calendar day** using CPT codes and the appropriate number of units of service. For any single CPT code, providers bill a single 15 minute unit for treatment greater than or equal to 8 minutes and less than 23 minutes. If the duration of a single modality or procedure is greater than or equal to 23 minutes to less than 38 minutes, then 2 units should be billed. Time intervals for larger numbers of units are as follows:

| | | | |
|---|---|---|---|
| 3 units | ≥ 38 minutes to < 53 minutes | 6 units | ≥ 83 minutes to < 98 minutes |
| 4 units | ≥ 53 minutes to < 68 minutes | 7 units | ≥ 98 minutes to < 113 minutes |
| 5 units | ≥ 68 minutes to < 83 minutes | 8 units | ≥ 113 minutes to < 128 minutes |

The pattern remains the same for treatment times in excess of 2 hours. Providers should not bill for services performed for < 8 minutes. The expectation (based on the work values for these codes) is that your time for each unit will average 15 minutes in length. If a provider has a practice of billing less than 15 minutes for a unit, these situations will be highlighted for review.

The beginning and ending time of the treatment should be recorded in the patient's medical record along with the note describing the treatment. (The total length of the treatment to the minute could be recorded instead.) **If more than one CPT code is billed during a calendar day, then the total number of units that can be billed is constrained by the total treatment time**. For example, if 24 minutes of 97112 and 23 minutes of 97110 was furnished, then the total treatment time was 47 minutes, so only 3 units can be billed for the treatment. The correct coding is 2 units of 97112 and one unit of 97110, assigning more units to the service that took the most time.

**NOTE**: The above schedule of times is intended to provide assistance in rounding time into 15 minute increments. It does not imply that any minute until the eighth should be excluded from the total count as the timing of active treatment counted includes all time.

1. Determining What Time Counts Towards 15 Minute Timed Codes.--Providers report the code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post- delivery services are not to be counted in determining the treatment service time. In other words, the time counted as intraservice care begins when the therapist or physician or an assistant under the supervision of a physician or therapist is delivering treatment services. The patient should already be in the treatment area (e.g., on the treatment table or mat or in the gym) and prepared to begin treatment.

The time counted is the time the patient is treated. For example, if gait training in a patient with a recent stroke requires both a therapist and an assistant, or even two therapists, to manage in the parallel bars, each 15 minutes the patient is being treated can only count as one unit of 97116. The time the patient spends not being treated because of the need for toileting or resting should not be billed. In addition, the time spent waiting to use a piece of equipment or for other treatment to begin is not considered treatment time.

Providers report in FLs 39-41, RT41, ANSI ASC X-12 837 Health Care Claim 2-225.F HI, and Health Care Claim: Institutional ANSI ASC X-12 837 version 4010 value code 50, 51, or 52 as appropriate the total number of physical therapy, occupational therapy, or speech therapy visits provided from start of care through the billing period. This item is visits; not service units.

D. Line Item Date of Service Reporting.--SNFs are required to report line item dates of service per revenue code line for Part B rehabilitation services and audiology services. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence. Line item dates of service are reported in FL 45 Service Date (MMDDYY for hard copy, and YYYYMMDD for the UB-92 flat file). See example below of reporting line item dates of service. This example is for physical therapy services provided twice during a billing period.

For the UB-92 flat file, report as follows:

| Record Type | Revenue Code | HCPCS | Dates of Service | Units | Total Charges |
|---|---|---|---|---|---|
| 61 | 0420 | 97001 | 20010506 | 1 | $60.90 |
| 61 | 0420 | 97110 | 20010529 | 2 | $44.02 |

For the hard copy UB-92 (Form HCFA-1450), report as follows:

| FL 42 | FL 44 | FL 45 | FL 46 | FL 47 |
|---|---|---|---|---|
| 0420 | 97001 | 050601 | 1 | $60.90 |
| 0420 | 97110 | 052901 | 2 | $44.02 |

For the ANSI ASC X-12 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, as well as the Health Care Claim: Institutional ANSI ASC X-12 837 version 4010, report as follows:

LX*1~
SV2*420*HC:97001*6090*UN*1~
DTP*472*D8*20010506~
LX*2~
SV2*420*HC:97110*4402*UN*2~
DTP*472*D8*20010529~

Intermediaries will return bills that span two or more dates if a line item date of service is not entered for each HCPCS reported.

SNFs report line item dates of service, in revenue code order by date of service. Services that do not require line item date of service reporting, may be reported before or after those services that require line item reporting.

E. Edit Requirements.--Intermediaries edit to assure the presence of a HCPCS code when revenue codes 0420, 0430, 0440 or 0470 are reported. They do not edit the matching of revenue codes to HCPCS codes or edit to limit provider reporting to only those HCPCS codes listed above.

F. Implementation of MPFS.--Effective for claims with dates of service on or after January 1, 1999, the Medicare Physician Fee Schedule (MPFS) is the method of payment when outpatient physical therapy (which includes outpatient speech-language pathology) and occupational therapy services are furnished by rehabilitation agencies (outpatient physical therapy providers and CORFs), hospitals (to outpatients and inpatients who are not in a covered Part A stay), SNFs (to residents not in a covered Part A stay and to non-residents who receive outpatient rehabilitation services from the SNF under a home health Plan of Treatment). The MPFS is used as a method of payment for outpatient rehabilitation services furnished under arrangement with any of these providers. In addition, the MPFS is also used as the payment system for audiology and certain CORF services identified by the HCPCS codes above. The Medicare allowed charge for the services is the lower of the actual charge or the MPFS amount. The Medicare payment for the services is 80 percent of the allowed charge after the Part B deductible is met. Coinsurance is made at 20 percent of the lower of the actual charge or the MPFS amount. The general coinsurance rule (20 percent of the actual charges) does not apply when making payment under the MPFS. This is a final payment.

An example of payment methodology in which the Part B deductible has previously been met is as follows:

**EXAMPLE**: $150 Provider charge;

$100 MPFS amount.

Payment is 80 percent of the lower of the actual charge or fee schedule amount which in this case is $80.00. ($100.00 x 80 percent.)

The resultant remaining 20 percent or $20 is the patient's coinsurance liability.

G. Discipline Specific Outpatient Rehabilitation Modifiers.--Providers are required to report one of the following modifiers to distinguish the type of therapist who performed the outpatient rehabilitation service (not the payment designation) or, if the service was not delivered by a therapist, then the discipline of the plan of treatment under which the service is delivered should be reported:

GN Service delivered personally by a speech-language pathologist under an outpatient speech-language pathology plan of care;

GO Service delivered personally by an occupational therapist or under an outpatient occupational therapy plan of care; or,

GP Service delivered personally by a physical therapist or under an outpatient physical therapy plan of care.

Reporting of the above modifications is for data collection purposes only.

If an audiology procedure (HCPCS) code is performed by an audiologist, the above modifiers are not required to be reported.

H. Coding Guidance for Certain Physical Medicine CPT Codes.--The following provides guidance about the use of codes 96105, 97150, 97545, 97546, and G0128.

CPT Codes 96105, 97545 and 97546

Providers report code 96105, assessment of aphasia with interpretation and report in 1 hour units. This code represents formal evaluation of aphasia with an instrument such as the Boston Diagnostic Aphasia Examination. If this formal assessment is performed during treatment, it is typically performed only once during treatment and its medical necessity should be documented. If the test is repeated during treatment, the medical necessity of the repeat administration of the test must also be documented. It is common practice for regular assessment of a patient's progress in therapy to be documented in the chart, and this may be done using test items taken from the formal examinations. This is considered to be part of the treatment and should not be billed as 96105 unless a full, formal assessment is completed.

Other timed physical medicine codes are 97545 and 97546. The interval for 97545 is 2 hours and for 97546, 1 hour. These are specialized codes to be used in the context of rehabilitating a worker to return to a job. The expectation is that the **entire** time period specified in the codes 97545 or 97546 would be the treatment period, since a shorter period could be coded with another code such as 97110, 97112, or 97114, or 97537. (These codes were developed for reporting services to persons in the worker's compensation program, thus we do not expect to see them reported for Medicare patients except under very unusual circumstances.)

## 533. BILLING PART B RADIOLOGY SERVICES AND OTHER DIAGNOSTIC PROCEDURES

Acceptable HCPCS codes for radiology and other diagnostic services are taken primarily from the CPT-4 portion of HCPCS. Payment is under the Medicare physician fee schedule. Revenue codes, dates of service, and applicable HCPCS modifiers are required. Use the revenue code that maps to your charge master. Charges must be reported by HCPCS code. If the same revenue code applies to two or more HCPCS codes, repeat the revenue code and show the charges for the related HCPCS code on the HCPCS line. Deductible and coinsurance apply, and coinsurance is based on the allowed amount.

There are some services, described in the following sections, for which the related ICD-9-CM diagnosis code is required to support the need for the service.

### 533.1 Special Billing Instructions.--

A. Aborted Procedure.--When a procedure is not completed, bill an unlisted code showing the actual charges for radiology services and for other diagnostic procedures.

B. Combined Procedures (Radiology).--There are no separate codes covering certain combined procedures, e.g., a hand and forearm included in a single x-ray. Use the code with the higher fee schedule amount.

C. Treatment Management Delivery.--Do not bill weekly treatment management services (codes 77419, 77420, 77425, 77430, and 77431). Instead, bill for radiation treatment delivery (codes 77401 - 77404, 77406 - 77409, 77411 - 77414, and 77416). Also, bill for therapeutic radiology port film (code 77417) which was previously a part of the weekly services. Enter the number of services in the units field.

D. "On Call" Charges.--These are not billed separately. The appropriate code for the performed procedures must be reported. Costs related to on call personnel may be included on the cost report and may be spread across individual charges related to the personnel.

E. Portable Equipment (C-Arm, Swing Arm, etc.).--When procedures are performed using portable equipment, bill using the appropriate code for the procedure. Additional set up charges for the use of portable equipment may be submitted where applicable. Use HCPCS code Q0092.

F. Payment for Contrast Material Other Than Low Osmolar Contrast Material (LOCM) (Radiology).--When you provide a radiology procedure with contrast material, bill using the CPT-4 code that indicates "with" contrast material. If the coding does not distinguish between "with" and "without" contrast material, use the available code.

Contrast material other than LOCM may be billed separately in addition to the radiology procedure, or it may be billed as part of the amount for the radiology procedure. If you bill separately for the contrast material and your charge for the procedure includes a charge for contrast material, you must adjust the charge for the procedure to exclude any amount for the contrast material. Regardless of the billing method used, charges are subject to the radiology fee schedule.

When billing separately for this contrast material, use revenue code 255 (drugs incident to radiology) and report the charges on the same bill as the radiology procedure. Your intermediary will not accept late charge bills for this service.

G. Payment for Low Osmolar Contrast Material (LOCM) (Radiology).--LOCM is paid on a reasonable cost basis (in addition to payment for the radiology procedure) when it is used in the following situations:

- In all intrathecal injections. The applicable HCPCS codes for such injections are:

70010 70015 72240 72255 72265 72270 72285 72295; or

- In intravenous and intra-arterial injections only when certain medical conditions are present in an outpatient. You must verify the existence of at least one of the following medical conditions, and report the applicable ICD-9-CM code(s) in item 67 (principal diagnosis code) or items 68 through 75 (other diagnosis codes) of the HCFA-1450:

-- A history of previous adverse reaction to contrast material. The applicable ICD-9-CM codes are V14.8 and V14.9. The conditions which should not be considered adverse reactions are a sensation of heat, flushing, or a single episode of nausea or vomiting. If the adverse reaction occurs on that visit with the induction of contrast material, codes describing hives, urticaria, etc. should also be present, as well as a code describing the external cause of injury and poisoning, E947.8;

-- A history or condition of asthma or allergy. The applicable ICD-9-CM codes are V07.1, V14.0 through V14.9, V15.0, 493.00, 493.01, 493.10, 493.11, 493.20, 493.21, 493.90, 493.91, 495.0, 495.1, 495.2, 495.3, 495.4, 495.5, 495.6, 495.7, 495.8, 495.9, 995.0, 995.1, 995.2, and 995.3;

-- Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension. The applicable ICD-9-CM codes are:

402.00, 402.01, 402.10, 402.11, 402.90, 402.91;

404.00, 404.01, 404.02, 404.03;

404.10, 404.11, 404.12, 404.13;

404.90, 404.91, 404.92, 404.93;

410.00, 410.01, 410.02, 410.10, 410.11, 410.12;

410.20, 410.21, 410.22, 410.30, 410.31, 410.32;

410.40, 410.41, 410.42, 410.50, 410.51, 410.52;

410.60, 410.61, 410.62, 410.70, 410.71, 410.72;

410.80, 410.81, 410.82, 410.90, 410.91, 410.92;

411.1, 415.0, 416.0, 416.1, 416.8, 416.9;

420.0, 420.90, 420.91, 420.99, 424.90, 424.91;

424.99, 427.0, 427.1, 427.2, 427.31, 427.32;

427.41, 427.42, 427.5, 427.60, 427.61, 427.69;

427.81, 427.89, 427.9, 428.0, 428.1, 428.9, 429.0;

429.1, 429.2, 429.3, 429.4, 429.5, 429.6, 429.71;

429.79, 429.81, 429.82, 429.89, 429.9, 785.50, 785.51, and 785.59;

– Generalized severe debilitation. The applicable ICD-9-CM codes are 203.00, 203.01, all codes for diabetes mellitus, 518.81, 585, 586, 799.3, 799.4, and V46.1; or

– Sickle Cell disease. The applicable ICD-9-CM codes are 282.4, 282.60, 282.61, 282.62, 282.63, and 282.69.

HCPCS codes are required when billing for LOCM. If one of the above conditions for payment is met, use one of the following HCPCS codes as appropriate:

| 1/1/92 through 12/31/93 | 1/1/94 on | |
|---|---|---|
| Q0105 | A4644 | Supply of low osmolar contrast material (100-199 mgs of iodine); |
| Q0106 | A4645 | Supply of low osmolar contrast material (200-299 mgs of iodine); or |
| Q0107 | A4646 | Supply of low osmolar contrast material (300-399 mgs of iodine). |

When billing for LOCM, use revenue code 636. If your charge for the radiology procedure includes a charge for contrast material, you must adjust the charge for the procedure to exclude any amount for the contrast material.

**NOTE:** LOCM is never billed with revenue code 255 or as part of the radiology procedure.

Your intermediary will edit for the intrathecal procedure codes and the above ICD-9-CM codes to determine if payment for LOCM is to be made. If an intrathecal procedure code is not present, or one of the ICD-9-CM codes is not present to indicate that a required medical condition is met, your intermediary will deny payment for LOCM. In these instances, LOCM is **not** covered and should not be billed to Medicare.

Noncovered charges may be billed to the Medicare beneficiary only if the beneficiary received written notice of noncoverage prior to the service being provided.

H. Payment for Radiopharmaceuticals.--Radiopharmaceuticals are not subject to the radiology fee schedule, but are paid based on reasonable cost. HCPCS codes are required for billing. Report HCPCS codes 79900, A4641, A4642, A9500, A9503, and A9505, as appropriate, with revenue codes 0333, 034x, or 0636.

**NOTE**: Do not report HCPCS code 78990. This code is not valid for Medicare purposes and has been replaced with code A4641.

**EXCEPTION**: HCPCS codes 77781, 77782, 77783, and 77784 include payment for the radiopharmaceutical in the technical component. When these procedures are performed, do not report radiopharmaceutical codes 79900, A4641, A4642, A9500, A9503, and A9505. Your intermediary will reject codes 79900, A4641, A4642, A9500, A9503, and A9505 when they are billed for supplies used in conjunction with procedure codes 77781, 77782, 77783, and 77784.

I Payment for IV Persantine.--The drug IV Persantine is paid based on the drug pricing methodology when used in conjunction with nuclear medicine and cardiovascular stress testing procedures furnished to SNF outpatients. Separate drug pricing methodology payments for IV-Persantine will be made in addition to payments made for the procedure. When billing for IV-Persantine, HCPCS coding is required. Report HCPCS code J1245 (injection, dipyridamole, per 10 mg.) with revenue code 636.

J. Transportation of Equipment.--When you transport portable x-ray equipment to a site by van or other vehicle, bill for the transportation costs using one of the following HCPCS codes along with the appropriate revenue code:

R0070 - Transportation of Portable X-Ray Equipment and Personnel to Home or Nursing Home, Per Trip to Facility or Location, One Patient Seen.

R0075 - Transportation of Portable X-Ray Equipment and Personnel to Home or Nursing Home, Per Trip to Facility or Location, More than One Patient Seen, Per Patient.

These HCPCS codes are subject to the fee schedule.

533.2 Positron Emission Tomography (PET) Scans.--PET, also known as positron emission transverse tomography (PETT), is a noninvasive imaging procedure that assesses perfusion and the level of metabolic activity in various organ systems of the human body. A positron camera (tomograph) is used to produce cross-sectional tomographic images by detecting radioactivity from a radioactive tracer substance (radiopharmaceutical) that is injected into the patient.

For dates of service on and after March 14, 1995, Medicare covers one use of PET scans, i.e., imaging of the perfusion of the heart using Rubidium 82 (Rb 82), provided that the following conditions are met:

- The PET is done at a PET imaging center with a PET scanner that has been approved by the FDA;

- The PET scan is a rest alone or rest with pharmacologic stress PET scan, used for noninvasive imaging of the perfusion of the heart for the diagnosis and management of patients with known or suspected coronary artery disease, using Rb 82; and

- Either the PET scan is used in place of, but not in addition to, a single photon emission computed tomography (SPECT) or the PET scan is used following a SPECT that was found inconclusive.

See Coverage Issues Manual, §50-36 for additional coverage instructions for PET scans.

Use the HCPCS "G" codes listed below to indicate the conditions under which a PET scan was done. These codes represent the technical component. Bill these codes under Revenue Code 404 (Positron Emission Tomography).

G0030 PET myocardial perfusion imaging, (following previous PET, G0030-G0047); single study, rest or stress (exercise and/or pharmacologic)

G0031 PET myocardial perfusion imaging, (following previous PET, G0030-G0047); multiple studies, rest or stress (exercise and/or pharmacologic)

G0032 PET myocardial perfusion imaging, (following rest SPECT, 78464); single study, rest or stress (exercise and/or pharmacologic)

G0033 PET myocardial perfusion imaging, (following rest SPECT, 78464); multiple studies, rest or stress (exercise and/or pharmacologic)

G0034 PET myocardial perfusion imaging, (following stress SPECT, 78465); single study, rest or stress (exercise and/or pharmacologic)

G0035 PET myocardial perfusion imaging, (following stress SPECT, 78465); multiple studies, rest or stress (exercise and/or pharmacologic)

G0036 PET myocardial perfusion imaging, (following coronary angiography, 93510-93529); single study, rest or stress (exercise and/or pharmacologic)

G0037 PET myocardial perfusion imaging, (following coronary angiography, 93510-93529); multiple studies, rest or stress (exercise and/or pharmacologic)

G0038 PET myocardial perfusion imaging, (following stress planar myocardial perfusion, 78460; single study, rest or stress (exercise and/or pharmacologic)

G0039 PET myocardial perfusion imaging, (following stress planar myocardial perfusion, 78460; multiple studies, rest or stress (exercise and/or pharmacologic)

G0040 PET myocardial perfusion imaging, (following stress echocardiogram, 93350); single study, rest or stress (exercise and/or pharmacologic)

G0041 PET myocardial perfusion imaging, (following stress echocardiogram, 93350); multiple studies, rest or stress (exercise and/or pharmacologic)

G0042 PET myocardial perfusion imaging, (following stress nuclear ventriculogram, 78481 or 78483); single study, rest or stress (exercise and/or pharmacologic)

G0043 PET myocardial perfusion imaging, (following stress nuclear ventriculogram 78481 or 78483); multiple studies, rest or stress (exercise and/or pharmacologic)

G0044 PET myocardial perfusion imaging, (following rest ECG, 93000); single study, rest or stress (exercise and/or pharmacologic)

G0045 PET myocardial perfusion imaging, (following rest ECG, 93000); multiple studies, rest or stress (exercise and/or pharmacologic)

G0046 PET myocardial perfusion imaging, (following stress ECG, 93015); single study, rest or stress (exercise and/or pharmacologic)

G0047 PET myocardial perfusion imaging, (following stress ECG, 93015); multiple studies, rest or stress (exercise and/or pharmacologic)

Effective July 1, 1999, Medicare expanded coverage of PET scans to include the evaluation of recurrent colorectal cancer in patients with rising levels of carcinoembryonic antigen (CEA), for the staging of lymphoma (both Hodgkins and non-Hodgkins) when the PET scan substitutes for a gallium scan or lymphangiogram, and for the staging of recurrent melanoma prior to surgery, provided certain conditions are met. All three indications are covered only when using the radiopharmaceutical FDA (2-[flourine-18]-fluoro-2-deoxy-D-glucose), and are further predicated on the legal availability of FDG for use in such scans.

Three new HCPCS codes for PET scans when performed on or after July 1, 1999 are listed below.

- G0163--Positron Emission Tomography (PET), whole body, for recurrence of colorectal or colorectal metastatic cancer.

- G0164--Positron Emission Tomography (PET), whole body, for staging and characterization of lymphoma.

- G0165-- Positron Emission Tomography (PET), whole body, for recurrence of melanoma or melanoma metastatic cancer.

These codes represent the technical component costs associated with these procedures and are payable on a fee schedule basis. They are reported with revenue code 404 (Positron Emission Tomography). SNFs can bill for the above PET scans performed on or after July 1, 1999, provided all the terms and conditions set forth in the coverage guidelines for PET are met.

Postpayment Review

As with any claim, but particularly in view of the limitations on this coverage, Medicare may decide to conduct post-payment reviews to determine that the use of PET scans is consistent with coverage instructions. SNFs must keep patient record information on file for each Medicare patient for whom a PET scan claim is made. These medical records will be used in any post-payment reviews and must include the information necessary to substantiate the need for the PET scan. These records must include standard information (e.g., age, sex, and height) along with sufficient patient histories to allow determination that the steps required in the coverage instructions were followed. Such information must include, but is not limited to, the date, place and results of previous diagnostic tests (e.g., cytopathology and surgical pathology reports, CT), as well as the results and reports of the PET scan(s) performed at the center. If available, such records should include the prognosis derived from the PET scan, together with information regarding the physician or institution to which the patient proceeded following the scan for treatment or evaluation. The ordering physician is responsible for forwarding appropriate clinical data to the PET scan facility.

533.3 Payment for Adenosine.--The drug adenosine is paid based on the drug payment methodology when used as a pharmacologic stressor for other diagnostic testing. Separate drug based payment for adenosine will be made in addition to payments made for the procedure. When billing for adenosine, HCPCS coding is required. Report HCPCS code J0150 (Injection, adenosine, 6 mg.) with revenue code 636.

533.4 Radiology or Other Diagnostic Unlisted Service or Procedure.--You may find radiology and other diagnostic services for which a corresponding code in HCPCS may not be found. This is

because these are typically services that are rarely provided, unusual, or new. Assign the appropriate "unlisted procedure" code to any such service. The following list contains the "unlisted procedure" codes along with the suggested revenue code for billing. These services are paid on a fee schedule if one exists or individual consideration if a fee has not been established. However before billing any of these codes you are to furnish a complete description of the radiology procedure to your intermediary for review and analysis. Include a narrative definition of the procedure and a description of the nature, extent and need for the procedure and the time, effort, and equipment necessary. Your intermediary will determine if you have correctly identified the procedure as "unlisted." If the procedure is not identified correctly, your intermediary will inform you of the correct HCPCS code to assign to the procedure. If there is no fee schedule amount established these services are paid based on individual consideration.

For Radiology

| Revenue Code | HCPCS | Definition |
|---|---|---|
| 032x | 76499 | Unlisted diagnostic radiologic procedure |
| 0402 | 76999 | Unlisted ultrasound procedure |
| 0333 | 77299 | Unlisted procedure, therapeutic radiology clinical treatment planning |
| 0333 | 77399 | Unlisted procedure, medical radiation physics, dosimetry and treatment devices |
| 0333 | 77499 | Unlisted procedure, therapeutic radiology clinical treatment management |
| 0333 | 77799 | Unlisted procedure, clinical brachytherapy |
| 034x | 78099 | Unlisted endocrine procedure, diagnostic nuclear medicine |
| 034x | 78199 | Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine |
| 034x | 78299 | Unlisted gastrointestinal procedure, diagnostic nuclear medicine |
| 034x | 78399 | Unlisted musculoskeletal procedure, diagnostic nuclear medicine |
| 034x | 78499 | Unlisted cardiovascular procedure, diagnostic nuclear medicine |
| 034x | 78599 | Unlisted respiratory procedure, diagnostic nuclear medicine |
| 034x | 78699 | Unlisted nervous system procedure, diagnostic nuclear medicine |
| 034x | 78799 | Unlisted genitourinary procedure, diagnostic nuclear medicine |
| 034x | 78999 | Unlisted miscellaneous procedure, diagnostic nuclear medicine |
| 034x | 79999 | Unlisted radiopharmaceutical therapeutic procedure |

For Other Diagnostic Procedures

| Revenue Code | HCPCS | Definition |
|---|---|---|
| 075x | 91299 | Unlisted diagnostic gastroenterology procedure |
| 047x | 92599 | Unlisted otorhinolaryngological service or procedure |
| 048x | 93799 | Unlisted cardiovascular service or procedure |
| 073x | 93799 | Unlisted cardiovascular service or procedure |
| 0921 | 93799 | Unlisted cardiovascular service or procedure |
| 046x | 94799 | Unlisted pulmonary service or procedure |
| 074x | 95999 | Unlisted neurological or neuromuscular diagnostic procedure |
| 0922 | 95999 | Unlisted neurological or neuromuscular diagnostic procedure |

E. EMC Formats.--Use record type 61 (Addendum A) on the UB-92 flat file and the SV2 segment on the ANSI ASC X-12 837 format to report Part B radiology services. Record type (on the flat file), sequence number, patient control number (if used), revenue code, HCPCS code, modifiers, units, line-item dates of service, and charges are required. The "from" and "through" dates of the bill are included in another record in the UB-92 flat file format.

533.5 Bone Mass Measurements.--Sections 1861(s)(15) and (rr)(1) of the Social Security Act (as added by §4106 of the Balanced Budget Act (BBA) of 1997) standardize Medicare coverage of medically necessary bone mass measurements by providing for uniform coverage under Medicare Part B. This standardized coverage is effective for claims with dates of service furnished on or after July 1, l998.

A. Conditions of Coverage.--Medicare pays for a bone mass measurement that meets all of the following criteria:

1. Is a radiologic or radioisotopic procedure or other procedure which

- Is performed with a bone densitometer (other than dual photon absorptiometry (DPA)) or a bone sonometer (i.e., ultrasound) device approved or cleared for marketing by the Food and Drug Administration (FDA);

- Is performed for the purpose of identifying bone mass or detecting bone loss or determining bone quality; and

- Includes a physician's interpretation of the results of the procedure.

2. Is performed on a qualified individual. The term “qualified individual” means a Medicare beneficiary who meets the medical indications for at least one of the five categories listed below:

- A woman who has been determined by the physician or a qualified nonphysician practitioner treating her to be estrogen-deficient and at clinical risk for osteoporosis, based on her medical history and other findings;

- An individual with vertebral abnormalities as demonstrated by an x-ray to be indicative of osteoporosis, osteopenia (low bone mass), or vertebral fracture;

- An individual receiving (or expecting to receive) glucocorticoid (steroid) therapy equivalent to 7.5 mg of prednisone, or greater, per day, for more than 3 months;

- An individual with primary hyperparathyroidism; or

- An individual being monitored to assess the response to or efficacy of an FDA-approved osteoporosis drug therapy.

3. Is ordered by the individual's physician or qualified nonphysician practitioner who is treating the beneficiary following an evaluation of the need for a measurement, including a determination as to the medically appropriate measurement to be used for the individual.

A physician or qualified nonphysician practitioner treating the beneficiary for purposes of this provision is one who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the patient. For the purposes of the bone mass measurement benefit, qualified nonphysician practitioners include physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives.

4. Is furnished by a qualified supplier or provider of such services under the appropriate level of supervision of a physician.

5. Is reasonable and necessary for diagnosing, treating, or monitoring the condition of a "qualified individual" as that term is defined above.

6. Is performed at a frequency that conforms to the requirements described below.

**NOTE:** Since not every woman who has been prescribed estrogen replacement therapy (ERT) may be receiving an "adequate" dose of the therapy, the fact that a woman is receiving ERT should not preclude her treating physician or other qualified treating nonphysician practitioner from ordering a bone mass measurement for her. If a bone mass measurement is ordered for a woman following a careful evaluation of her medical need, however, it is expected that the ordering treating physician (or other qualified treating nonphysician practitioner) will document in her medical record why he or she believes that the woman is estrogen-deficient and at clinical risk for osteoporosis.

B. Frequency Standard.--Medicare pays for a bone mass measurement meeting the criteria as stated above once every 2 years (at least 23 months have passed since the month the last bone mass measurement was performed). However, if it is medically necessary, Medicare may pay for a bone mass measurement for a beneficiary more frequently than every 2 years. Examples of situations where more frequent bone mass measurement procedures may be medically necessary include, but are not limited to, the following medical circumstances:

- Monitoring beneficiaries on long-term glucocorticoid (steroid) therapy of more than 3 months; and

- Allowing for a confirmatory baseline bone mass measurement (either central or peripheral) to permit monitoring of beneficiaries in the future if the initial test was performed with a technique that is different from the proposed monitoring method (for example, if the initial test was performed using bone sonometry and monitoring is anticipated using bone densitometry, cover the baseline measurement using bone densitometry).

C. HCPCS Coding.--The following HCPCS codes should be used when billing for bone mass measurements:

- 76075 - Dual energy x-ray absorptiometry (DEXA), bone density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine);

- 76076 - Dual energy x-ray absorptiometry (DEXA), bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel);

- 76078 - Radiographic absorptiometry (photo densitometry), one or more sites; and

- 78350 - Bone density (bone mineral content) study, one or more sites, single photon absorptiometry; and

- 76977 - Ultrasound bone density measurement and interpretation, peripheral site(s), any method.

**NOTE:** For claims with dates of service on or after January 1, 1999, code 76977 replaces HCPCS code G0133. Code G0133 was discontinued December 31, 1998.

- G0130 - Single energy x-ray absorptiometry (SEXA) bone density study, one or more sites, appendicular skeleton (peripheral) (e.g., radius, wrist, heel) (Short descriptor: SINGLE ENERGY X-RAY STUDY);

- G0131 - Computerized tomography bone mineral density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine) (Short descriptor: CT SCAN, BONE DENSITY STUDY);

- G0132 - Computerized tomography bone mineral density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel) (Short descriptor: CT SCAN, BONE DENSITY STUDY); and

- G0133 - Ultra-sound bone mineral density study, one or more sites, appendicular skeleton (peripheral) (e.g., radius, wrist, heel) (Short descriptor: ECHO EXAM, BONE DENSITY STUDY).

All of the aforementioned codes are bone densitometry measurements except codes G0133 and 76977 which qualify as bone sonometry measurements. Any of the above codes, as appropriate, should be used when billing for bone mass measurements.

Follow the general instructions in §560. Bill on Form HCFA-1450 or its electronic equivalent.

D. Applicable Bill Types.--The appropriate bill types are 22x and 23x. If you utilize the UB-92 flat file to bill use record type 40, field 4, to report bill type. For electronic billing on the ANSI ASC X-12 837 Health Care Claim, and the Health Care Claim: Institutional ANSI ASC X-12 837 version 4010, is 2-130-CLM05-01 and 2-130-CLM05-03. If you utilize the hard copy UB-92 (Form HCFA-1450) report the applicable bill type in FL 4 “Type of Bill”.

E. Coding Requirements.--You must report HCPCS codes for bone mass measurements under revenue code 320. In addition, report the number of units, and line item dates of service per revenue code line for each bone mass measurement reported. Line item date of service reporting is effective for claims with dates of service on or after October 1, 1998. See record formats for the Form HCFA-1450, the UB-92 flat file, the ANSI ASC X-12 837 Health Care Claim, and the Health Care Claim: Institutional ANSI ASC X-12 837 version 4010.

If you utilize the hard copy UB-92 (Form HCFA-1450) report the appropriate HCPCS code in FL 44 “HCPCS/Rates,” and revenue code 0320 in FL 42 “Revenue Code.” The date of service is reported in FL 45 “Service Date” and the number of service units in FL 46 “Service Units.”

F. Payment Methodology.--Part B deductible and coinsurance apply. Bone mass measurements are paid under the current payment methodology for radiology services.

## 534. BILLING FOR DURABLE MEDICAL EQUIPMENT (DME), ORTHOTIC/PROSTHETIC DEVICES, AND SURGICAL DRESSINGS

A. General.-- 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 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 §264.C.)

Prosthetics and orthotic devices are included in the Part A PPS rate unless specified as being outside the rate in section F below. Those that are considered outside the PPS rate may be billed by the SNF to the intermediary, or if furnished by a qualified outside entity, that entity may bill its normal contractor.

The SNFs or other entity that furnishes prosthetic and/or orthotic devices to SNF residents for whom Part A benefits are not payable (no Part A entitlement or benefits exhausted) may bill for such items.

A SNF may qualify as a supplier and bill for outpatient DME. In such cases, billing is to the DMERC and the DMERC will furnish billing guidelines.

Prosthetic and orthotic devices for purposes of this instruction are:

- Prosthetic devices (other than dental) which replace all or, part of an internal body organ (including connective tissue) or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repair of such devices. (See §260.4.)

- Leg, arm, and neck braces, trusses, and artificial legs, arms, and eyes, including adjustments, repairs, and replacement required because of breakage, wear, loss, or a change in the patient's physical condition. (See §260.5.)

B. Billing.--Bill your intermediary for prosthetic/orthotic devices and surgical dressings on Form HCFA-1450 or the electronic equivalent. Follow requirements for submission of Form HCFA-1450 in §560.

Bill prosthetic and orthotic devices under revenue code 274, along with the appropriate HCPCS code. When billing for maintenance and servicing of these items, use revenue code 274 along with the appropriate HCPCS code.

C. Reporting Units of Service.--Report under Item 52 "Units of Service" on Form HCFA-1450 the number of items billed to your intermediary for orthotics and prosthetics.

D. Determining Payment and Patient Liability.--To determine your Part B payment, subtract any unmet Part B deductible from the lower of the actual charge or the fee schedule amount for the item or service and multiply the remainder by 80 percent. This is the final payment. The patient's liability is the remaining 20 percent plus any deductible remaining to be met.

E. Coordination With Intermediaries, DMERCs, and Local Carriers.--There may be prosthetic and orthotic devices, or surgical dressings for which you bill that are not included in the fee schedule. When fee schedule amounts are not available for a particular item, your intermediary, DMERC, or local carrier will establish a fee.

F. Billable Services.--Customized prosthetic devices that are not included in the Part A PPS rate and are excluded from consolidated billing are identified in §516.5.

If the SNF is also a supplier, the SNF must enroll with National Supplier Clearinghouse. The supplier must bill the DMEPOS on Form HCFA-l500. If these services are billed separately by the supplier, payment will be made directly to the supplier. If these services are billed by the SNF, no additional payment will be made.

## 535. BILLING FOR SURGICAL DRESSINGS

Bill your intermediary for surgical dressings under bill type 22x or 23x, as applicable. Use revenue code 623. HCPCS codes for reporting surgical dressing are normally found in the Level II HCPCS codes in the A6000 series.

Your intermediary makes payment based on the surgical dressing fee schedule. Where fee amounts have not been established, the intermediary determines the fee in consultation with the DMERC. Updated fee amounts are published on the HCFA Web site.

## 536. BILLING FOR DRUGS

536.1 Self-Administered Drugs and Biologicals.--Drugs and biologicals furnished to outpatients for therapeutic purposes that are self-administered are not covered by Medicare unless those drugs and biologicals must be put directly into an item of durable medical equipment or a prosthetic device. The statute provides for such coverage (including blood clotting factors, drugs used in immunosuppressive therapy, erythropoietin (EPO), certain oral anti-cancer drugs and their associated anti-emetics), or the ordinarily non-covered, self-administered drug insulin if administered in an emergency situation to a patient in a diabetic coma.

Where covered under Part B, bill self-administered drugs with bill type 22x for SNF inpatients not entitled to Part A benefits and use bill type 23x for SNF outpatients.

A. Self-Administered Drug Administered In An Emergency Situation.--Medicare pays for the ordinarily non-covered, self-administered drug insulin administered in an emergency situation to a patient in a diabetic coma. Bill for drug on Form HCFA-1450 or its electronic equivalent with bill type 22x or 23x, as appropriate. Enter value code A4 and its related dollar amount (the amount included in covered charges for the ordinarily non-covered, self-administered drug insulin administered to the patient in an emergency situation) in FLs 39-41 under revenue code 637 (self-administerable drugs not requiring detailed coding) in FL 42. Complete the remaining items in accordance with regular billing instructions.

**NOTE:** Do not use revenue code 637 (self-administrable drugs not requiring detailed coding) for the reporting of those self-administrable drugs and biologicals that are statutorily covered. Follow the existing reporting requirements for those self-administered drugs and biologicals.

B. Self-Administered Oral Cancer Drugs.--Section 13553 of OBRA 1993 provides coverage for self-administered oral versions of covered injectable cancer drugs prescribed as an anti-cancer chemotherapeutic on or after January 1, 1994. To be covered, an oral cancer drug must:

- o Be prescribed by a physician or practitioner as an anti-cancer chemotherapeutic agent;
- o Be a drug or biological approved by the Food and Drug Administration (FDA);
- o Have the same active ingredients as a non-self-administrable anti-cancer chemotherapeutic drug or biological that is covered when furnished incident to a physician's service. The oral anti-cancer drug and the non-self-administrable drug must have the same chemical/generic name as indicated by the FDA's Approved Drug and Products (Orange Book), Physician's Desk Reference (PDR), or an authoritative drug compendium; or
- o Effective January 1, 1999, be a FDA-approved oral anti-cancer Prodrug, an oral drug ingested into the body that metabolizes into the same active ingredient that is found in the non-self-administrable form of the drug;
- o Be used for the same indications (including off-label uses) as the non-self-administrable version of the drug; and
- o Be reasonable and necessary for the individual patient.

| Generic/Chemical Name | How Supplied | HCPCS | |
|---|---|---|---|
| Busulfan | 2 mg/ORAL | J8510 | |
| Capecitabine | 150 mg/ORAL | J8520 | |
| Capecitabine | 500 mg/ORAL | J8521 | |
| Cyclophosphamide | 25 mg/ORAL | J8530 | |
| | 50 mg/ORAL | J8530 | (Treat 50 mg. as 2 units) |
| Etoposide | 50 mg/ORAL | J8560 | |
| Melphalan | 2 mg/ORAL | J8600 | |
| Methotrexate | 2.5 mg/ORAL | J8610 | |
| Temozolomide (Temodar) 56, 20, 100, 250mgs | | | |
| Prescription Drug, Chemotherapeutic, NOS | ORAL | J8999 | |

Effective January 1, 2000, 3 additional codes may be used to bill oral anticancer drugs. They are HCPCS codes, J8510, J8520, and J8521. These HCPCS codes were included in the 2000 HCFA HCPCS update that was released in October 1999. SNFs must report a cancer diagnosis code in FLs 67-75 when billing for these HCPCS codes.

Part B of Medicare pays 80 percent of the reasonable cost of oral cancer drugs furnished by a provider. Deductible and coinsurance apply. Bill for these drugs on the Form HCFA-1450 or its electronic equivalent with bill type 22x or 23x, as appropriate. Enter revenue code 636 in FL 42 of the Form HCFA-1450, the name and HCPCS of the oral drug in FLs 43 (for paper submissions only) and 44 on the Form HCFA-1450, and the number of tablets or capsules in FL 46 of the Form HCFA-1450. Each tablet or capsule is equal to one unit, except for 50 mg/ORAL of cyclophosphamide (J8530), which is shown as 2 units. Report oral anti-cancer Prodrugs under revenue code 636 in FL 42 and HCPCS code J8999 in FL 44. Complete the remaining items in accordance with regular billing instructions. A cancer diagnosis must be entered in FLs 67-75 of Form HCFA-1450, RT 70, or institutional ANSI ASC X-12 837 for coverage of an oral cancer drug or an oral cancer Prodrug.

C. Self-Administered Antiemetic Drugs.--Effective with dates of service on or after January 24, 1996, Medicare pays for self-administrable oral or rectal versions of self-administered antiemetic drugs when they are necessary for the administration and absorption of primary Medicare covered oral anti-cancer chemotherapeutic agents when a high likelihood of vomiting exists. The self-administered antiemetic drug is covered as a necessary means for the administration of the oral anti-cancer drug (similar to a syringe and needle necessary for injectable administration). Self-administered antiemetics which are prescribed for use to permit the patient to tolerate the primary anti-cancer drug in high doses for longer periods are not covered. In addition, self-administered antiemetics used to reduce the side effects of nausea and vomiting brought on by the primary drug are not included beyond the administration necessary to achieve drug absorption. (See §230.4.)

Part B of Medicare pays 80 percent of the reasonable cost of self-administered antiemetic drugs furnished by a provider. Deductible and coinsurance apply. Bill for these drugs on Form HCFA-1450 or its electronic equivalent with bill type 22x or 23x, as appropriate. Enter revenue code 636 in FL 42. For claims with dates of service on or after January 24, 1996 through March 31, 1996, enter HCPCS code J3490 in FL 44. For dates of service on or after April 1, 1996, enter one of the following HCPCS codes in FL 44, as appropriate:

- K0415 Prescription anti-emetic drug, oral, per 1 mg, for use in conjunction with oral anti-cancer drug, not otherwise specified; or

- K0416 Prescription anti-emetic drug, rectal, per 1 mg, for use in conjunction with oral anti-cancer drug, not otherwise specified.

Enter the name of the self-administered antiemetic drug in FL 43 and the number of units in FL 46. Each milligram of the tablet, capsule, or rectal suppository is equal to one unit. Complete the remaining items in accordance with regular billing instructions.

Claims are edited to assure that the beneficiary is receiving the self-administered antiemetic drug in conjunction with a Medicare covered oral anti-cancer drug.

D. Oral Anti-Nausea Drugs as Full Therapeutic Replacements for Intravenous Dosage Forms As Part of a Cancer Chemotherapeutic Regimen.--Section 4557 of the Balanced Budget Act of 1997 provides coverage for claims with dates of service on or after January 1, 1998 for oral anti-emetic

drugs as full therapeutic replacements for intravenous dosage forms as part of a chemotherapeutic regimen provided that the drug(s) be administered or prescribed by a physician for use immediately before, at, or within 48 hours after the time of administration of the chemotherapeutic agent.

For purposes of this provision, the allowable period of covered therapy is defined to include day one, the date of service of the chemotherapy drug (beginning with the time of treatment), plus a period not to exceed 2 additional calendar days, or a maximum period up to 48 hours. The oral anti-emetic drug(s) should only be prescribed on a per chemotherapy treatment basis. For example, only enough of the oral anti-emetic(s) for one 24 or 48-hour dosage regimen (depending upon the drug) should be prescribed/supplied for each incidence of chemotherapy treatment at a time. The beneficiary's medical record must be documented to reflect that the beneficiary is receiving the oral anti-emetic drug(s) as full therapeutic replacement for an intravenous anti-emetic drug as part of a cancer chemotherapeutic regimen. This will indicate that the Q codes listed in §422.4A are being reported when billing for the oral anti-emetic(s). The use of the appropriate Q code(s) on the claim will serve as affirmation of the correct use of the benefit. A cancer diagnosis must be entered in FLs 67-75, RT 70, or institutional ANSI ASC X-12 837 for coverage of these drugs.

Payment for these drugs is made under Part B. Medicare pays 80 percent of the reasonable cost of these drugs furnished by a provider. Deductible and coinsurance apply.

Bill for these drugs on Form HCFA-1450 or its electronic equivalent with bill type 22x or 23x, as appropriate.

E. Revenue Code and HCPCS Reporting.--Report the oral anti-emetic drug(s) under revenue code 0636 in FL 42 “Revenue Code.” For claims with dates of service on or after January 1, 1998 through March 31, 1998, report the HCPCS code J3490 in FL 44 “HCPCS/Rates.” For dates of service on or after April 1, 1998, report the following HCPCS code(s), as appropriate, in FL 44:

Q0163 DIPHENHYDRAMINE HYDROCHLORIDE, 50 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at time of chemotherapy treatment not to exceed a 48 hour dosage regimen.

Q0164 PROCHLORPERAZINE MALEATE, 5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Q0165 PROCHLORPERAZINE MALEATE, 10 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Q0166 GRANISETRON HYDROCHLORIDE, 1 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 24 hour dosage regimen.

Q0167 DRONABINOL, 2.5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Q0168 DRONABINOL, 5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Q0169 PROMETHAZINE HYDROCHLORIDE, 12.5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Q0170 PROMETHAZINE HYDROCHLORIDE, 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Q0171 CHLORPROMAZINE HYDROCHLORIDE, 10 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Q0172 CHLORPROMAZINE HYDROCHLORIDE, 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Q0173 TRIMETHOBENZAMIDE HYDROCHLORIDE, 250 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Q0174 THIETHYLPERAZINE MALEATE, 10 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Q0175 PERPHENAZINE, 4 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Q0176 PERPHENAZINE, 8 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hours dosage regimen.

Q0177 HYDROXYZINE PAMOATE, 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Q0178 HYDROXYZINE PAMOATE, 50 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Q0179 ONDANSETRON HYDROCHLORIDE, 8 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Q0180 DOLASETRON MESYLATE, 100 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 24 hour dosage regimen.

Q0181 UNSPECIFIED ORAL DOSAGE FORM, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for a IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

**NOTE:** The 24 hour maximum drug supply limitation on dispensing, for HCPCS codes Q0166 and Q0180, has been established to bring the Medicare benefit as it applies to these two therapeutic entities in conformance with the "Indications and Usage" section of currently Food and Drug Administration approved product labeling for each affected drug product. In addition, when billing for chemotherapy drugs (which includes oral cancer and IV chemotherapy drugs), you must report the HCPCS code of the chemotherapy drug in FL 44 under revenue code 0636 in FL 42.

**NOTE:** When billing for an oral anti-emetic drug(s) on the hard copy UB-92 (Form HCFA-1450), report the name of the oral anti-emetic drug(s) in FL 43 "Description" on the appropriate revenue lines.

F. Line Item Dates of Service Reporting.--When billing for an oral anti-emetic drug(s) used as full replacement for intravenous forms, you are required to report line item dates of service for the oral anti-emetic(s). Line item dates of service are reported in FL 45 "Service Date" (MMDDYY) on the hard copy Form HCFA-1450 or UB-92. (See example below.) For the UB-92 flat file use RT 61, field 13, (YYYYMMDD).

G. Service Unit Reporting.--Report the number of units of the oral anti-emetic drug(s) in FL 46 "Service Units" for each drug reported. Each HCPCS code descriptor is equal to one service unit. Complete the remaining items in accordance with regular billing instructions.

536.2 Special Billing Instructions for Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines.--Part B of Medicare pays 100 percent for pneumococcal pneumonia vaccines (PPV) and influenza virus vaccines and their administration. Payment is made on a cost basis. Deductible and coinsurance do not apply. Part B of Medicare also covers the hepatitis B vaccine and its administration. Deductible and coinsurance apply.

A. Coverage Requirements.--Effective for services furnished on or after July 1, 2000, Medicare does not require for coverage purposes, that the PPV vaccine and its administration be ordered by a doctor of medicine or osteopathy. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

Effective for services furnished on or after September 1, 1984, hepatitis B vaccine and its administration are covered if ordered by a doctor of medicine or osteopathy and are available to Medicare beneficiaries who are at high or intermediate risk of contracting hepatitis B.

Effective for services furnished on or after May 1, 1993, influenza virus vaccine and its administration are covered when furnished in compliance with any applicable State law. Typically, this vaccine is administered once a year in the fall or winter. Medicare does not require for coverage purposes that the vaccine must be ordered by a doctor of medicine or osteopathy. Therefore, the beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

B. General Billing Requirements.--Follow the general billing instructions in §560. You must file your claim on a Form HCFA-1450, using bill types 22x and 23x. For these bills, you must complete Item 44 (HCPCS) on the Form HCFA-1450. (See §560.) Bill for the vaccines and their administration on the same claim. There is no requirement for a separate bill for the vaccines and their administration.

C. HCPCS Coding.--Bill for the vaccines using the following HCPCS codes listed below:

90657 Influenza virus vaccine, split virus, 6-35 months dosage, for intramuscular or jet injection use;
90658 Influenza virus vaccine, split virus, 3 years and above dosage, for intramuscular or jet injection use;
90659 Influenza virus vaccine, whole virus, for intramuscular or jet injection use;
90732 Pneumococcal polysaccharide vaccine, 23-valent, adult dosage, for subcutaneous or intramuscular use;
90744 Hepatitis B vaccine, pediatric or pediatric/adolescent dosage, for intramuscular use;
90745 Hepatitis B vaccine, adolescent/high risk infant dosage, for intramuscular use;
90746 Hepatitis B vaccine, adult dosage, for intramuscular use;
90747 Hepatitis B vaccine, dialysis or immunosuppressed patient dosage, for intramuscular use;
90748 Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use.

These codes are for reporting of the vaccines only. Bill for the administration of the vaccines using HCPCS code G0008 for the influenza virus vaccine, G0009 for the PPV vaccine, and G0010 for the hepatitis B vaccine.

D. Applicable Revenue Codes.--Bill for the vaccines using revenue code 636. Bill for the administration of the vaccines using revenue code 771.

E. Other Coding Requirements.--You must report a diagnosis code for each vaccine if the sole purpose for the visit is to receive a vaccine or if a vaccine is the only service billed on a claim. Report code V04.8 for the influenza virus vaccine, code V03.82 for PPV, and code V05.3 for the hepatitis B vaccine. In addition, for the influenza virus vaccine, report UPIN code SLF000 if the vaccine is not ordered by a doctor of medicine or osteopathy.

F. Simplified Billing of Influenza Virus Vaccine by Mass Immunizers.--Some potential "mass immunizers" have expressed concern about the complexity of billing for the influenza virus vaccine and its administration. Consequently, to increase the number of beneficiaries who obtain needed preventive immunizations, simplified (roster) billing procedures are available to mass immunizers. A mass immunizer is defined as any entity that gives the influenza virus vaccine to a group of beneficiaries, e.g., at Public Health Clinics, shopping malls, grocery stores, senior citizen homes, and health fairs. To qualify for roster billing, immunizations of at least five beneficiaries on the same date is required.

The simplified process involves use of the Form HCFA-1450 with preprinted standardized information relative to you and the benefit. When conducting mass immunizations, attach a standard roster to a single pre-printed Form HCFA-1450 that contains the variable claims information regarding the service provider and individual beneficiaries. The roster must contain, at a minimum, the following information:

- Provider name and number;
- Date of service;
- Patient name and address;
- Patient date of birth;
- Patient sex;
- Patient health insurance claim number; and
- Beneficiary signature or stamped "signature on file".

**NOTE:** A stamped "signature on file" can be used in place of the beneficiary's actual signature provided you have a signed authorization on file to bill Medicare for services rendered. In this situation, you are not required to obtain the patient signature on the roster. However, you have the option of reporting "signature on file" in lieu of obtaining the patient's actual signature.

The modified Form HCFA-1450 shows the following preprinted information in specific FLs:

- The words "See Attached Roster" in FL 12, (Patient Name);
- Patient Status code 01 in FL 22 (Patient Status);
- Condition code M1 in FLs 24-30 (Condition Code) (See NOTE: below);
- Condition code A6 in FLs 24-30 (Condition Code);
- Revenue code 636 in FL 42 (Revenue Code), along with the appropriate HCPCS code in FL 44 (HCPCS Code);
- Revenue code 771 in FL 42 (Revenue Code), along with HCPCS code G0008 FL 44 (HCPCS Code);
- "Medicare" on line A of FL 50 (Payer);
- The words "See Attached Roster" on line A of FL 51 (Provider Number);
- UPIN SLF000 in FL 82; and
- Diagnosis code V04.8 in FL 67 (Principal Diagnosis Code).

When conducting mass immunizations, you are required to complete the following FLs on the preprinted Form HCFA-1450:

- FL 4 (Type of Bill);
- FL 47 (Total Charges);
- FL 85 (Provider Representative); and
- FL 86 (Date).

**NOTE:** Medicare Secondary Payer (MSP) utilization editing is by-passed in CWF for all mass immunizer roster bills. However, if the provider knows that a particular group health plan covers the influenza virus vaccine and all other MSP requirements for the Medicare beneficiary are met, the primary payer must be billed.

If you do not mass immunize, continue to bill for the influenza virus vaccine using normal billing procedures; i.e., submission of a Form HCFA-1450 or electronic billing for each beneficiary.

G. Simplified Billing of Pneumococcal Pneumonia Vaccine (PPV) by Mass Immunizers.--The simplified (roster) claims filing procedure has been expanded for PPV. A mass immunizer is defined as any entity that gives the PPV to a group of beneficiaries, e.g., at Public Health Clinics, shopping malls, grocery stores, senior citizen homes, and health fairs. To qualify for roster billing, immunizations of at least five beneficiaries on the same date is required. The simplified process involves use of the HCFA-1450 with preprinted standardized information relative to the provider and the benefit. Mass immunizers attach a standard roster to a single pre-printed Form HCFA-1450 which will contain the variable claims information regarding the service provider and individual beneficiaries.

The roster must contain, at a minimum, the following information:

- Provider name and number;
- Date of service;
- Patient name and address;
- Patient date of birth;
- Patient sex;
- Patient health insurance claim number; and
- Beneficiary signature or stamped "signature on file".

**NOTE:** A stamped "signature on file" can be used in place of the beneficiary's actual signature provided you have a signed authorization on file to bill Medicare for services rendered. In this situation, you are not required to obtain the patient signature on the roster. However, you have the option of reporting "signature on file" in lieu of obtaining the patient's actual signature.

The roster should contain the following language to be used by you as a precaution to alert beneficiaries prior to administering the PPV.

**WARNING:** The beneficiary's vaccination status must be verified before administering the PPV. It is acceptable to rely on the patient's memory to determine prior vaccination status. If the patient is uncertain whether they have been vaccinated within the past 5 years, administer the vaccine. If patients are certain that they have been vaccinated within the past 5 years, do not revaccinate.

The modified Form HCFA-1450 shows the following preprinted information in the specific form locators (FLs):

- The words "See Attached Roster" in FL 12, (Patient Name);
- Patient Status code 01 in FL 22 (Patient Status);
- Condition code M1 in FLs 24-30 (Condition Code);
- Condition code A6 in FLs 24-30 (Condition Code);
- Revenue code 636 in FL 42 (Revenue Code), along with HCPCS code 90732 in FL 44 (HCPCS Code);
- Revenue code 771 in FL 42 (Revenue Code), along with HCPCS code G0009 in FL 44 (HCPCS Code);
- "Medicare" on line A of FL 50 (Payer);
- The words "See Attached Roster" on line A of FL 51 (Provider Number); and
- Diagnosis code V03.82 in FL 67 (Principal Diagnosis Code).

When conducting mass immunizations, you are required to complete the following FLs on the preprinted Form HCFA-1450:

- FL 4 (Type of Bill);
- FL 47 (Total Charges);
- FL 85 (Provider Representative); and
- FL 86 (Date).

**NOTE:** Medicare Secondary Payer (MSP) utilization editing is by-passed in CWF for all mass immunizer roster bills. However, if you know that a particular group health plan covers the PPV and all other MSP requirements for the Medicare beneficiary are met, the primary payer must be billed.

If you do not mass immunize, continue to bill for PPV using the normal billing method i.e., submission of a Form HCFA-1450 or electronic billing for each beneficiary.

## 537. BILLING FOR MAMMOGRAPHY SCREENING

### 537.1 Mammography Quality Standards Act (MQSA).--

A. Background.--The MQSA requires the Secretary to ensure that all facilities that provide mammography services meet national quality standards. Effective October 1, 1994, all facilities providing screening and diagnostic mammography services (except VA facilities) must have a certificate issued by the FDA to continue to operate. On September 30, 1994, HCFA stopped conducting surveys of screening mammography facilities. The responsibility for collecting certificate fees and surveying mammography facilities (screening and diagnostic) was transferred to FDA, Center for Devices and Radiological Health.

B. General.--Your intermediary will pay diagnostic and screening mammography services for claims submitted by you only if you have been issued a MQSA certificate by the FDA. Your intermediary is responsible for determining that you have a certificate prior to payment. In addition,

it is responsible for ensuring that payment is not made in situations where your certificate has expired, or it has been suspended or revoked or you have been issued a written notification by FDA stating that you must cease conducting mammography examinations because you are not in compliance with certain critical FDA certification requirements.

C. Under Arrangements.--When you obtain mammography services for your patients under arrangements with another facility, you must ensure that the facility performing the services has been issued a MQSA certificate by FDA.

D. Denied Services.--When your intermediary determines the facility that performed the mammography service has not been issued a certificate by FDA or the certificate is suspended or revoked, your claim will be denied utilizing the denial language in §537.2G, related to certified facilities.

537.2 Mammography Screening.--Section 4163 of the Omnibus Budget Reconciliation Act of 1990 added §1834(c) of the Act to provide for Part B coverage of mammography screening for certain women entitled to Medicare for screenings performed on or after January 1, 1991. The term "screening mammography" means a radiologic procedure provided to an asymptomatic woman for the purpose of early detection of breast cancer and includes a physician's interpretation of the results of the procedure. Unlike diagnostic mammographies, there do not need to be signs, symptoms, or history of breast disease in order for the exam to be covered.

There is no requirement that the screening mammography examination be prescribed by a physician for an eligible beneficiary to be covered. A screening mammography may be furnished to a woman at her direct request. Whether or not payment can be made is determined by a woman's age and statutory frequency parameters.

Prior to October 1, 1994, if you perform screening mammographies, you must request and be recommended for certification by the State certification agency and approved by HCFA before payment is made. Effective October 1, 1994, if you perform mammography services (diagnostic and screening), you must be issued a certificate from the Food and Drug Administration (FDA) before payment is made. (See §538 for more detailed instructions.) If you arrange for another entity to perform a screening mammography for one of your patients prior to October 1, 1994, you must assure that the entity is certified to perform the screening, or on or after October 1, 1994, you must assure that the entity has been issued a certificate by FDA. Your intermediary will deny claims when it determines that the entity that performed the screening is not certified. It will utilize denial language in subsection G.

Section 4101 of the Balanced Budget Act (BBA) of 1997 provides for annual screening mammographies for women over 39 and waives the Part B deductible. Coverage applies as follows:

- No payment may be made for a screening mammography performed on a woman under 35 years of age;

- You will be paid for only one screening mammography performed on a woman between her 35th and 40th birthdays (ages 35 thru 39); and

- For a woman over 39, you will be paid for a screening mammography performed after 11 full months have passed following the month in which the last screening mammography was performed.

A. Determining 11 Month Period.--To determine the 11 and 23 month periods, your intermediary starts their count beginning with the month after the month in which a previous screening mammography was performed.

**EXAMPLE:** The beneficiary received a screening mammography in January 1999. Intermediaries start their count beginning with February 1999. The beneficiary is eligible to receive another screening mammography in January 2000 (the month after 11 full months have elapsed).

B. Payment Limitations.--There is no Part B deductible. However, coinsurance is applicable. Following are three categories of billing for mammography services:

- Professional component of mammography services (that is, for the physician's interpretation of the results of the examination);

- Technical component (all other services); and

- Both professional and technical components (global). Bill globally if your staff performed the entire service or you have an arrangement with a physician by which you bill.

When the technical and professional components of the screening mammography are billed separately, the payment limit is adjusted to reflect either the professional or technical component only. That is, the limitation applicable to global billing for screening is allocated between the professional and technical components as set forth by regulations. Below are the limitation amounts applicable each calendar year.

| Calendar Year | Global Payment Limit |
|---|---|
| 1996 | $62.10 |
| 1997 | $63.34 |
| 1998 | $64.73 |
| 1999 | $66.22 |
| 2000 | $67.81 |
| 2001 | $69.23 |

For example, in calendar year 2000, 32 percent of the $67.81 limit, or $21.69, is used in determining payment for the professional component, and 68 percent of the $67.81 limit, or $46.12, is used in determining payment for the technical component.

Payment for the technical component equals 80 percent of the least of the:

- Actual charge for the technical component of the service;

- Amount determined for the technical component of a bilateral diagnostic mammogram (HCPCS code 76091) for the service under the radiology fee schedule in 1991 or for services furnished on or after January 1, 1992, under the Medicare physicians' fee schedule; or

- Technical portion of the screening mammography limit. This is an amount determined by multiplying the screening mammography limit ($60.88 in calendar year 1995, $62.10 for calendar year 1996, $63.34 in calendar year 1997, $64.73 in calendar year 1998, $66.22 in calendar year 1999, $67.81 for calendar year 2000, and $69.23 for calendar year 2001) by 68 percent.

- The amount of payment for the global charge equals 80 percent of the least of:

- The actual charge for the procedure;

- The amount determined with respect to the global procedure under the Medicare Fee Schedule; or

- The limit for the procedure. The amount for 2001 is $69.23 ($67.81 in 2000).

On January 1 of each subsequent year, the overall limit is updated by the percentage increase in the Medicare Economic Index. Bill your intermediary on Form HCFA-1450 for the technical component portion of the screening and/or globally if an agreement exists to do so.

C. Billing Requirements.--Bill the technical component portion of the screening mammography on Form HCFA-1450 under bill type 22x or 23x along with HCPCS code 76092 and modifier 26 (technical component billing only). A separate bill is required. Include on the bill only charges for mammography screening.

Bill global mammography services on Form HCFA-1450 under bill type 22x or 23x using the same HCPCS code (76092) without a modifier. A separate bill is required. Include on the bill only charges for mammography screening.

On every screening claim, with dates of service October 1, 1997 thru December 31, 1997, where the patient is not a high risk individual, enter in FL 67, “Principal Diagnosis Code,” the following code:

- V76.12 "Other screening mammography."

- If the screening is for a high risk individual, enter in FL 67, “Principal Diagnosis Code,” the following code:

- V76.11 “Screening mammogram for high risk patient.”

- In addition, for high risk individuals, report one of the following applicable codes in FL 68, “Principal Diagnoses Codes”:

- V10.3 "Personal history - Malignant neoplasm female breast;"

- V16.3 "Family history - Malignant neoplasm breast;" and

- V15.89 "Other specified personal history representing hazards to health."

The following chart indicates the ICD-9 diagnosis codes to be reported for each high risk category:

| High Risk Category | Appropriate Diagnosis Code |
|---|---|
| A personal history of breast cancer | V10.3 |
| A mother, sister, or daughter who has breast cancer | V16.3 |
| Not given birth prior to age 30 | V15.89 |
| A personal history of biopsy-proven benign breast disease | V15.89 |

On every screening claim with dates of service on or after January 1, 1998, you must enter in FL 67, "Principal Diagnosis Code," the following code:

- V76.12 "Other screening mammography."

**NOTE:** Code ICD-9 diagnosis code for mammography to the applicable fourth or fifth digit. Omit decimal points for data entry purposes. In addition, due to the BBA of 1997, there is no need for you to continue to report the high risk diagnosis code effective January 1, 1998.

D. Actions Required.--Your intermediary will consider the following when determining whether payment may be made:

- Presence of revenue code 0403;
- Presence of HCPCS code 76092;
- Presence of high risk diagnosis code indicator;
- Date of last screening mammography; and
- Age of beneficiary.

E. Determining Payment Amount for Global or Technical Component.-Following are payment calculations for either mammography global billing or technical component billing. Technical component is paid when modifier TC is reported. For services in 2000, your intermediary will pay the lower of:

- Billed charges for HCPCS code 76092 with modifier TC;
- $46.12; or
- The physicians' fee schedule amount for the technical component of HCPCS code 76091.

**EXAMPLE**: $90.00 Facility charges
$75.00 Physicians' fee schedule amount
$46.12 Technical portion screening mammography limit (68% of $67.81)

Payment is 80 percent of the lower of:

$90.00 Hospital charges;
$75.00 Physicians' fee schedule amount for the technical component; or
$46.12 Technical portion screening mammography limit.

To calculate the payment, your intermediary selects the lower of:

$90.00 Charges;
$75.00 Physicians' fee schedule amount for the technical component; or
$46.12 Technical portion of screening mammography limit.

Your intermediary will pay 80 percent of the remainder. This is a final payment to you.

In this case:

$46.12 x 80% = $36.90.

To determine the patient's liability to you, multiply the actual charge by 20 percent. The result plus the unmet deductible is the patient's liability.

In this case:

$90.00 x 20% = $18.00 (coinsurance)

In this example, $18.00 is the coinsurance.

Global payment is made when a modifier is not reported on the claim.

The amount of payment for the global charge equals 80 percent of the least of:

The actual charge for the procedure;

The amount determined with respect to the global procedure under the Medicare Fee Schedule; or

The limit for the procedure. The limiting amount for 2001 is $69.23 ($67.81 in 2000).

F. Special Billing Instructions When a Radiologist Interpretation Results in Additional Films.--Radiologists who interpret screening mammographies are allowed to order and interpret additional films based on the results of the screening mammogram while the beneficiary is still at your facility for the screening exam. Where a radiologist interpretation results in additional films, the mammography is no longer considered a screening exam for application of age and frequency standards or for payment purposes. When this occurs, the claim will be paid as a diagnostic mammography instead of a screening mammography. However, since the original intent for the exam was for screening, for statistical purposes, the claim is considered a screening.

Prepare the claim reflecting the diagnostic revenue code (0401) along with HCPCS code 76090 or 76091 and modifier GH "Diagnostic mammogram converted from screening mammogram on same day". Payment will be made to you on a fee schedule basis. Statistics will be collected based on the presence of modifier GH. A separate claim is not required. Regular billing instructions remain in place for mammographies that do not fit this situation. (See subsection C for appropriate bill types.)

G. Medicare Summary Notice (MSN) and Explanation of Your Medicare Benefits (EOMB) Messages.--If your intermediary has converted to MSN, they should utilize the following MSN messages. If your intermediary has NOT converted to MSN, they should utilize the following EOMB messages.

If the claim is denied because the beneficiary is under 35 years of age, your intermediary states on the EOMB or MSN the following message:

"Screening mammography is not covered for women under 35 years of age."
(MSN message number 18-3, or EOMB message under 18.18)

If the claim is denied for a woman 35-39 because she has previously received this examination, your intermediary states on the EOMB or MSN the following message:

"A screening mammography is covered only once for women age 35-39."
(MSN message number 18-6 or EOMB message number 18.19)

If the claim is denied because the period of time between screenings for the woman based on age has not passed, your intermediary states on the EOMB or MSN the following message:

> "This service is being denied because it has not been 12 months since your last examination of this kind."
> (MSN message number 18-4 or EOMB message number 18.20)

If the claim is denied because the provider that performed the screening is not certified, your intermediary states on the EOMB or MSN the following message:

> "This service cannot be paid when provided in this location/facility."
> (MSN message number 16-2 or EOMB message number 16.4)

In addition to the above denial messages, your intermediary has the option of using the following message on the EOMB or MSN:

> "Screening mammograms are covered annually for women 40 years of age and older."
> (MSN message number 18-12 or EOMB message number 18.21)

If the claim is denied because the provider that performed the screening is not certified, your intermediary states on the EOMB or MSN the following message:

> "This service cannot be paid when provided in this location/facility."
> (MSN message number 16-2 or EOMB message number 16.4)

In addition to the above denial messages, your intermediary has the option of using the following message on the EOMB or MSN:

> "Screening mammograms are covered annually for women 40 years of age and older."
> (MSN message number 18-12 or EOMB message number 18.21)

I. Remittance Advice Messages.--If the claim is denied because the beneficiary is under 35 years of age, your intermediary uses existing ANSI ASC X-12 835 claim adjustment reason code/message 6, "The procedure code is inconsistent with the patient's age" along with line level remark code M37, "Service is not covered when the beneficiary is under age 35." If the claim is denied for a woman 35-39 because she has previously received this examination, your intermediary uses existing ANSI ASC X-12 835 claim adjustment reason code/message 119, "Benefit maximum for this time period has been reached" along with line level remark code M89, "Not covered more than once under age 40."

If the claim is denied for a woman age 40 and above because she has previously received this examination within the past 12 months, your intermediary uses existing ANSI ASC X-12 835 claim adjustment reason code/message 119, "Benefit maximum for this time period has been reached" along with line level remark code M90, "Not covered more than once in a 12-month period."

If the claim is denied because the provider that performed the screening is not certified, your intermediary uses existing ANSI ASC X-12 835 claim adjustment reason code/message B7, "This provider was not certified for this procedure/service on this date of service."

## 539. BILLING FOR PART B AMBULANCE SERVICES

Your intermediary processes claims for Part B ambulance services provided under arrangements between you and an ambulance company or ambulance services furnished directly by you to a beneficiary in a Part B stay.

Furnish the following data when needed by your intermediary. Your intermediary will make arrangements with you about the method and media for submitting the data, i.e., with the claim or upon your intermediary's written request, paper or the electronic record, Addenda A and B, record type 75.

- o A detailed statement of the condition necessitating the ambulance service;
- o Your statement indicating whether or not the patient was admitted as an inpatient. If applicable, show the name and address of the facility;
- o Name and address of certifying physician;
- o Name and address of physician ordering service if other than certifying physician;
- o Point of pickup (identify place and completed address);
- o Destination (identify place and complete address);
- o Number of loaded miles (the number of miles traveled when the beneficiary was in the ambulance);
- o Cost per mile;
- o Mileage charge;
- o Minimum or base charge; and
- o Charge for special items or services. Explain.

A. General.--§4531(a)(1) of the Balanced Budget Act (BBA) of 1997 provides that in determining the reasonable cost of ambulance services furnished by a provider of services, the Secretary shall not recognize the cost per trip in excess of the prior year's reasonable cost per trip updated by an inflation factor equal to the consumer price index for all urban consumers (CPI-U) minus 1 percent, effective with services furnished during Federal Fiscal Year (FFY) 1998 (between October 1, 1997 and September 30, 1998), FFY 1999, and as much of FFY 2000 as precedes January 1, 2000.

The following provides billing instructions for implementing the above provision and is needed to determine the reasonable cost per ambulance trip. You are to bill for Part B ambulance services using the billing method of base rate including supplies, with mileage billed separately as described below.

B. Applicable Type of Bills.--The appropriate type of bills are 22x and 23x. Ambulance is a Part B benefit and cannot be reported on a 21x type of bill.

C. Value Code Reporting.--For claims with dates of service on or after January 1, 2001, you must report on every Part B ambulance claim value code A0 (zero) and the related zip code of the geographic location from which the beneficiary was placed on board the ambulance in FLs 39-41 "Value Codes." The value code is defined as "Zip Code of the location from which the beneficiary is initially placed on board the ambulance." Report the number in dollar portion of the form location

right justified to the left to the dollar/cents delimiter. Providers utilizing the UB-92 flat file use Record Type 41 fields 16-39. On the X-12 institutional claims transactions, show HI*BE:A0:::12345~, 2300 Loop, HI segment.

More than one ambulance trip may be reported on the same claim if the zip code of all points of pickup are the same. However, since billing requirements do not allow for value codes (zip codes) to be line item specific and only one zip code may be reported per claim, you must prepare a separate claim for a beneficiary for each trip if the points of pickup are located in different zip codes.

D. Revenue Code/HCPCS Reporting.--You must report revenue code 054x and one of the following HCFA Common Procedure Coding System (HCPCS) codes in FL 44 "HCPCS/Rates" for each ambulance trip provided during the billing period: A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328 or A0330. In addition, report one of the following mileage HCPCS codes: A0380 or A0390. No other HCPCS codes are acceptable for reporting ambulance services and mileage. For purposes of revenue code reporting, report one of the following codes: 0540, 0542, 0543, 0545, 0546, or 0548. Do not report revenue codes 0541, 0544, and 0547. For claims with dates of service on or after January 1, 2001, you must report revenue code 540 and one of the following HCPCS codes in FL 44 "HCPCS/Rates" for each ambulance trip provided during the billing period: **A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433**, or **A0434**. In addition, report one of the following mileage HCPCS codes: A0380, A0390, **A0435**, or **A0436**.

Since billing requirements do not allow for more than one HCPCS code to be reported for per revenue code line, you must report revenue code 0540 (ambulance) on two separate and consecutive lines to accommodate both the Part B ambulance service and the mileage HCPCS codes for each ambulance trip provided during the billing period. Each loaded (i.e., a patient is onboard) one-way ambulance trip must be reported with a unique pair of revenue code lines on the claim. Unloaded trips and mileage are NOT reported.

However, in the case where the beneficiary was pronounced dead after the ambulance was called but before pickup, the service to the point of pickup is covered. In this situation, report the appropriate HCPCS code of either A0322 (if a basic life support (BLS) vehicle is used) or A0328 (if an advanced life support (ALS) vehicle is used.) Report the mileage HCPCS code A0380 (BLS) or A0390 (ALS) from the point of dispatch to the point of pickup. No further mileage is billed (e.g., the mileage after the ambulance arrives at the point of pickup is neither billed nor covered.) (See §262.3.H for a more detailed explanation.)

E. Modifier Reporting.--You must report an origin and destination modifier for each ambulance trip provided in FL 44 "HCPCS/Rates". Origin and destination modifiers used for ambulance services are created by combining two alpha characters. Each alpha character, with the exception of x, represents an origin code or a destination code. The pair of alpha codes creates one modifier. The first position alpha code equals origin; the second position alpha code equals destination. Origin and destination codes and their descriptions are listed below:

- D: Diagnostic or therapeutic site other than "P" or "H" when these are used as origin codes;

- o E: Residential, Domiciliary, Custodial Facility (other than an 1819 facility);
- o H: Hospital;
- o I: Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport;
- o J: Non-hospital based dialysis facility;
- o N: Skilled Nursing Facility (SNF) (1819 facility);
- o P: Physician's office (Includes HMO non-hospital facility, clinic, etc.);
- o R: Residence;
- o S: Scene of accident or acute event; or
- o X: (Destination Code Only) intermediate stop at physician's office enroute to the hospital. (Includes HMO non-hospital facility, clinic, etc.)

In addition, you must report one of the following modifiers with every HCPCS code to describe whether the service was provided under arrangement or directly:

- o QM: Ambulance service provided under arrangement by a provider of services; or
- o QN: Ambulance service furnished directly by a provider of services.

F. Line-Item Dates of Service Reporting.--You are required to report line-item dates of service per revenue code line. This means that you must report two separate revenue code lines for every ambulance trip provided during the billing period along with the date of each trip. This includes situations in which more than one ambulance service is provided to the same beneficiary on the same day. Line-item dates of service are reported on the hard copy UB-92 in FL 45 "Service Date" (MMDDYY), and on RT 61, field 13, "Date of Service" (YYYYMMDD) on the UB-92 flat file. (See examples below.) (For an exception to the rule for loaded miles see §262.3.H.)

G. Service Units Reporting.--For line items reflecting HCPCS codes A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328 or A0330, you are required to report in FL 46 "Service Units" each ambulance trip provided during the billing period. Therefore, the service units for each occurrence of these HCPCS codes are always equal to one. In addition, for line items reflecting HCPCS code A0380 or A0390, you must also report the number of loaded miles. (See examples below.) For claims with dates of service on or after January 1, 2001, line items reflecting HCPCS codes **A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433**, or **A0434,** you are required to report in FL 46 "Service Units" for each ambulance trip provided. Therefore, the service units for each occurrence of these HCPCS codes are always equal to one. In addition, for line items reflecting HCPCS code A0380, A0390, **A0435, or A0436**, report the number of loaded miles.

H. Total Charges Reporting.--For line items reflecting HCPCS codes A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328 or A0330, you are required to report in FL 47 "Total Charges" the actual charge for the ambulance service including all supplies used for the ambulance trip but excluding the charge for mileage. For line items reflecting HCPCS codes A0380 or A0390, report the actual charge for mileage. For claims with dates of service on or after January 1, 2001, line items reflecting HCPCS codes **A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433**, or **A043**4 you are required to report in FL 47 "Total Charges" the actual charge for the ambulance service including all supplies used for the ambulance trip but excluding the charge for mileage. For line items reflecting HCPCS codes A0380, A0390, **A0435**, or **A0436**, report the actual charge for mileage.

**NOTE:** There are cases where you do not incur any cost for mileage (e.g., you receive a subsidy from a local municipality or the transport vehicle is owned and operated by a governmental or volunteer entity.) In these situations, report the ambulance trip in accordance with subsections C through G above. In addition, for purposes of reporting mileage, report on a separate line item the appropriate HCPCS code, modifiers, and units. For the related charges, report $1.00 in FL 48 "Non-covered Charges." Prior to submitting the claim to CWF, your intermediary will remove the entire revenue code line containing the mileage amount reported in FL 48 "Non-covered Charges" to avoid nonacceptance of the claim.

**EXAMPLES:** The following provides examples of how bills for Part B ambulance services should be completed based on the reporting requirements above. These examples reflect ambulance services furnished directly by you. Ambulance services provided under arrangement between you and an ambulance company are reported in the same manner except you report a QM modifier instead of a QN modifier. The following examples are for claims submitted with dates of service on or after January 1, 2001.

Example 1 - Claim containing only one ambulance trip.

For the UB-92 Flat File, report as follows:

| Record Type | Revenue Code | HCPCS | Modifier #1 | Modifier #2 | Date of Service | Units | Total Charges |
|---|---|---|---|---|---|---|---|
| 61 | 0540 | A0428 | RH | QN | 082797 | 1 (trip) | 100.00 |
| 61 | 0540 | A0380 | RH | QN | 082797 | 4 (mileage) | 8.00 |

For the hard copy UB-92 (HCFA-1450), report as follows:

| FL 42 | FL 44 | FL 45 | FL 46 | FL 47 |
|---|---|---|---|---|
| 0540 | A0428RHQN | 082797 | 1 (trip) | 100.00 |
| 0540 | A0380RHQN | 082797 | 4 (mileage) | 8.00 |

Example 2 - Claim containing multiple ambulance trips.

For the UB-92 Flat File, report as follows:

| Record Type | Revenue Code | HCPCS | Modifier #1 | Modifier #2 | Date of Service | Units | Total Charges |
|---|---|---|---|---|---|---|---|
| 61 | 0540 | A0429 | RH | QN | 082897 | 1 (trip) | 100.00 |
| 61 | 0540 | A0380 | RH | QN | 082897 | 2 (mileage) | 4.00 |
| 61 | 0540 | A0330 | RH | QN | 082997 | 1 (trip) | 400.00 |
| 61 | 0540 | A0390 | RH | QN | 082997 | 3 (mileage) | 6.00 |
| 61 | 0540 | A0426 | RH | QN | 083097 | 1 (trip) | 500.00 |
| 61 | 0540 | A0390 | RH | QN | 083097 | 5 (mileage) | 10.00 |
| 61 | 0540 | A0390 | RH | QN | 082997 | 3 (mileage) | 6.00 |
| 61 | 0540 | A0426 | RH | QN | 083097 | 1 (trip) | 500.00 |
| 61 | 0540 | A0390 | RH | QN | 083097 | 5 (mileage) | 10.00 |

For the hard copy UB-92 (Form HCFA-1450), report as follows:

| FL 42 | FL 44 | | | FL 45 | FL 46 | FL 47 |
|---|---|---|---|---|---|---|
| 0540 | A0429 | RH | QN | 082897 | 1 (trip) | 100.00 |
| 0540 | A0380 | RH | QN | 082897 | 2 (mileage) | 4.00 |
| 0540 | A0330 | RH | QN | 082997 | 1 (trip) | 400.00 |

Example 3 - Claim containing more than one ambulance trip provided on the same day.

For the UB-92 Flat File, report as follows:

| Record Type | Revenue Code | HCPCS | Modifier #1 | #2 | Date of Service | Units | Total Charges |
|---|---|---|---|---|---|---|---|
| 61 | 0540 | A0429 | RH | QN | 090297 | 1 (trip) | 100.00 |
| 61 | 0540 | A0380 | RH | QN | 090297 | 2 (mileage) | 4.00 |
| 61 | 0540 | A0429 | HR | QN | 090297 | 1 (trip) | 100.00 |
| 61 | 0540 | A0380 | HR | QN | 090297 | 2 (mileage) | 4.00 |

For the hard copy UB-92 (HCFA-1450), report as follows:

| FL 42 | FL 44 | | | FL 45 | FL 46 | FL 47 |
|---|---|---|---|---|---|---|
| 0540 | A0429 | RH | QN | 090297 | 1 (trip) | 100.00 |
| 0540 | A0380 | RH | QN | 090297 | 2 (mileage) | 4.00 |
| 0540 | A0429 | HR | QN | 090297 | 1 (trip) | 100.00 |
| 0540 | A0380 | HR | QN | 090297 | 2 (mileage) | 4.00 |

H. Edits.--Your intermediary will edit to assure proper reporting as follows:

- Each pair of revenue codes 0540 must have one of the following ambulance trip HCPCS codes A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328 or A0330 and one of the following mileage HCPCS codes A0380 or A0390;

- For claims with dates of service on or after January 1, 2001, each pair of revenue codes 0540 must have one of the following ambulance HCPCS codes **A0426, A0427, A0428**, **A0429, A0430, A0431, A0432, A0433** or **A0434** and one of the following mileage HCPCS codes: A0380, A0390, **A0435**, or **A0436**;

- The presence of an origin and destination modifier and a QM or QN modifier for every line item containing revenue code 0540;

- For claims with dates of service on or after January 1, 2001, the presence of an origin and destination modifier and a QM or QN modifier for every line item containing revenue code 0540;

- The units field is completed for every line item containing revenue code 0540;

- For claims with dates of service on or after January 1, 2001, the units field is completed for every line item containing revenue code 0540;

- Service units for line items containing HCPCS codes A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328 and A0330 always equal “1”

- For claims with dates of service on or after January 1, 2001, service units for line items containing HCPCS codes **A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433** or **A0434** always equal "1"; and

- For claims with dates of service on or after July 1, 2001, each one-way ambulance trip, line-item dates of service for the ambulance service and corresponding mileage are equal.

## 541. BILLING FOR LABORATORY TESTS

A. General.--Section 1833(h)(5) of the Act (as enacted by The Deficit Reduction Act of 1984, P.L. 98-369) requires the establishment of a fee schedule for clinical diagnostic laboratory tests paid under Part B.

Laboratory tests performed for your Medicare inpatients covered under Part A are included in the PPS SNF payment. Laboratory services rendered to inpatients not covered under Part A (inpatient Part B services) and outpatients are billed by the SNF or the rendering provider. Part B clinical diagnostic lab services are paid based on the clinical diagnostic lab fee schedule. Pathologists services are considered physician's services and may be billed to the carrier by the physician. You may obtain pathologists services under arrangements and bill your intermediary. They are paid based on the physician fee schedule.

Record charges for patients occupying beds in non-Medicare certified areas as non Medicare charges for the purpose of apportioning the SNF's laboratory costs. Bill as 22x type of bill. Payment is based on the lab fee schedule.

Bill lab tests on Form HCFA-1450 (UB-92). Report the HCPCS code for the lab in the HCPCS field, the number of times the specific test was done in units, and the date in the date of service fields.

One of the diagnoses in the diagnoses fields should reflect a diagnosis for which the lab service applies.

Use bill type 22x for lab services to Part B residents and 23x for non residents.

Neither deductible nor coinsurance applies to lab fee schedule payments.

B. Specimen Collection Fee.--The SNF may be paid separately under Part B for drawing or collecting specimens. Only one collection fee is allowed for each type of specimen (e.g., blood, urine) for each patient encounter, regardless of the number of specimens drawn. When a series of specimens is required to complete a single test (e.g., glucose tolerance test), treat the series as a single encounter. A specimen collection fee is allowed in circumstances such as drawing a blood sample through venipuncture (i.e., inserting into a vein a needle with syringe or vacutainer to draw the specimen) or collecting a urine sample by catheterization.

Special rules apply when such services are furnished to dialysis patients. The specimen collection fee is not separately payable for any patients dialyzed in the facility or for any patients dialyzed at home under payment Method I. Payment for this service is included under the ESRD composite rate (Provider Reimbursement Manual, Part 1 §2711.1B4 ) for separately billable laboratory tests, as well as those included in the composite rate. Fees for taking specimens from home dialysis patients who have elected payment Method II (Provider Reimbursement Manual, Part 1 §§2740ff.) may be paid separately, provided all other criteria for payment are met.

A specimen collection fee is not allowed for blood samples where the cost of collecting the specimen is minimal (such as a throat culture or a routine capillary puncture for clotting or bleeding time). The intermediary will not make payment for routine handling charges where a specimen is referred by one laboratory to another.

A specimen collection fee is allowed when it is medically necessary for a laboratory technician to draw a specimen from either a nursing home or homebound patient. The technician must personally draw the specimen, e.g., venipuncture or urine sample by catheterization. A specimen collection fee is not allowed for the visiting technician where a patient in a facility is not confined to the facility.

Payment may be made to the SNF regardless whether SNF staff or lab staff perform the specimen collection.

Specimen collection performed by nursing home personnel for patients covered under Part A is paid for as part of the facility's payment for its PPS amount, not on the basis of the specimen collection fee.

Use the following HCPCS codes for billing.

G0001 Routine venipuncture for collection of specimen(s).
P9615 Catheterization for collection of specimen(s).

Show the revenue code, HCPCS code, date of service, allowable units and charges on the UB-92.

For all specimen collection codes, payment is the lesser of the charge or $3 per patient.

C. Travel Allowance.--In addition to a specimen collection fee allowed under subsection B, a travel allowance is payable to cover the costs of collecting a specimen from a nursing home or homebound patient.

Per Mile Travel Allowance (P9603) - There is a minimum of 75 cents a mile. The per mile travel allowance is to be used in situations where the average trip to patients' homes is longer than 20 miles round trip, and is to be pro-rated in situations where specimens are drawn or picked up from non-Medicare patients in the same trip. The lab is responsible for providing the SNF with the pro-rate information. The per mile allowance was computed using the Federal mileage rate of 31 cents a mile plus an additional 44 cents a mile to cover the technician's time and travel costs. Contractors have the option of establishing a higher per mile rate in excess of the minimum of 75 cents a mile if local conditions warrant it. The minimum mileage rate will be reviewed and updated in conjunction with the clinical lab fee schedule as needed. At no time will the laboratory be allowed to bill for more miles than are reasonable or for miles not actually traveled by the laboratory technician.

**EXAMPLE 1**: A laboratory technician travels 60 miles round trip from a lab in a city to a remote rural location, and back to the lab to draw a single Medicare patient's blood. The total payment would be $45.00 (60 miles x .75 cents a mile), plus the specimen collection fee of $3.00.

**EXAMPLE 2**: A laboratory technician travels 40 miles from the lab to a Medicare patient's home to draw blood, then travels an additional 10 miles to a non-Medicare patient's home and then travels 30 miles to return to the lab. The total miles traveled would be 80 miles. The claim submitted would be for one half of the miles traveled or $30.00 (40 x .75), plus the specimen collection fee of $3.00.

Flat Rate (P9604) - There is a minimum of $7.50 one way. The flat rate travel allowance is to be used in areas where average trips are less than 20 miles round trip. The flat rate travel fee is to be pro-rated for more than one blood drawn at the same address, and for stops at the homes of Medicare and non-Medicare patients. The pro-ration is done by the laboratory when the claim is submitted based on the number of patients seen on that trip. The specimen collection fee will be paid for each patient encounter.

This rate was based on an assumption that a trip is an average of 15 minutes and up to 10 miles one way. It uses the Federal mileage rate of 31 cents a mile and a laboratory technician's time of $17.66 an hour, including overhead. Contractors have the option of establishing a flat rate in excess of the minimum of $7.50, if local conditions warrant it. The minimum national flat rate will be reviewed and updated in conjunction with the clinical laboratory fee schedule, as necessitated by adjustments in the Federal travel allowance and salaries.

**EXAMPLE 3:** A laboratory technician travels from the laboratory to a single Medicare patient's home and returns to the laboratory without making any other stops. The flat rate would be calculated as follows: 2 x $7.50 for a total trip payment of $15.00, plus the $3.00 specimen collection fee.

**EXAMPLE 4:** A laboratory technician travels from the laboratory to the homes of five patients to draw blood, four of the patients are Medicare patients and one is not. An additional flat rate would be charged to cover the 5 stops and the return trip to the lab (6 x $7.50 =$45.00). Each of the claims submitted would be for $9.00 ($45.00 /5 = $9.00). Since one of the patients is non-Medicare, four claims would be submitted for $9.00 each, plus the $3.00 specimen collection fee.

**EXAMPLE 5** A laboratory technician travels from a laboratory to a nursing home and draws blood from 5 patients and returns to the laboratory. Four of the patients are on Medicare and one is not. The $7.50 flat rate is multiplied by two to cover the return trip to the laboratory (2 x $7.50 = $15.00) and then divided by five (1/5 of $15.00 = $3.00). Since one of the patients is non-Medicare, four claims would be submitted for $3.00 each, plus the $3.00 specimen collection fee.

541.1 Clinical Laboratory Improvement Amendments (CLIA).--

A. Background.--CLIA of 1988 changes clinical laboratories' certification. Effective September 1, 1992, clinical laboratory services are paid only if the entity furnishing the services has been issued a CLIA number. However, laboratories may be paid for a limited number of laboratory services if they have a CLIA certificate of waiver or a certificate for physician-performed microscopy procedures. These laboratories are not subject to routine on-site surveys.

B. Verification Responsibilities.--You are responsible for verifying CLIA certification prior to ordering laboratory services under arrangements. The survey process validates that laboratory services are provided by approved laboratories.

C. CLIA Numbers.--The CLIA number construction is:

- Positions 1 and 2 are the State code (based on the laboratory's physical location at time of registration);
- Position 3 is an alpha letter "D"; and
- Positions 4-10 are a unique number assigned by the CLIA billing system. (No other lab in the country will have this number.)

D. Certificate for Physician-Performed Microscopy Procedures.--Effective January 19, 1993, a laboratory that holds a certificate for physician-performed microscopy procedures may perform only those tests specified as physician-performed microscopy procedures and waived tests, as

described in §541.2 E. below, and no others. The following codes may be used:

| HCPCS Code | Test |
|---|---|
| Q0111 | Wet mounts, including preparations of vaginal, cervical or skin specimens; |
| Q0112 | All potassium hydroxide (KOH) preparations; |
| Q0113 | Pinworm examinations; |
| Q0114 | Fern test; |
| Q0115 | Post-coital direct, qualitative examinations of vaginal or cervical mucous; and |
| 81015 | Urine sediment examinations. |

E. Certificate of Waiver.--Effective September 1, 1992, all laboratory testing sites (except as provided in 42 CFR 493.3(b)) must have either a CLIA certificate of waiver or certificate of registration to legally perform clinical laboratory testing anywhere in the United States. A grace period starting May 1, 1993, and ending on July 31, 1993, has been granted to allow providers time to adapt to the new coding system. Physicians, suppliers, and providers may submit claims for services furnished this grace period with 1992 or 1993 lab codes. Claims for services provided prior to the grace period (prior to May 1, 1993) must reflect 1992 codes even if received after the end of the grace period (after July 1, 1993). Claims with dates of services prior to May 1, 1993, which reflect 1993 codes, are denied. Payment for covered laboratory services furnished on or after September 1, 1992, by laboratories that have a waiver is limited to the following eight procedures:

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

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

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

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

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

541.2 Screening Pap Smears.--Sections 1861(s)(14) and 1861(nn) of the Act, (as enacted by Section 6115 of the Omnibus Budget Reconciliation Act of 1989) provides for coverage of screening pap smears for services provided on or after July 1, 1990. Screening pap smears are diagnostic laboratory tests consisting of a routine exfoliative cytology test (Papanicolaou test) provided for the purpose of early detection of cervical cancer. It includes a collection of the sample of cells and a physician's interpretation of the test.

The screening pap smear examination must be prescribed by a physician for an eligible beneficiary to be covered. Payment will be made under the clinical diagnostic laboratory fee schedule.

A. Completion of Form HCFA-1450.-Use revenue code 311 (laboratory, pathology, cytology) or, if your intermediary agrees, 923 (pap smear). Report the screening pap smear as a diagnostic clinical laboratory service using one of the following HCPCS codes:

o Q0060--Screening Papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision; or

o Q0061--Screening Papanicolaou smear, cervical or vaginal, up to three smears requiring interpretation by physician.

o Report the diagnosis codes in Item 77 (Principal) and 78 (Other). The codes are:

o V72.6 (Laboratory examination) and V76.2 (Special screening for malignant neoplasms, cervix) report these codes when the beneficiary has not had a screening pap smear in the past 3 years; or

o V72.6 (Laboratory examination) and V15.89 (Other specified personal history presenting hazards to health), when reporting a beneficiary who, based upon the physician's recommendation based upon the patient's medical history or other findings, determines that the test needs to be performed more frequently.

o V76.49 to be used to allow a screening pelvic examination for a woman who has had a hysterectomy with total removal of the cervix.

B. Coverage Limitation.--Coverage for screening pap smears is limited to one every 3 years unless the physician has evidence, due to the patient's medical history or other findings, that the patient is at a high risk of developing cervical cancer and the test should be performed more frequently.

**(the next page is 5-25.22)**

## 542. BILLING FOR IMMUNOSUPPRESSIVE DRUGS FURNISHED TO TRANSPLANT PATIENTS

A. Immunosuppressive Drugs Furnished to Transplant Patients.--Part B of Medicare covers the reasonable cost of FDA-approved immunosuppressive drugs. Payment is made for those immunosuppressive drugs that have been specifically labeled as such and approved for marketing by the FDA, as well as those prescription drugs, such as prednisone, that are used in conjunction with immunosuppressive drugs as part of a therapeutic regimen reflected in FDA-approved labeling for immunosuppressive drugs. Therefore, antibiotics, hypertensives, and other drugs that are not directly related to rejection are not covered. Deductible and coinsurance apply.

Until January 1, 1995, immunosuppressive drugs are covered for a period of 1 year following discharge from a hospital for a Medicare covered organ (e.g., kidney or heart) transplant. HCFA interprets the l-year period after the date of the transplant procedure to mean 365 days from the day on which an inpatient is discharged from the hospital. Coverage of immunosuppressive drugs received as a result of a transplant is contingent upon the transplant being covered by Medicare.

Beneficiaries are eligible to receive additional Part B coverage within 18 months after the discharge date for drugs furnished in 1995; within 24 months for drugs furnished in 1996; within 30 months for drugs furnished in 1997; and within 36 months for drugs furnished after 1997. Beginning January 1, 2000, §227 of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 extended coverage to eligible beneficiaries whose coverage for drugs used in immunosuppressive therapy expires during the calendar year to receive an additional 8 months of coverage beyond the current 36 month period. This benefit does not extend to special entitlement ESRD enrollees who lose Medicare coverage 36 months after a transplant. Medicare pays for immunosuppressive drugs which are provided outside the approved benefit period if they are covered under some other provision of the law (e.g., when the drugs are covered as inpatient hospital services or are furnished incident to a physician's service).

During a covered stay, payment for these drugs is included in Medicare's Part A payment to you. If the same patient receives a subsequent transplant operation the immunosuppressive coverage period begins anew (even if the patient is mid-way through the coverage period when the subsequent transplant operation was performed).

The FDA has identified and approved for marketing only the following specifically labeled immunosuppressive drugs:

- Sandimmune (cyclosporine), Sandoz Pharmaceutical (oral or parenteral form);
- Imuran (azathioprine), Burroughs-Wellcome (oral);
- Atgam (antithymocyte/globuline), Upjohn (parenteral);
- Orthoclone (OKT3 (muromonab-CD3), Ortho Pharmaceutical (parenteral);
- Prograf (tacrolimus), Fujisawa USA, Inc.; and
- Cellcept (mycophenolate mofetil), Roche Laboratories.
- Daclizumab (Zenapax)
- Cyclophosphamide (Cytoxan)

- Prednisone
- Prednisolone

In addition to the above listed drugs, prescription drugs used in conjunction with immunosuppressive drugs as part of a therapeutic regimen reflected in FDA-approved labeling for immunosuppressive drugs are also covered. Your intermediary is expected to keep you informed of FDA additions to the list of the immunosuppressive drugs. Prescriptions generally should be non-refillable and limited to a 30 day supply. The 30 day guideline is necessary because dosage frequently diminishes over a period of time, and further, it is not uncommon for the physician to change the prescription. Also, these drugs are expensive and the coinsurance liability on unused drugs could be a financial burden to the beneficiary. Unless there are special circumstances, your intermediary does not consider a supply of drugs in excess of 30 days to be reasonable and necessary and denies payment accordingly.

B. Billing Requirements.--Bill on Form HCFA-1450 or its electronic equivalent with bill type 22x with the following entries:

- Occurrence code 36 and date in FLs 32-35;
- Revenue code 0636 in FL 42;
- HCPCS code of the immunosuppressive drug in FL 44;
- Number of units in FL 46 (the number of units billed must accurately reflect the definition of one unit of service in each code narrative. For example, if fifty 10 mg. Prednisone tablets are dispensed, bill J7506, 100 units (l unit of J7506 = 5 mg); and
- Narrative description in FL 43.

Complete the remaining items in accordance with regular billing instructions.

C. MSN Messages.--If the claim for an immunosuppressive drug is denied because it was not approved by the FDA, your intermediary states on the MSN to the beneficiary:

6.2 "Drugs not specifically classified as effective by the Food and Drug Administration are not covered."

If the claim for an immunosuppressive drug is denied because the benefit period has expired, your intermediary states on the MSN to the beneficiary:

4.2 "This service is covered up to (insert appropriate number) months after transplant and release from the hospital."

If the claim for an immunosuppressive drug is partially denied because of the 30 day limitation, the following message is used:

4.3 "Prescriptions for immunosuppressive drugs are limited to a 30-day supply."

If the claim for an immunosuppressive drug is denied because a transplant was not covered, the following message is used:

6.1 "This drug is covered only when Medicare pays for the transplant."

**(the next page is 5-27)**

## 543. EPOETIN (EPO)

EPO is a biologically engineered protein which stimulates the bone marrow to make new red blood cells. The FDA approved labeling for EPO states that it is indicated in the treatment of anemia induced by the drug zidovudine (commonly called AZT), anemia associated with chronic renal failure, and anemia induced by chemotherapy in patients with non-myeloid malignancies. EPO is covered for these indications when it is furnished incident to a physician's service. Patients with anemia associated with chronic renal failure include all ESRD patients regardless of whether they are on dialysis. Chronic renal failure patients with symptomatic anemia considered for EPO therapy should have a hematocrit less than 30 percent or a hemoglobin less than 10 when therapy is initiated.

In addition to coverage incident to a physician's service, EPO is covered for the treatment of anemia for patients with chronic renal failure who are on dialysis when:

- It is administered in a renal dialysis facility; or
- It is self-administered in the home by any dialysis patient (or patient caregiver) who is determined competent to use the drug and meets the other conditions detailed below.

For patients with chronic renal failure (but not yet on dialysis), Medicare pays for EPO administered in a SNF on the fee schedule. When billing for these services, use revenue codes 0634 (EPO with less than 10,000 units) and 0635 (EPO with 10,000 or greater units).

In addition to revenue codes, you must report either the hemoglobin or hematocrit reading taken before the last administration of epoetin (EPO). Use value code 48 to report the hemoglobin reading or value code 49 for the hematocrit. The value amount associated with hemoglobin is usually reported in three positions with a decimal. Use the right of the delimiter for the third digit. The hematocrit reading is usually reported in two positions (a percentage) to the left of the dollar/cents delimiter. If the reading is provided with a decimal, use the position to the right of the delimiter for the third digit. Also use value code 68 to indicate EPO units administered during the billing period. Report units of EPO administered in the value amount associated with value code 68 in whole units to the left of the dollar/cents delimiter.

**NOTE:** The total amount of EPO injected during the billing period is reported. If there were 2 doses, the sum of the units administered for the 2 doses is reported as the value to the left of the dollar/cents delimiter.

The coinsurance and deductible are based upon the Medicare allowance payable. This service is not included in PPS or consolidated billing and may be billed separately if coverage guidelines are met.

## 544. BILLING FOR ENTERAL AND PARENTERAL NUTRITIONAL THERAPY COVERED AS A PROSTHETIC DEVICE

A. Billing Procedure.--Parenteral and enteral nutritional (PEN) therapies including the necessary equipment, medical supplies and nutrients provided to an inpatient (where Part A payment cannot be made), or to individuals who are not inpatients are covered as a prosthesis under the Part B prosthetic device benefit as long as the requirements in the Coverage Issues Manual, §§65-l0 through 65-10.3 are met, and the required documentation is submitted.

The SNF or the supplier must bill the DMERC. If the SNF bills, it must obtain a supplier number from the National Supplier Clearinghouse and must bill on Form HCFA-1500 or the related NSF or ANSI ASC X-12 837 format.

DMERC jurisdictions, based on the residence of the beneficiary are:

**A - Region A - Healthcare Now**

| | | | |
|---|---|---|---|
| Maine | Vermont | New Hampshire | Massachusetts |
| Rhode Island | Connecticut | New York | New Jersey |
| Pennsylvania | Delaware | | |

**B - Region B - Adminastar Federal**

| | | | |
|---|---|---|---|
| Maryland | Washington, D.C. | Virginia | West Virginia |
| Ohio | Indiana | Illinois | Wisconsin |
| Minnesota | Michigan | | |

**C - Region C - Palmetto Government Benefits Administration**

| | | | |
|---|---|---|---|
| North Carolina | South Carolina | Georgia | Florida |
| Alabama | Mississippi | Kentucky | Arkansas |
| Louisiana | Oklahoma | New Mexico | Colorado |
| Texas | Tennessee | Puerto Rico | Virgin Islands |

**D - Region D - Connecticut General Life Insurance Co. (CIGNA)**

| | | | |
|---|---|---|---|
| Alaska | Arizona | Montana | Hawaii |
| Iowa | Washington | Kansas | California |
| Nebraska | Nevada | South Dakota | Oregon |
| North Dakota | Missouri | Wyoming | Utah |
| Idaho | Guam | Marianna Islands | American Samoa |

B. Preparation of Form HCFA-l500 for Supplies and Equipment Provided for Enteral and Parenteral Nutrition Therapies.--Prepare the Form HCFA-l500 for services to be billed.

- FL 24B-Enter code 31 (SNF), Place of Service.

- FL 24D-Enter all applicable five position HCPCS codes identifying appliances, supplies and solutions. Enter the 2 position modifiers (more than two modifiers may be required) next to the code where necessary. Refer to the most recent HCPCS directory or billing instructions distributed by the DMERC for current HCPCS coding information.

Retention and Destruction of Health Insurance Records

## 556. RETENTION OF HEALTH INSURANCE RECORDS

Maintain the several categories of health insurance materials related to services rendered under title XVIII for the prescribed retention periods outlined below unless State law stipulates a longer period. They should be made available for reference to HCFA, intermediary, DHHS audit or other specially designated components for bill review, audit, and other references during the retention period.

556.1 Categories of Health Insurance Record to Retain.--If these records are microfilmed, see §556.3.

A. Billing Material.--SNF copies of Forms HCFA-1450 and any other billing forms, supporting documents and forms, charge slips, daily patient census records, and other business and accounting records which refer to specific claims.

B. Cost Report Material.--All data necessary to support the accuracy of the entries on the annual cost reports, including original invoices, cancelled checks, SNF copies of material used in preparing annual cost reports and other similar cost reports, schedules and related worksheets), and contracts or records of dealings with outside sources of medical supplies and services or with related organizations.

C. Medical Record Material.--Utilization review committee reports, physicians' certifications and recertifications, discharge summaries, clinical and other medical records relating to health insurance claims.

D. SNF Physician Material.--SNF physician agreements upon which Part A-Part B allocations are based.

556.2 Retention Period.--Retain all materials referred to above for a period of 5 years after the month the cost report to which they apply is filed with the intermediary.

**EXAMPLE:** Billing materials support claims filed during a cost report period ending l0/3l/98. The cost report for the period ending l0/3l/98 was filed with the intermediary on l/l5/99. Retain all billing materials until 2/l/04.

After payment of the bill, you need not retain administrative and billing work records provided that, and only to the extent that, such material does not represent critical detail in support of summaries related to the records outlined in § 545.l. These records include punch cards, adding machine tapes, internal controls, or other similar material not required for record retention.

Retain clinical records as follows:

- o The period of time required by State law;
- o Five years from the date of discharge when there is no requirement in State law; or
- o For a minor, 3 years after a resident reaches legal age under State law.

556.3 Microfilming Records.--You may, at your option, microfilm all health insurance records.

- o Billing material with any attachments that you have furnished your intermediary may be destroyed providing the microfilm accurately reproduces all original documents.
- o Retain copies of all other categories of health insurance records listed in §545.l in their original form. If you microfilm these records, store them in a low cost facility for the retention period.

556.4 Destruction of Records.--When material need no longer be retained for Title XVIII purposes, it may be destroyed unless State law stipulates a longer period of retention.

To insure the confidentiality of the records, we request that they be destroyed by shredding, mutilation or other protective measures. The method of final disposition of the records may provide for their sale as salvage. Report monies received as an adjustment to expense in the cost report for the year sold.

Uniform Billing

## 560. COMPLETION OF FORM HCFA-1450 FOR INPATIENT AND/OR OUTPATIENT BILLING

This form, also known as the UB-92, serves the needs of many payers. Some data elements may not be needed by a particular payer. All items on the Form HCFA-1450 are described, but detailed information is given only for items required for Medicare claims.

This section details only the data elements which are required for Medicare billing. When billing multiple third parties, complete all items required by each payer who is to receive a copy.

Instructions for completion are the same for inpatient and outpatient claims unless otherwise noted.

FL 1. (Untitled) Provider Name, Address, and Telephone Number
Required. The minimum entry is your name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine-digit ZIP codes are acceptable. This information is used in connection with the Medicare provider number (FL 51) to verify provider identity. Phone and/or Fax numbers are desirable.

FL 2. (Untitled)
Not required. This is one of four State use fields which have not been assigned for national use. Use of the field, if any, is assigned by the SUBC and is uniform within a State.

FL 3. Patient Control Number
Required. The patient's control number may be shown if you assign one and need it for association and reference purposes.

FL 4. Type of Bill
Required. This three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is a "frequency" code.

Code Structure (only codes used to bill Medicare are shown).

1st Digit-Type of Facility
1 - Hospital
2 - Skilled Nursing Facility
4 - Religious Non-Medical (Hospital)
5 - Religious Non-Medical (Extended Care)
6 - Intermediate Care
7 - Clinic or Hospital Based Renal Dialysis Facility (requires special information in second digit below)
8 - Special facility or hospital ASC surgery (requires special information in second digit below)
9 - Reserved for National Assignment

2nd Digit-Bill Classification (Except Clinics and Special Facilities)
1 - Inpatient (Part A)
2 - Inpatient Part B (Hospital and SNF residents)
3 - Hospital and SNF Part B services to non-residents

4 - Other - Part B - (not used by SNFs)
7 - Subacute Inpatient (revenue code 019x required)
8 - Swing Bed (may be used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement)
9 - Reserved for National Assignment

| 3rd Digit-Frequency | Definition |
|---|---|
| A - Hospice Admission Notice | Use when the hospice is submitting the Form HCFA-1450 as an Admission Notice. |
| B - Hospice Termination/ Revocation Notice | Use when the hospice is submitting the Form HCFA-1450 as a notice of termination/revocation for a previously posted hospice election. |
| C - Hospice Change of Provider Notice | Use when the Form HCFA-1450 is used as a Notice of Change to the hospice provider. |
| D - Hospice Election Void/ Cancel | Use when the Form HCFA-1450 is used as a Notice of a Void/Cancel of hospice election. |
| E - Hospice Change of Ownership | Use when the Form HCFA-1450 is used as a Notice of Change in Ownership for the hospice. |
| 0 - Nonpayment/zero claims | Use this code when you do not anticipate payment from the payer for the bill, but are informing the payer about a period of nonpayable confinement or termination of care. The "Through" date of this bill (FL 6) is the discharge date for this confinement. Medicare requires "nonpayment" bills only to extend the spell-of-illness in inpatient cases. Other nonpayment bills are not needed and may be returned to you. |
| 1 - Admit Through Discharge Claim | Use this code for a bill encompassing an entire inpatient confinement or course of outpatient treatment for which you expect payment from the payer or which will update deductible for inpatient or Part B claims when Medicare is secondary to an EGHP. |
| 2 - Interim-First Claim | Use this code for the first of an expected series of bills for which utilization is chargeable or which will update inpatient deductible for the same confinement of course of treatment. |
| 3 - Interim-Continuing Claims (Not valid for PPS Bills) | Use this code when a bill for which utilization is chargeable for the same confinement or course of treatment had already been submitted and further bills are expected to be submitted later. |

| Code | Title | Definition |
|---|---|---|
| A2 | Coinsurance Payer A | Enter the amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer. |
| B2 | Coinsurance Payer B | Enter the amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer. |
| C2 | Coinsurance Payer C | Enter the amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer. |
| A3 | Estimated Responsibility Payer A | Enter the amount estimated to be paid by the indicated payer. |
| B3 | Estimated Responsibility Payer B | Enter the amount estimated to be paid by the indicated payer. |
| C3 | Estimated Responsibility Payer C | Enter the amount estimated to be paid by the indicated payer. |
| D3 | Estimated Responsibility Patient | Enter the amount estimated to be paid by the indicated patient. |
| A4 | Covered Self-administrable Drugs - Emergency | The amount included in covered charges for self-administrable drugs administered to the patient in an emergency situation. (**The only covered Medicare charges for an ordinarily non-covered, self-administered drug are for insulin administered to a patient in a diabetic coma.)** |

FL42. Revenue Code
Required. Enter the appropriate revenue codes from the following list to identify specific accommodation and/or ancillary charges. Enter the appropriate numeric revenue code on the adjacent line in FL 42 to explain each charge in FL 47.

Enter revenue code 0001 instead in FL 42. Thus, the adjacent charges entry in FL 47 is the sum of charges billed. This is the same line on which non-covered charges, in FL 48, if any, are summed. Right justify all 3 digits revenue codes to prevent confusion.

To assist in bill review, list revenue codes in ascending numeric sequence and do not repeat on the same bill to the extent possible.

Provide detail level coding for the following revenue code series:

| | |
|---|---|
| 0304 | - renal dialysis/laboratory |
| 033x | - radiology therapeutic |
| 042x | - physical therapy |
| 043x | - occupational therapy |
| 044x | - speech-language pathology |
| 0636 | - drugs requiring detailed coding (HCPCS) |
| 080x | - ESRD services |

000l Total Charge

002x SNF PPS HIPPS Code

Billing code used for skilled nursing facilities on prospective payment system. This code must be reported on Part A PPS claims with revenue code 0022. Report the HIPPS code in the HCPCS /rate field. The first three characters are the RUG code. The last two are the assessment indicator.

| Subcategory | Standard Abbreviations |
|---|---|
| 2 - SNF PPS Payment | PPS/PAY |

003x
to
006x Reserved for National Assignment

007x
to
009x Reserved for State Use

ACCOMMODATION REVENUE CODES (010x – 021x)

010x All Inclusive Rate

Flat fee charge incurred on either a daily basis for services rendered. Charge may cover room and board plus ancillary services or room and board only.

| Subcategory | Standard Abbreviations |
|---|---|
| 0 - All-Inclusive Room and Board Plus Ancillary | ALL INCL R&B/ANC |
| 1 - All-Inclusive Room and Board | ALL INCL R&B |

011x Room & Board - Private (Medical or General)
Routine service charges for single bed rooms.

098x Professional Fees (Cont.)

| Subcategory | Standard Abbreviations |
|---|---|
| 1 - Emergency Room | PRO FEE/ER |
| 2 - Outpatient Services | PRO FEE/OUTPT |
| 3 - Clinic | PRO FEE/CLINIC |
| 4 - Medical Social Services | PRO FEE/SOC SVC |
| 5 - EKG | PRO FEE/EKG |
| 6 - EEG | PRO FEE/EEG |
| 7 - Hospital Visit | PRO FEE/HOS VIS |
| 8 - Consultation | PRO FEE/CONSULT |
| 9 - Private Duty Nurse | FEE/PVT NURSE |

099x Patient Convenience Items

Charges for items that are generally considered by the third party payers to be strictly convenience items and, as such, are not covered.

Rationale: Permits identification of particular services as necessary.

| Subcategory | Standard Abbreviation |
|---|---|
| 0 - General Classification | PT CONVENIENCE |
| 1 - Cafeteria/Guest Tray | CAFETERIA |
| 2 - Private Linen Service | LINEN |
| 3 - Telephone/Telegraph | TELEPHONE |
| 4 - TV/Radio | TV/RADIO |
| 5 - Nonpatient Room Rentals | NONPT ROOM RENT |
| 6 - Late Discharge Charge | LATE DISCHARGE |
| 7 - Admission Kits | ADMIT KITS |
| 8 - Beauty Shop/Barber | BARBER/BEAUTY |
| 9 - Other Patient Convenience Items | PT CONVENCE/OTH |

FL 43. Revenue Description
Not Required. Enter a narrative description or standard abbreviation for each revenue code shown in FL 42 on the adjacent line in FL 43. The information assists clerical bill review. Descriptions or abbreviations correspond to the revenue codes. "Other" code category descriptions are locally defined and individually described on each bill. The investigational device exemption (IDE) or procedure identifies a specific device used only for billing under the specific revenue code 624. The IDE will appear on the paper format of Form HCFA-1450 as follows: **FDA IDE# A123456 (17 spaces)**. The description must be shown in HCPCS codes on Part B claims (Type of Bill 22x or 23x). (Also, see FL 84, Remarks.)

FL 44. HCPCS/Rates
Required. When coding HCPCS for outpatient services (i.e., clinical diagnostic laboratory bills for outpatients, radiology, other diagnostic services, orthotic/prosthetic devices, take home surgical dressings, therapies, other rehabilitation services, preventive services, drugs and SNF Part B inpatient services) enter the HCPCS code describing the procedure here. On inpatient SNF bills, the accommodation rate is shown here. HIPPS codes are also shown in this field for SNF inpatient bills.

Effective April 1, 2001, a line-item date of service is required on all Part B claims.

FL 45. Service Date
Required for SNF outpatient and SNF inpatient Part B. Report line item dates of service for every line where a Part B HCPCS code is required effective April, 2001, including claims where the from and thru dates are equal. Effective April 1, 1995, a line-item date of service is required on all laboratory claims.

FL 46. Units of Service
Required. Enter the number of digits or units of service on the line adjacent to revenue code and description where appropriate on the hard copy Form HCFA-1450 or UB-92, e.g., number of covered days in a particular type of accommodation, pints of blood. For the UB-92 flat file use RT 61, filed 9 to show covered units of service. However, when HCPCS codes are required for Part B services, the units are equal to the number of times the procedure/service being reported was performed. Provide the number of covered days, visits treatments, tests, etc. as applicable for the following:

Accommodation days – 010x-015x, 020x, 021x (days)
Blood pints – 038x (pints)
Emergency room visits – 045x (HCPCS code definition for visit or procedure)
Dialysis treatments – 080x (sessions or days)
Orthotic/prosthetic devices - 0274 (items)
Outpatient therapy visits – 041x, 042x, 043x, 044x, 048x, 091x, and 094x (visits)
Outpatient clinical diagnostic laboratory tests – 030x - 031x (tests)
Radiology - 032x, 034x, 035x, 040x, 061x, and 0333 (HCPCS code definition of tests or services)
RUG-III Rates – 0022 (units must be equal to total accommodation units (010x – 022x) minus 018x units)
Drugs requiring detailed coding (HCPCS) - 0636

Enter up to seven numeric digits. Show charges for noncovered services as noncovered.

FL 47. Total Charges
Required. Sum the total charges for the billing period by revenue code (FL 42) or in the case of Part B services by HCPCS procedure code and enter them on the adjacent line in FL 47. The last revenue code entered in FL 42 "0001" represents the grand total of all charges billed. FL 47 totals on the adjacent line. Each line allows up to nine numeric digits (0000000.00).

HCFA policy is for providers to bill Medicare on the same basis that they bill other payers. This policy provides consistency of bill data with the cost report so that bill data may be used to substantiate the cost report.

Medicare and non-Medicare charges for the same department must be reported consistently on the cost report. This means that the professional component is included on, or excluded from, the cost report for Medicare and non-Medicare charges. Where billing for the professional components is not consistent for all payers, i.e., where some payers require net billing and others require gross, the provider must adjust either net charges up to gross or gross charges down to net for cost report preparation. For outpatient Part B billing, only charges believed to be covered are submitted in FL 47. Non-covered charges are omitted from the bill.

For outpatient Part B billing, only charges believed to be covered are submitted in FL 47. Noncovered charges are omitted from the bill.

## 561. FREQUENCY OF BILLING

Your intermediary will inform you about the frequency with which it can accept billing records and the frequency with which you may bill on individual cases.

In its requirements, your intermediary considers your systems operation, intermediary systems requirements, and Medicare program and administrative requirements.

Inpatient Billing.--SNFs and non-PPS hospitals (i.e., excluded units or hospitals) bill upon discharge or after 30 days (and if necessary, every 30 days thereafter.) You may bill more frequently if you bill electronically. Your intermediary will inform you of the frequency of billing that is acceptable. Each bill must include all diagnoses and procedures applicable to the admission. However, do not include charges that were billed on an earlier bill. The from date must be the day after the through date on the earlier bill. If you receive PIP, you may not submit interim bills.

Outpatient Billing.--Bill repetitive Part B services to a single individual monthly (or at the conclusion of treatment). This avoids Medicare processing costs in holding such bills for monthly review and reduces bill processing costs for relatively small claims. Services are:

| Service | Revenue Code |
|---|---|
| Therapeutic Radiology | 0330 - 0339 |
| Therapeutic Nuclear Medicine | 0342 |
| Respiratory Therapy | 0410 - 0419 |
| Physical Therapy | 0420 - 0429 |
| Occupational Therapy | 0430 - 0439 |
| Speech Pathology | 0440 - 0449 |
| Cardiac Rehabilitation Services | 0943 |
| Psychological Services | 091x |

Where there is an inpatient stay, or outpatient surgery, during a period of repetitive outpatient services, you may submit one bill for the entire month if you use an occurrence span code 74 to encompass the inpatient stay. This permits you to submit a single bill for the month, and simplifies the review of these bills. This is in addition to the bill for the inpatient stay of outpatient surgery.

Other one time Part B services must be billed upon completion of the services.

## 562. GUIDELINES FOR SUBMITTING CORRECTED BILLS

A. General.--When an initial bill has been submitted and you or the intermediary discover an error on the bill, submit an adjustment bill if the change involves one of the following:

- o A change in the inpatient cash or Part B deductible of more than $1;
- o A change in the number of inpatient days;
- o A change in the blood deductible;
- o A change in provider number;
- o A change in coinsurance which involves an amount greater than $1.99;
- o A change in the HIPPS code to correct a data input error or;
- o Effective for changes for services June 1, 2000, change in HIPPS code due to an MDS correction. (Such adjustments are required within 120 days of the through date on the initial bill.)

Where there are money adjustments other than a coinsurance amount greater than $1.99, record the difference on a record sufficiently documented to establish an accounting data trail broken out by patient name and HICN, admission, from and thru dates, difference in charge broken out by the ancillary services for the difference, and any unique numbering or filing code necessary for you to associate the adjustment charge with the original billing.

B. Billing Late Charges.--Late charge billing (type of bill xx5) is not acceptable for SNF Part A services. Late charge (xx5 type of bill) is acceptable to report additional unbilled services for SNF inpatient B residents and SNF outpatients. Should a pattern of an excessive volume of late charge bills be determined through audit, you may be required to adjust your billing schedule and procedures by the intermediary. If a you fail to include a particular item or service on its initial bill, an adjustment request to include such an item or service is not permitted after the expiration of the time limitation for filing a bill. Late charge(s) bills are subject to the same requirements for timely filing as original bills. However, to the extent that an adjustment request otherwise corrects or supplements information previously submitted on a timely bill about specified services or items furnished to a specified individual, it is subject to the rules governing administrative finality, rather than the time limitation for filing.

C. Procedures.--Follow the procedures for bill completion in §560. Complete all items as applicable for the initial bill except:

FL 37 - Internal Control Number (ICN)/Document Control Number (DCN) of the claim to be adjusted is required for adjustments and late charges. This is in Record Type 31, Positions 155 - 177 of the UB-92 flat file format, version 6. The intermediary reports this to you on the remittance record.

For late charge bills use type of bill 225 or 235, as appropriate, and in FL 42 - 48, report only the services not reported on first bill (revenue code, HCPCS code, units, dates of service). For adjustment requests use type of bill 217, 227, or 237, as appropriate, and in FL 42 - 48, report all services applicable including those correctly reported on the first bill. See instructions for FLs 24 - 30 (Condition Codes) for reporting the reason for the adjustment (Claim Change Reasons). This is reported in RT 41 of the UB-92 flat file version 6. Claim Change Reason Codes applicable to SNFs are:

| | | | |
|---|---|---|---|
| D0 | Changes to Service Dates | D6 | Cancel only to repay a duplicate OIG payment |
| D1 | Changes to Charges | D7 | Change to Make Medicare Secondary Payer |
| D2 | Changes in Revenue Codes/HCPCS | D8 | Change to Make Medicare Primary Payer |
| D4 | Changes in Grouper code | D9 | Any Other Change |
| D5 | Cancel to correct HICN or Provide ID | E0 | Change in Patient Status |

Select the one code that best describes the change reason. You may make multiple changes even though only one reason code is reported.

Standard System and CWF Edits and Error Resolution Procedures

## 595. CONSOLIDATED BILLING EDITS AND RESOLUTION - NOT YET IMPLEMENTED

Following is a general description of the proposed Medicare systems edits relating to SNF Part A PPS and Part A consolidated billing.

In general:

- Where a claim is received for services that are considered included in the SNF Part A PPS rate and a SNF PPS paid claim is on record, the claim with the duplicate services will be rejected. In connection with this some claims may be developed instead of rejected.

- Where a SNF PPS claim is received and there is a claim on record that contains services that are considered included in the PPS rate, the PPS claims will be paid and the claim on record will be auto-canceled by CWF.

- Where a claim encounters a claim on record for the same HCPCS code and for the same date the second claim will be rejected or developed.

Your intermediary will furnish processing instructions.

The following remark and reason codes are used on the remittance to identify the situation for the SNF:

Claim level remark code MA101: (A SNF is responsible for payment of outside providers who furnish these services/supplies to its residents.) will be used on the supplier remittance where a supplier bills for services included in the Part A PPS amount.

Claim level remark code MA133: (Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.)

Claim adjustment reason code 97: (Payment is included in the allowance for the basic service/procedure with group code CO.)

Claim adjustment reason code B6: (This service/procedure is denied/reduced when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty) with group code CO.)

Claim level remark code MA67: (Correction to a prior claim.)

The following remark and reason codes are used on the remittance to identify duplicates.

Claim adjustment reason code 18: (Duplicate claim/service.)

Line level remark code M86: (Service denied because payment already made for similar procedure.)