Program Memorandum Intermediaries

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

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CHANGE REQUEST 1323

SUBJECT: FEE SCHEDULE AND CONSOLIDATED BILLING FOR SKILLED NURSING FACILITY (SNF) SERVICES

Part B physical, occupational and speech therapy services remain subject to consolidated billing regulations. Until further notice, consolidated billing will not be implemented for all other services and supplies. SNFs may choose to bill for all other Part B services and supplies, and will be paid in accordance with the provisions of this program memorandum. However, SNFs may elect to have suppliers continue to bill Medicare directly for these Part B services.

I. General

This Program Memorandum (PM) contains instructions about:

- New Common Working File (CWF) edit requirements relating to consolidated billing for SNF Part A services, and related contractor resolution procedures, effective April 1, 2001;
- New CWF edit requirements to detect duplicate Part B claims billed by SNFs and other providers and suppliers, effective April 1, 2001; and
- Intermediary payment to SNFs under a fee schedule for SNF Part B services, effective for services provided April 1, 2001.

It does not change intermediary claims processing requirements in PMs A-00-01, A-00-08, or AB-00-18; except that consolidated billing for Part B services other than therapies is rescinded.

There are no changes in program requirements not identified in this PM, such as SNF demand bills, spell of illness requirements, MSP requirements, and basic coverage rules.

SNF instructions are being issued in SNF Manual §§515-516.6, 529 - 544 and 595.

This instruction does not apply to Medicare beneficiaries enrolled in a Medicare managed care program. SNF Part A PPS and consolidated billing applies only to Medicare fee-for-service beneficiaries. Managed care beneficiaries are identified on CWF with an applicable Plan ID, entitlement and termination periods on the GHOD screen. The Plan ID is a 4 position number preceded with 'H'. Claims received on or after the MCO effective date and prior to the MCO termination date are exempt from these instructions. In addition, Condition code'04' on the UB-92 identifies a risk-based MCO enrollee.

II. Fee Schedule for SNF Part B Services

Section 1888(e)(9) of the Social Security Act as modified by the BBA of 1997 requires that the payment amount for Part B services furnished to SNF Part B inpatients and outpatients (22X and 23X types of bill) 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 (or charge if less than the applicable fee amount) will be paid.

This requirement will be implemented beginning with services provided on and after April 1, 2001.

Fee schedules currently exist for the following services:

- Therapy;
- Lab;
- Radiology and other diagnostic tests;
- Prosthetic and orthotic devices; and
- Surgical dressings.

SNFs will continue to bill on Form UB-92 or the electronic equivalents to intermediaries.

Fee schedules will be a based on either the locality of the provider or statewide (or carrier-wide within the State when multiple carriers exist within the State) depending upon the payment structure of the specific fee schedule**.**

A. Application of Part B Deductible and Coinsurance

Where payment for SNF Part B services (bill type 22X and 23X) is made under a fee schedule any applicable beneficiary deductible and coinsurance are based on the approved amount. This includes situations where fee amounts for specific services are not included in the fee schedule but are determined on an individual basis.

Where payment is made on a reasonable cost basis, deductible and coinsurance continue to be based on SNF charges for the service.

Neither deductible nor coinsurance apply to clinical diagnostic lab services.

Neither deductible nor coinsurance apply to pneumococcal pneumonia vaccine (PPV), influenza virus vaccines or to the administration of either.

Deductible does not apply to screening mammography services.

B. Services Not Covered by SNF Part B Fee Schedule

Fee schedules are not yet developed for the following. All other services on bill types 22X and 23X are to be paid via fee schedule.

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

PEN Codes.--See Medicare Intermediary Manual §3660.6 for Part B coverage. These services, if covered under Part B continue to be billed to the DMERC.

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

Blood Products

P9010 P9011 P9012 P9013 P9016 P9017 P9018 P9019 P9020 P9021 P9022

Transfusion Medicine

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

All Drugs

Drug payment methodology is not changed (reasonable cost for SNFs except where special rules apply).

C. Publication of Fee Schedules

SNF fee schedule prices and related installation instructions will be provided to intermediaries through the Mainframe Telecommunications System in the same manner that other fee schedule information is provided.

Analysis is not yet completed on whether SNF fee schedule data for intermediaries will be included with other data or whether a separate file will be released.

There will be some differences from current fee schedules in that:

- SNFs bill only the technical or facility component for most services, except where they furnish the complete service or obtain the complete service under arrangements;

- Some services cannot be paid to SNFs; and

- Some services for SNF Part A inpatients for which Part A benefits are payable, cannot be paid to anyone else.

Modifiers will be needed to determine the correct payment amount unless the related HCPCS code definition sufficiently describes the physician/facility component.

SNFs may not obtain physician services under arrangements except for services from physician therapists providing physical, occupational or speech language therapy services, which are required under consolidated billing. Services of physician employees of the SNF are not considered arranged for services, and related current Medicare Intermediary Manual (MIM) and SNF Manual provisions about billing for provider based physician services on Form HCFA-1500 continue to apply.

In addition to mainframe telecommunications system data, HCFA will publish a public use file on the Internet in HTML or PDF format for SNF inquiry and/or downloading and use as reference material. Complete details for this file have not been finalized, but it will contain the following data elements.

- Fee schedule year;
- HCPCS code;
- Applicable modifiers;
- Narrative description of the HCPCs code;
- Medicare coverage status (whether or not the item is a Medicare covered service);
- The professional or technical component (PC/TC) indicator for the service; and
- Whether the code is billable by SNFs.

For codes billable by SNFs:

- Whether included or excluded from Part A PPS;
- Bundling requirements for billing if applicable; and
- Whether code for service considered technical (facility), professional or complete procedure.

SNFs will be expected to access this file for basic information about each HCPCS code. The file will not be included in the SNF Manual. Intermediaries may assist SNFs as appropriate. This file may also be used by intermediaries and carriers in resolving inquiries. Additional related instructions will be issued later.

D. Special Payment Rules Relating to Fee Schedules for SNFs

A SNF may provide many services to its inpatients either directly or under arrangement. Part A PPS rate includes all services rendered to a SNF inpatient except excluded services identified in section IV of this PM. Services excluded from the SNF PPS rate may not be billed by the SNF under Part B except preventive and screening services (pneumococcal pneumonia, influenza virus and, hepatitis B vaccines, screening mammography, etc.).

Where Part A PPS payment is not applicable to a resident, payment may be made for certain (MIM §3626.1) services under Part B. The fee schedule payment methodology applies to those services as well as outpatient services.

Following are special payment for services provided directly or under arrangement billed by the SNF for patients with coverage under Part B.

1. Set Up Services in SNFs for Portable X-Ray Equipment

Diagnostic portable x-ray services are covered under Part B when provided in participating SNFs and hospitals, under circumstances in which they cannot be covered under hospital insurance, i.e., the services are not furnished by the participating institution either directly or under arrangements that provide for the institution to bill for the services.

In order to avoid payment for services which are inadequate or hazardous to the patient, the scope of the covered portable x-ray benefit is defined as:

- Skeletal films involving arms and legs, pelvis, vertebral column, and skull;

- Chest films which do not involve the use of contrast media (except routine screening procedures and tests in connection with routine physical examinations); and

- Abdominal films which do not involve the use of contrast media.

Set up costs for portable x-ray equipment in the SNF is billed using HCPCS code Q0092. Set up costs are not applicable for lab or EKG services.

2. Specimen Collection

Specimen collection is allowed for SNF residents in circumstances such as drawing blood through venipuncture or collecting a urine sample by catheter. Applicable HCPCS codes are:

G0001 Routine venipuncture for collection of specimen(s).
P9615 Catheterization for collection of specimen(s).

A separate specimen collection is not paid for throat cultures, routine capillary puncture for clotting or bleeding time, stool specimens.

Costs for related supplies and items such as gloves and slides are also not separately billed.

The current fee amount for specimen collection under the lab fee schedule is paid to the SNF if it draws the blood.

Neither deductible nor coinsurance apply to specimen collection payments.

3. Travel Allowance

Travel allowance may be payable to the SNF in connection with the following services provided under arrangement with a supplier:

- Lab; and
- Radiology.

Current HCFA rules for carriers for determining payment for travel/transportation will be used. These are described immediately below:

Where allocating miles or the flat rate between SNF patients and other supplier patients on a single trip is required, the supplier is expected to make all necessary calculations and bill the SNF only for the part of the travel allowed by Medicare. The SNF must bill only for the part of the travel allowed by Medicare.

a. Travel Allowance to Collect Lab Specimen.--In addition to a specimen collection fee, a travel allowance is payable to the SNF to cover the costs of related travel to the SNF where the lab separately charges the SNF for travel. The allowance covers the estimated travel costs of collecting a specimen and reflects the technician's salary and travel costs. The following HCPCS codes are used for travel allowances:

P9603 -- Travel allowance - one way, in connection with medically necessary laboratory specimen collection drawn from a SNF resident; prorated miles actually traveled (intermediary allowance on per mile basis); or

P9604 -- Travel allowance - one way, in connection with medically necessary laboratory specimen collection drawn from a SNF resident; prorated trip charge (intermediary allowance on flat fee basis).

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 distance from the lab to the SNF is longer than 20 miles round trip. It may be paid to the SNF where the lab bills travel expense to the SNF. Payment is the lower of the SNFs charge or the allowance. Actual miles must be shown on the claim in the units field.

The per mile allowance was computed using the Federal mileage rate of 32.5 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 SNF be paid 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 SNF in a remote rural location, and back to the lab to draw a single Medicare patient's blood. The total reimbursement 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 SNF 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 the distance from the lab to the SNF is less than 20 miles round trip. The flat rate travel fee is to be pro-rated for more than one blood specimen drawn at the same SNF, and for stops at a SNF and another location. The SNF must obtain a proration from the laboratory for submission on the claim based on the number of patients seen on that trip, in order to bill Medicare properly.

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 32.5 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 SNF 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 reimbursement 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 five 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 SNF and draws blood from five 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.

HCFA has no requirement with respect to what the lab may bill the SNF or what the SNF may pay the lab. The requirements relate only to what the intermediary may pay the SNF.

b. Travel Allowance for Radiology .--Pay the SNF for non-lab travel expenses only in connection with furnishing covered portable x-ray services under arrangements for Part B patients.

SNFs report travel related to portable x-rays services with the following codes:

Q0092 Set-up portable x-ray equipment;
R0070 - For transportation of portable x-ray equipment where only one patient seen;
R0075 - For transportation of portable x-ray equipment where more than one patient seen (this code is billed for each patient); and
99082 - Unusual travel.

Intermediaries are now required to install an edit to allow payment for codes Q0092, R0070, and R0075 to SNFs only in connection with HCPCS codes 70000 through 79999.

Pay the SNF separately for unusual travel (CPT code 99082) only when the SNF submits documentation to demonstrate that the travel was very unusual. CPT 99082 is paid on individual consideration only.

4. Questions on Special Payment Rules

Intermediaries should direct any questions about application of these special payment rules to their regional office.

III. UB 92 Bill Types, Frequency of Billing, and Late Charges

When billed by the SNF, Bill type 22x is to be used for all services to Part B residents whether in a certified bed or otherwise, including services obtained from outside suppliers.

When billed by the SNF, Bill type 23x is to be used for all Part B outpatient services furnished to those other than residents. The distinction between 22x and 23x is not related to receipt of skilled care but is determined solely on the basis of being a resident.

The current requirements for monthly billing continue to apply. The SNF is expected to make a reasonable effort to include all services on the bill. However there will be situations in which the SNF receives billing data from suppliers after the billing cut off, just as internal billing data can be received in the SNF system after the cut off.

An adjustment bill is necessary to increase the units for the same HCPCS code on the same day. Adjustment bills remain necessary to delete charges. The adjustment bill must be completed in its entirety.

Services for different HCPCS codes not included on the original bill for the same dates of service may be submitted as a new bill.

Late charge bills remain unacceptable for Part A SNF bills.

There are no other changes in requirements for reporting data elements on the UB-92 (HCFA-1450).

IV. Services Not Included in SNF Part A PPS

Services excluded from SNF PPS that must be billed separately by the rendering provider or supplier are listed below.

A. Providers

Services rendered by the following providers are billed by the rendering provider to the carrier 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;
- Physician assistant services not employed by the SNF, working under a physician's supervision;
- Nurse practitioner and clinical nurse specialist services not employed by the SNF, working in collaboration with a physician;
- Certified mid-wife services;
- Qualified psychologist services, and
- Certified registered nurse anesthetist services.

1. Professional (PC) and Technical Component (TC) Indicators

The PC/TC indicator in the Medicare Physician Fee Schedule (MPFS) will be used in the SNF fee schedule to identify the applicability of technical and/or physician component for the HCPCS codes. The following table describes intermediary processing for the PC/TC indicator when the SNF provides the service or receives the service under arrangement and bills for the service.

In summary, intermediary standard system requirements are to:

- Pay if PC/TC code is 3, 5, 7, or 9.
- Pay if PC/TC 1 and modifier TC is present, otherwise reject.
- Reject if PC/TC indicator is 0, 2, 6 or 8.
- Reject PC/TC code 4 unless the HCPCS code is for a service listed as an exception to Part A PPS in section IV.

PC/TC Indicator	SNF Consolidated Billing/Payment Policy for Intermediaries for MPFS Services
0	Physician Service Code: Codes with a 0 indicator are not considered to have a separately identifiable professional or technical components. They will never be seen with a TC or 26 modifier. Intermediaries reject the service and notify the SNF to request the physician to bill the carrier. Physicians submit these services to the carrier for processing and reimbursement.
1	Diagnostic Tests or Radiology Services: An indicator of 1 signifies a global code that when billed without a modifier includes both the PC and TC. The code can also be submitted using a 26 or TC modifier to bill just the PC or TC of that service (e.g., G0030, G003026 and G0030TC). Intermediaries pay the service when submitted with the TC modifier If a global code is submitted, e.g., G0030 with no modifier, reject the service and notify the SNF to resubmit only the TC. If modifier 26 is submitted, reject the service and notify the SNF that the 26 must be billed by the physician to the carrier.
2	Professional Component Only Codes: Codes with an indicator of 2 signify services that only have a PC. Intermediaries reject these services and notify the SNF that the service must be billed to the carrier.
3	Technical Component Only Codes: Codes with an indicator of 3 signify services that have only a TC. Intermediaries pay these without a modifier.
4	Global Test Only Codes: Codes with an indicator of 4 signify services that include both the PC and TC. The 26 and TC modifiers are not applicable. However, there are associated codes that describe only the technical and professional components of the service. Reject the service and notify the SNF to resubmit the service using the code that represents the TC only.
5	Incident To Codes: These codes are not considered physician services in the SNF setting. These codes are paid by the intermediary.
6	Laboratory Physician Interpretation Codes: These codes are for physician services to interpret lab tests.

PC/TC Indicator	SNF Consolidated Billing/Payment Policy for Intermediaries for MPFS Services
	Intermediaries do not pay for these services. Reject the service and notify the SNF that the services must be billed to the carrier. Considered a billable physician service and may be paid by the carrier.
7	Physician Therapy Services: These services are only billable by the SNF to the intermediary. Intermediaries pay.
8	Physician Interpretation Codes: An indicator of 8 signifies codes that represent the professional component of a clinical lab code for which separate payment may be made. It only applies to codes 88141, 85060, and P3001-26. A TC indicator is not applicable. Intermediaries do not pay for these services. Reject the service and notify the SNF that the services must be billed to the carrier. Carriers reimburse the physician for these codes when submitted.
9	Concept of a Professional/Technical Component Does Not Apply: An indicator of 9 signifies a code that is not considered to be a physician service. Intermediaries pay for these services.

Per §4432(b)(4) of the BBA, when physicians provide services to a beneficiary residing in an SNF, the physician must include the Medicare facility provider number of the SNF on the claims form or electronic record. This provision is being implemented effective April 1, 2001. SNFs must provide physicians with the proper Medicare provider number so that they can file claims with the carrier for professional services.

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.

1. Certain Dialysis-Related Services Including Covered Ambulance Transportation to Obtain the Dialysis Services

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. They are identified by type of bill 72X.

Some dialysis related services for Method 2 beneficiaries are billed by a hospital or ESRD facility. The following revenue codes must be accompanied by the dialysis related diagnosis code 585.

Revenue Codes for Method 2 beneficiaries:

- 825 – Hemodialysis Support Services
- 835 – Peritoneal Dialysis Support Services

- 845 – Continuous Ambulatory Peritoneal Dialysis (CAPD) Support Services
- 855 – Continuous Cycling Peritoneal Dialysis (CCPD) Support Services

Acute outpatient dialysis services are billed by a hospital type of bill 13X. Diagnosis code 585 must be on the bill. Revenue codes they may be billed are listed below:

Revenue Codes:

- 27X – Medical Surgical Supplies
- 30X – Laboratory
- 31X – Laboratory Pathological
- 32X – Radiology – Diagnostic
- 38X – Blood
- 39X – Blood Storage and Processing
- 636 – Drugs Requiring Detailed Coding

- 73X – EKG/ECG (Electrocardiogram)

2. Erythropoietin (EPO) for Certain Dialysis Patients

EPO is identified with the following revenue codes:

- 634 (EPO with less than 10,000 units); and
- 635 (EPO with 10,000 or greater units).

3. Hospice Care Related to a Terminal Condition

Hospice services are excluded from SNF PPS and billed by the hospice to the RHHI using type of bill 81X or 82X.

4. Certain Ambulance Trips

Ambulance trips that convey a beneficiary to the SNF for initial admission or from the SNF following final discharge, are excluded. In addition, reasonable and necessary ambulance trips offsite during the SNF stay (including the return trip to the SNF) are excluded when used for the following purposes:

- Ambulance transportation related to dialysis services;
- Ambulance services that convey a beneficiary to a hospital or CAH to receive any of the following excluded services (See section C below):

  - 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; and
  - Lymphatic and venous procedures.

C. Outpatient Services Furnished in a Medicare-participating Hospital or Critical Access Hospital

1. Cardiac Catheterization Services

Cardiac catheterization services are not included in SNF PPS when furnished in a Medicare participating hospital or critical access hospital. The following HCPCS codes identify the excluded services.

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						

2. Computerized Axial Tomography (CT Scans)

CT scans are not included in SNF PPS when furnished in a Medicare participating hospital or critical access hospital. The following HCPCS codes identify the excluded services.

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

3. Magnetic Resonance Imaging (MRIs)

MRIs are not included in SNF PPS when furnished in a Medicare participating hospital or critical access hospital. The following HCPCS codes identify the excluded services.

70336	70540	70551	70552	70553	71550	71555	72141	72142
72146	72147	72148	72149	72156	72157	72158	72159	72196
72198	73220	73221	73225	73720	73721	73725	74181	74185
75552	75553	75554	75555	75556	76093	76094	76390	76400

4. Radiation Therapy

Radiation therapy is not included in SNF PPS when furnished in a Medicare participating hospital or critical access hospital. The following HCPCS codes identify the excluded services.

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

5. Ambulatory Surgery Involving the Use of a Hospital Operating Room

Most ambulatory surgery services performed in a hospital or CAH operating room are excluded from SNF Part A consolidated billing. This exclusion does not apply to services provided in an ASC.

Generally, ambulatory surgery codes ranging from 10040 through 69979 are excluded from SNF Part A consolidated billing. However, there are some minor procedures that are included under SNF Part A consolidated billing, and must be billed by the SNF. The ambulatory surgery codes that are included under SNF PPS are listed below.

10040	10060	10080	10120	11040	11041	11042	11043	11044
11055	11056	11057	11200	11300	11305	11400	11719	11720
11721	11740	11900	11901	11920	11921	11922	11950	11951
11952	11954	11975	11976	11977	15780	15781	15782	15783
15786	15787	15788	15789	15792	15793	15810	15811	16000
16020	17000	17003	17004	17110	17111	17250	17340	17360
17380	17999	20000	20974	21084	21085	21497	26010	29058
29065	29075	29085	29105	29125	29126	29130	29131	29200
29220	29240	29260	29280	29345	29355	29358	29365	29405
29425	29435	29440	29445	29450	29505	29515	29540	29550
29580	29590	29700	29705	29710	29715	29720	29730	29740
29750	29799	30300	30901	31720	31725	31730	36000	36140
36400	36405	36406	36406	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	95970-95975				

6. Emergency Services

Emergency services are not included in SNF PPS when furnished in a Medicare participating hospital or critical access hospital. They are identified by the hospital or CAH using revenue code 045X.

7. Angiography Services

Angiography services are not included in SNF PPS when furnished in a Medicare participating hospital or critical access hospital. The following codes identify the excluded services.

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		

8. Lymphatic and Venous Procedures

Lymphatic and venous procedures are not included in SNF PPS when furnished in a Medicare participating hospital or critical access hospital. The excluded HCPCS codes appear in the list of excluded angiography codes above, beginning with 75801 and continuing through 75893.

D. Additional Excluded Services Rendered by A Certified Provider

The following services, when provided by <u>any</u> Medicare provider licensed to provide them, are excluded from PPS.

1. Chemotherapy

Chemotherapy services identified by the following HCPCS codes, when provided by any Medicare provider licensed to provide them, are excluded from PPS.

J9000	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	J9170
J9181	J9182	J9185	J9200	J9201	J9206	J9208	J9211	J9230

J9245 J9265 J9266 J9268 J9270 J9280 J9290 J9291 J9293

J9310 J9320 J9340 J9350 J9360 J9370 J9375 J9380 J9390

J9600

2. Chemotherapy Administration

Chemotherapy administration identified by the following HCPCS codes, when provided by any Medicare provider licensed to provide the service, is 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

3. Radioisotope Services

Radioisotope services identified by the following HCPCS codes, when provided by any Medicare provider licensed to provide them, are excluded from PPS.

79030 79035 79100 79200 79300 79400 79420 79440

4. 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-L5340	L6050-L6370
L5500-L5611	L6400-L6880
L5613-L5986	L6920-L7274
L5988	L7362-L7366

E. Transportation Costs of Electrocardiogram Equipment

For services furnished during 1998 only, the transportation costs of electrocardiogram equipment for electrocardiogram test services are excluded from Part A SNF PPS.

F. MCO Beneficiaries

All services provided to risk based MCO beneficiaries are excluded from Part A SNF PPS.

V. Edits for CWF and Contractors

A. General

Effective for services beginning April 1, 2001, for Part A residents, CWF will reject outpatient bills received from intermediaries or carriers where a history record already exists for a SNF inpatient Part A and the outpatient or carrier CWF record includes specified services. At the same time, edits to detect claims for duplicate services will be implemented.

- Services considered included in the SNF Part A PPS rate can not be billed by other providers or suppliers. Such billing would be duplicate billing.

- Duplicate "crossover" edits to assure that Part B payment is not made to both the SNF and a supplier are described in section B below.

Where an inpatient Part A bill is received and an outpatient or Part B history bill exists on CWF for specified services, CWF will process the inpatient SNF bill and send an unsolicited auto-cancel response to the carrier or intermediary for the Part B or outpatient bill. The carrier or intermediary must correct its records to agree with CWF, and must initiate overpayment procedures to retract the incorrect outpatient or Part B payment.

To detect duplicates, HCPCS codes, modifiers and dates of service on inpatient Part B records will be compared to HCPCS codes, modifiers and dates of service on outpatient records and carrier/DMERC records.

Contractor action (carrier, intermediary, or DMERC) on rejects will be to:

- Reject the pending claim where the services fall within dates of service on record and all services on the pending claim are non billable.

- Return to the provider to correct claim data where the incoming claim has both billable and non billable services or where service dates overlap the history.

- If the outpatient, carrier or DMERC Part B claim (that would be rejected if the inpatient bill were received first) is posted before the inpatient claim is received by CWF, the contractor must accept the CWF auto-cancel response, recover the overpayment and update the action taken on their history.

B. Intermediary Resolution of Edits

The following resolution procedures are to be used by intermediaries to complete processing of claims that reject due to Part A PPS and duplicate billing edits. Applicable remittance reason codes and MSN codes are provided for rejected claims. The CWF edit code is shown in the left column**.** Contractors are responsible for determining appropriate notification procedures and any related coding requirements for providers for cases that are developed.

AB Crossover Coverage Edits.--(Error codes are to be assigned when developed by CWF. The number in the left column now corresponds to internal HCFA documentation and will be replaced by the edit number when assigned.)

Error code	EXPLANATION
To Be Assigned (1)	Outpatient Therapy Claim **Within** Inpatient Part A or Inpatient Part B SNF Claim History An outpatient bill type ('12X', '13X', '14X', '23X', '33X', '34X', ‘71X’, ‘73X’, '74X', '75X', ‘76X’, ‘83X’, or ‘85X’) is rejected because the services are physical, occupational, speech therapy or audiologic function tests for an SNF inpatient (‘21X’ or ‘22X’ type of bill). The dates of service are **within** the inpatient stay.

Error code	EXPLANATION
	Purpose: To ensure that therapy services for a SNF inpatient are not separately paid from the SNF bill. The provider is responsible for submitting the charges to and receiving payment from the SNF. The SNF must submit the charges on the inpatient Part A or inpatient Part B SNF claim to the intermediary. Resolution: Reject the claim for the provider and the beneficiary if the Part B or outpatient services are within the inpatient stay. Remittance Codes: Use Claim Adjustment Reason Code 97: Payment is included in the allowance for the basic service/procedure. Use Group Code CO: Contractual Obligation Use Claim Level Remark Code MA101: A SNF is responsible for payment of outside providers who furnish these services/supplies to its residents. MSN Codes: Use Beneficiary MSN Message 21.7 This service should be included on your inpatient bill.
To Be Assigned (2)	Outpatient Therapy Claim **Overlaps** Inpatient Part A or Inpatient Part B SNF History An outpatient claim (type of bill ('12X', '13X', '14X', '23X', '33X', '34X', **‘**71X’, ‘73X’, '74X', '75X', ‘76X**’,** ‘83X’, or ‘85X’**)** is rejected because the services are physical, occupational, speech therapy or audiologic function tests for an inpatient SNF patient. The dates of service **overlap** the inpatient stay (21X or 22X type of bill). The services within or equal to the SNF dates must be billed by the SNF. The outpatient services outside the SNF stay may be billed by the rendering provider. Purpose: To ensure that outpatient therapy services for a SNF patient are not separately paid from the SNF bill. The provider is responsible for submitting the charges to and receiving payment from the SNF. The SNF must submit the charges on the SNF claim. Resolution: Reject or return (develop) the claim to the provider if the dates of service overlap the SNF claim unless those services rendered within the SNF service

dates can be identified. If they can be identified, reject the charges within the SNF service dates and continue processing remaining services outside the SNF service dates.

Remittance Codes:

For Reject, use Claim Adjustment Reason Code 97: Payment is included in the allowance for the basic service/procedure.

Use Group Code CO: Contractual Obligation

To reject only the services within the inpatient service dates: Use Claim Level Remark Code MA101: A SNF is responsible for payment of outside providers who furnish these services/supplies to its residents.

To reject all services: Use Claim Level Remark Code MA 133: Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.

MSN Codes:

Use Beneficiary MSN Message 17.11: This item or service cannot be paid as billed.

To Be Assigned (3)

Outpatient Claim (no therapy) **Within** Inpatient Part A SNF Claim History

An outpatient claim (type of bill is 13X, 22X, 23X, 33X, 71X, 73X, 74X, 75X, 76X, 83X, and 85X) not containing therapy is rejected because the services rendered to a SNF Part A inpatient (21X) are **within** the SNF dates of service. The outpatient services are not excluded from Part A PPS rate and must be billed by the SNF to the intermediary.

Note: '22X' type of bill is allowed when a '210' claim is on history.

Purpose:

To ensure that services for a SNF patient that are not excluded from consolidated billing are not separately paid from the SNF bill. The provider is responsible for submitting the charges to and receiving payment from the SNF. The SNF must submit the charges on the SNF claim to the intermediary.

Resolution:

Reject the claim for the provider and the beneficiary if the Part B outpatient services are within the inpatient stay.

Remittance Codes:

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

Use Group Code CO: Contractual Obligation

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

MSN Codes:

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

To Be Assigned (4)

Outpatient Claim (no therapy) **Overlaps** Inpatient Part A SNF Claim History

An outpatient claim (type of bill is 13X, 22X, 23X, 33X, 71X, 73X, 74X, 75X, 76X, 83X, and 85X) is rejected because the services rendered to a SNF inpatient (21X) **overlap** the SNF dates of service. The outpatient services are not excluded from consolidated billing and must be billed by the SNF.

Note: '22X' type of bill is allowed when a '210' claim is on history.

Purpose:

To ensure that services for a SNF patient that are not excluded from consolidated billing are not separately paid from the SNF bill. The provider is responsible for submitting the charges to and receiving payment from the SNF. The SNF must submit the charges on the SNF claim.

Resolution:

Reject or return (develop) the claim with the provider if the dates of service **overlap** the SNF claim unless those services rendered within the SNF service dates can be identified. If they can be identified, reject the charges within the SNF service dates and continue processing the remaining services outside the SNF service dates.

Remittance Codes:

For reject, use Claim Adjustment Reason Code 97: Payment is included in the allowance for the basic service/procedure.

Use Group Code CO: Contractual Obligation

To reject only the services within the inpatient service dates: Use Claim Level Remark Code MA101: A SNF is responsible for payment of outside providers who furnish these services/supplies to its residents.

To reject all services: Use Claim Level Remark Code 133: Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.

MSN Codes:

Use Beneficiary MSN Message 17.11: This item or service cannot be paid as billed.

To Be Assigned (5)

Inpatient Part A or Inpatient Part B SNF Claim **Within** Outpatient Therapy Claim History

An inpatient Part A or Inpatient Part B SNF claim (21X or 22X type of bill) is received and the dates of service are **within** an outpatient (type of bill is 13X, 23X, 33X, 71X, 73X, 74X, 75X, 76X, 83X, and 85X) therapy claim dates of service on history. The outpatient therapy history claim must be canceled. The services must be billed by the SNF.

Purpose:

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

charges on the SNF inpatient claim.

Resolution:

CWF will accept the inpatient '21X' and '22X' claim and send an unsolicited auto-cancel response to the intermediary for the outpatient therapy. The intermediary will continue processing the inpatient '21X' and '22X' claim.

Cancel the outpatient therapy claim(s) on history.

Remittance Code:

For Cancel/reject of Outpatient Therapy claim, use Claim Adjustment Reason Code 97: Payment is included in the allowance for the basic service/procedure.

Use Group Code CR: Correction

Use Claim Level Remark Code 101: A SNF is responsible for payment of outside providers who furnish these services/supplies to its residents.

MSN Code:

Use Beneficiary MSN code 31.1 This is a correction to a previously processed claim and/or deductible record.

To Be Assigned (6) Inpatient Part A or Inpatient Part B SNF Claim **Overlaps** Outpatient Therapy Claim History

An inpatient Part A or inpatient Part B SNF claim (21X or 22X type of bill) is received and the dates of service **overlap** an outpatient (type of bill is 13X, 23X, 33X, 71X, 73X, 74X, 75X, 76X, 83X, and 85X) therapy claim dates of service on history. The services must be billed by the SNF.

Purpose:

To ensure therapy Part B services for a SNF patient are not separately paid from the SNF bill.

Resolution:

CWF will accept the inpatient '21X' and '22X' claim and send an unsolicited auto-cancel response to the intermediary for the outpatient therapy. The intermediary will continue processing the inpatient '21X' and '22X' claim.

Cancel the outpatient claim(s) on history.

Remittance Codes:

Retract the incorrect payment. Follow the remittance advice correction/ reversal requirements (group code CR). Include Claim Level Remark Code MA 133 (Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.) Offset the incorrect payment against other payments due the provider.

MSN Codes:

Use beneficiary MSN code 31.1 This is a correction to a previously processed claim and/or deductible record.

To Be Assigned (7)

Inpatient Part A SNF Claim **Within** Outpatient (no therapy) Claim History

An inpatient Part A SNF claim (21X) is received and the dates of service are **within** an outpatient (type of bill is 13X, 22X, 23X, 33X, 71X, 73X, 74X, 75X, 76X, 83X, and 85X) claim dates of service on history and the outpatient claim is not for a service excluded from Part A PPS. The services must be billed by the SNF.

Note: '22X' type of bill is allowed on history when the inpatient Part A SNF claim is type of bill '210'.

Purpose:

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

Resolution:

CWF will accept the inpatient '21X' claim and send an unsolicited auto-cancel response to the intermediary for the outpatient claim. The intermediary will continue processing the inpatient '21X' claim.

Cancel the outpatient claim(s) on history.

Remittance Codes:

Retract the incorrect payment.

Follow the remittance advice correction/reversal requirements (group code CR).

Include claim level remark code MA101 (A SNF is responsible for payment of outside providers who furnish these services/supplies to its residents).

MSN Codes:

Use Beneficiary MSN code 31.1 This is a correction to a previously processed claim and/or deductible record.

To Be Assigned (8)

Inpatient Part A SNF Claim **Overlaps** Outpatient (no therapy) Claim History

An inpatient (21X) Part A SNF claim is received and the service dates **overlap** an outpatient (type of bill is 13X, 22X, 23X, 33X, 71X, 73X, 74X, 75X, 76X, 83X, and 85X) claim dates of service on history and the outpatient claim is not for a service excluded from consolidated billing. The services within the inpatient dates of service must be billed by the SNF.

Note: '22X' type of bill is allowed on history when the inpatient Part A SNF claim is type of bill '210'.

Purpose:

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

charges on the SNF inpatient claim.

Resolution:

CWF will accept the inpatient '21X' claim and send an unsolicited auto-cancel response to the intermediary for the outpatient claim. The intermediary will continue processing the inpatient '21X' claim.

Cancel the outpatient claim on history. Advise the provider to bill Medicare for services that are outside the inpatient SNF dates of service. Services within the SNF inpatient stay that are not excluded from consolidated billing should be billed to the SNF and included on the SNF inpatient claim.

Remittance Codes:

Retract the incorrect payment.

Follow the remittance advice correction/reversal requirements (group code CR).

Include Claim Level Remark Code MA 133 (Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay).

MSN Codes:

Use beneficiary MSN code 31.1 This is a correction to a previously processed claim and/or deductible record.

To Be Assigned (9) Inpatient Part A or Inpatient Part B SNF Claim **Within** Carrier Therapy Claim on History

An inpatient Part A or inpatient Part B SNF claim (21X or 22X type of bill) is received and dates of service are **within** a carrier Part B therapy claim dates of service on history. The services must be billed by the SNF.

Purpose:

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

Resolution:

CWF will accept the inpatient '21X' or '22X' claim and send an unsolicited auto-cancel response to the carrier.

The carrier must initiate overpayment procedures and reflect the action taken on the carrier Part B claim(s) on their history.

The intermediary will process the inpatient SNF claim.

Remittance Codes:

No special processing applies for intermediary claims.

MSN Codes:

No special processing applies for intermediary claims.

To Be Assigned (10)

Inpatient Part A or Inpatient Part B SNF Claim **Overlaps** Carrier Therapy Claim on History

An inpatient Part A SNF claim (21X or 22X type of bill) is received and the dates of service **overlap** the dates of service of a carrier Part B therapy claim on history. The services must be billed by the SNF.

Purpose:

To ensure that certain carrier Part B services for a SNF patient are not separately paid from the SNF bill.

Resolution:

CWF will accept the inpatient '21X' or '22X' claim and send an unsolicited auto-cancel response to the carrier.

The carrier must initiate overpayment procedures and reflect the action taken on the carrier Part B claim(s) on history.

The intermediary will process the 21X and 22X claim.

Remittance Codes:

No special processing applies for intermediary claims.

MSN Codes:

No special processing applies for intermediary claims.

To Be Assigned (11)

Inpatient Part A SNF Claim **Within** Carrier (No therapy) Claim History

An inpatient Part A (21X) claim is received and the dates of service are **within** dates of service of a carrier Part B claim on history and the services are not excluded from SNF Part A PPS. The services must be billed by the SNF.

Purpose:

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

Resolution:

CWF will accept the inpatient '21X' claim and send an unsolicited auto-cancel response to the carrier.

The carrier must initiate overpayment procedures and reflect the action taken on the carrier Part B claim(s) on history.

The intermediary will process the inpatient '21X' claim.

Remittance Codes:

No special processing applies for intermediary claims.

MSN Codes:

No special processing applies for intermediary claims.

To Be Assigned (12) Inpatient Part A SNF Claim **Overlaps** Carrier (no therapy) Claim History

An inpatient Part A SNF claim is received and the dates of service **overlap** the dates of service of a carrier Part B claim on history. The services on the carrier Part B claim are not excluded from SNF Part A PPS. The services must be billed by the SNF.

Purpose:

To ensure that certain carrier Part B services for a SNF patient are not separately paid from the SNF bill.

Resolution:

CWF will accept the inpatient '21X' claim and send an unsolicited auto-cancel response to the carrier.

The carrier must initiate overpayment procedures and reflect the action taken on the carrier Part B claim(s) on history.

The intermediary will process the inpatient claim.

Remittance Codes:

No special processing applies for intermediary claims.

MSN Codes:

No special processing applies for intermediary claims.

Duplicate Edit Resolution (Error codes are to be assigned; the memo reference refers to the PM section describing edit logic.)

Error code	EXPLANATION
To Be Assigned (13)	A SNF outpatient Part B claim (23X) for ambulance services is rejected if a carrier Part B claim is already paid with ambulances services for the same date of service.

Purpose:

To ensure that a SNF outpatient Part B (23X) claim for ambulance service is not paid if a carrier Part B claim for the same ambulance service on the same day is already paid.

Resolution:

Error code	EXPLANATION
	Reject the SNF outpatient claim based on the CWF response. Remittance Codes: Use adjustment reason code 18: Duplicate claim/service. Use line level remark code M86 - Service denied because payment already made for similar procedure. MSN Codes: Beneficiary MSN Message is 7.1: This is a duplicate of a charge already submitted.
To Be Assigned (14)	An outpatient Part B claim (12X, 13X, 14X, 23X, 33X, 71X, 73X, 74X, 75X, 76X, 83X, and 85X) is rejected if a SNF inpatient Part B claim (22X) is already paid with the same HCPCS codes for the same date of service. Purpose: To ensure that SNF services are not paid in duplicate to a SNF, a hospital or other provider. Resolution: Reject the outpatient Part B claim based on the CWF response. Remittance Codes: Use adjustment reason code 18: Duplicate claim/service. Use line level remark code M86 - Service denied because payment already made for similar procedure. MSN Codes: Beneficiary MSN Message is 7.1: This is a duplicate of a charge already submitted.
To Be Assigned (15)	An outpatient Part B claim or inpatient Part B SNF claim (type of bill is 12X, 13X, 14X, 22X, 23X, 33X, 71X, 73X, 74X, 75X, 76X, 83X, and 85X) claim is rejected if a carrier/DMERC Part B claim is already paid with the same HCPCS and modifier codes for the same date of service. Purpose: To ensure that services are not paid in duplicate to a SNF, another provider or a carrier Part B provider. Resolution: Reject the outpatient Part B claim or the inpatient Part B SNF claim based on

	the CWF response. Remittance Codes: Use adjustment reason code 18: Duplicate claim/service. Use line level remark code M86 - Service denied because payment already made for similar procedure. MSN codes: Beneficiary MSN Message is 7.1: This is a duplicate of a charge already submitted.
To Be Assigned (16)	An inpatient Part B SNF (22X) claim is rejected if an outpatient Part B claim 12X, 13X, 14X, 23X, 33X, 71X, 73X, 74X, 75X, 76X, 83X, and 85X) is already paid with the same HCPCS codes for the same date of service. Purpose: To ensure that services are not paid in duplicate to a SNF, or another provider. Resolution: Reject the inpatient Part B SNF claim. Remittance Codes: Use adjustment reason code 18: Duplicate claim/service. Use line level remark code M86 - Service denied because payment already made for similar procedure. MSN Codes: Beneficiary MSN Message is 7.1: This is a duplicate of a charge already submitted.

The *implementation date* of this Program Memorandum (PM) is April 1, 2001.

The *effective date* of this PM is April 1, 2001.

Funding will be made available through the regular budget process for implementation.

This PM should be discarded after January 1, 2002.

Contractors should contact the appropriate regional office with any questions.