

Related Change Request (CR) #: 3910

MLN Matters Number: MM3910

Related CR Release Date: November 1, 2005

Related CR Transmittal #: 740

Effective Date: January 1, 2006

Implementation Date: April 3, 2006

Changes for Medicare's Skilled Nursing Facility (SNF) Consolidated Billing (CB) Edits for Evaluation and Management (E&M) Services Billed by Hospitals to Fiscal Intermediaries (FIs)

Note: This article was updated on February 11, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Hospitals billing affected services to Medicare fiscal intermediaries (FIs)

Provider Action Needed



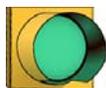
STOP – Impact to You

This article is based on information from Change Request (CR) 3910, which revises the claims processing procedures to follow when a hospital bills for “facility charges” (overhead expenses) in connection with clinic services of hospital-based physicians.



CAUTION – What You Need to Know

Currently, when a hospital bills for these facility charges and the beneficiary involved is a Part A SNF resident, the claim for the facility charge is being rejected by Medicare and the SNF is responsible for the charge. CR3910 changes this, effective January 1, 2006, although the change will not be implemented until April 3, 2006, in Medicare systems.



GO – What You Need to Do

Hospitals, including critical access hospitals (CAHs), billing for these facility charges must bill them on bill types 13x or 85x with revenue code 0510 (clinic visit) when an E & M code in the range of 99201-99245 is

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appropriate. Also, because of Medicare's implementation date of April 3, 2006, hospitals should wait until that date before submitting such charges for dates of service on or after January 1, 2006.

Background

These instructions revise the claims processing procedures to follow when a hospital submits an outpatient claim containing "facility charges" (overhead expenses) in connection with hospital-based physicians. When the beneficiary receiving these clinic services performed by a physician is a Part A resident of a SNF, the associated hospital claim for a facility charge is currently being rejected, due to the SNF CB edits. (SNF CB is the provision that requires the SNF itself to assume the Medicare billing responsibility for all of the services that its Part A residents receive during the course of a covered stay, other than those services, such as physician services, that are specifically excluded from this provision.)

While the physician in this situation would bill his or her own professional services for the clinic visit directly to the Part B carrier, the physician would be reimbursed at the facility rate of the Medicare physician fee schedule, which does not include overhead expenses. The hospital historically has submitted a separate Part B "facility charge" for the associated overhead expense to its fiscal intermediary (FI).

The hospital's facility charge **does not** involve a separate service (such as a diagnostic test) being furnished **in addition to** the physician's clinic service; rather, it represents solely the overhead expense associated with furnishing the clinic service itself.

Accordingly, hospitals bill for facility charges under the physician evaluation and management (E&M) HCPCS codes. As noted above, however, when the beneficiary who receives the physician clinic services is a Part A SNF resident, the associated hospital claim for a facility charge is currently being rejected, and SNFs have been responsible for these charges.

Accordingly, CR3910 revises the existing procedures so that the SNF CB edits will no longer reject such claims. This change in policy is effective January 1, 2006, with an implementation date of April 3, 2006. Hospitals should refrain from submitting their claims, with the clinic visit charges identified below, to the FIs until the Medicare system is updated on April 3, 2006.

Hospital providers, including CAHs, billing for the clinic visits identified above must submit the charges on 13x or 85x bill types. In addition, the CWF will bypass CB edits only when billed with revenue code 0510 (clinic visit) with an E&M HCPCS code in the range of 99201-99245.

Note: Unless otherwise excluded in one of the Five Major Categories for billing services to FIs, physician services codes are billed to the carrier by the physician. Facility charges associated with the physician's clinic visit must be reported as explained above and will be excluded from SNF CB edits.

Implementation

The implementation date for this instruction is April 3, 2006, although the change is effective for services provided on or after January 1, 2006. For affected claims to be processed correctly, hospitals should not submit claims with these services until April 3, 2006.

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Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed by going to <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R740CP.pdf> on the CMS website.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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