CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 76 **Date: FEBRUARY 6, 2004**

CHANGE REQUEST 3133

I. SUMMARY OF CHANGES: In the conversion of the MCM to the IOM, Chapter IV, §4210.7, A-L, was not appropriately included. All action included in this section has been previously implemented and requires no new action on the part of Part B standard systems or Medicare carriers. This is simply a mechanism to include the information in the IOM. The information will be added to Chapter 6, SNF Inpatient Part A billing and Chapter 7, SNF Part B Billing (including Inpatient Part B and Outpatient Fee Schedule).

CLARIFICATION – EFFECTIVE/IMPLEMENTATION DATE: Not Applicable.

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.

II. CHANGES IN MANUAL INSTRUCTIONS: (R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	6/20/Services Included in Part A PPS Payment Not Billable Separately by the SNF
R	6/20.1/Services Beyond the Scope of the Part A SNF Benefit
N	6/110/Carrier Claims Processing for Consolidated Billing for Physician and Non-Physician Practitioner Services Rendered to Beneficiaries in a Part A SNF Stay
N	6/110.1/Correct Place of Service (POS) Code for SNF Claims
N	6/110.2/CWF Edits
N	6/110/2.1/Reject and Unsolicited Response Edits
N	6/110/2.2/Utilization Edits
N	6/110/2.3/Duplicate Edits
N	6/110/2.4/Edit for Ambulance Services
N	6/110/2.5/Edit for Clinical Social Workers (CSWs)
N	6/110.3/CWF Override Codes
N	6/110.4/Coding Files and Updates
N	6/110.4.1/Annual Update Process
R	7/10/C/Beneficiaries in a Part A Covered Stay
N	7/110/ Carrier Claims Processing for Consolidated Billing for Physician and Non-Physician Practitioner Services Rendered to Beneficiaries in a Non-Covered SNF Stay

***III. FUNDING:**

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification

***Medicare contractors only**

Medicare Claims Processing Manual

Chapter 6 - SNF Inpatient Part A Billing

Table of Contents

(Rev. 76, 02-06-04)

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

(Rev. 76, 02-06-04)

For cost reporting periods beginning on and after July 1, 1998, SNF services paid under Part A include posthospital SNF services for which benefits are provided under Part A, and all items and services which, prior to July 1, 1998, had been paid under Part B but furnished to SNF residents during a Part A covered stay regardless of source, except for the exclusions listed in the SNF Help File. View the SNF Help file at http://qa.cms.hhs.gov/manuals/104_claims/clm104c06snfhelp.pdf. This file lists services by HCPCS code and describes their status with respect to whether the service is included in the Part A PPS payment or if the service can be billed separately under Part B. For separately billable services the file also describes whether the SNF is required to bill or whether the rendering provider/supplier must bill. Some services must be billed by the SNF while others must be billed by the rendering provider (SNF or otherwise).

Services paid under Part A cannot be billed under Part B. Any service paid under Part A that is billed separately will not be paid separately, or payment will be recovered if already paid at the time of the SNF billing. The following subsections list the types of services that can be billed under Part B for SNF residents for whom Part A payment is made. See the Help File for related HCPCS codes. *Physicians, non-physician practitioners, and suppliers billing the carrier should consult the CMS Web site at www.cms.hhs.gov/medlearn/snfcode.asp for lists of separately billable services.*

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

(Rev. 76, 02-06-04)

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

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

(Rev. 76, 02-06-04)

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

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

(Rev. 76, 02-06-04)

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

110.2 - CWF Edits

(Rev. 76, 02-06-04)

The following edits have been implemented in CWF.

110.2.1 – Reject and Unsolicited Response Edits

(Rev. 76, 02-06-04)

A. Reject Edits

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

Based on the CWF line item rejects, carriers must deny assigned and unassigned services they have been billed that should have been consolidated and paid by the SNF and/or billed to the FI. Appeals rights must be offered on all denials. Standard systems must

develop, and along with carriers must implement, an automated resolution process whereby when they receive a reject from CWF, they must pay those services correctly billed and only deny those services on the claim incorrectly billed to them.

B. Unsolicited Response Edits

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

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

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

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

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

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

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

Remittance Advice

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

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

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

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

Medicare Summary Notice (MSN)

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

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

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

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

110.2.2 - Utilization Edits

(Rev. 76, 02-06-04)

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

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

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

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

Bypass the edit in the following situations:

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

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

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

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

Bypass the edit in the following situations:

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

- *The Part B claim contains ambulance codes per the files supplied to CWF in the annual and quarterly updates with modifiers other than N (SNF) in both the origin and destination on the same claim.*

- *The Part B claim is a CANCEL ONLY (Action Code 4) claim.*

- *The Part B claim is denied.*

- *The Part B service has a Payment Process Indicator other than A (allowed).*

- *The Part B claim contains only separately payable services per the files supplied to CWF in the annual and quarterly updates.*

110.2.3 - Duplicate Edits

(Rev. 76, 02-06-04)

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

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

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

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

- *The claim is a CANCEL ONLY (Action Code 4) claim.*

- *The claim is denied.*

- *The incoming claim payment process indicator is other than A (allowed).*

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

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

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

- *The claim is a CANCEL ONLY (Action Code 4) claim.*
- *The claim is denied.*
- *HCPCS code is not present on the intermediary claim.*
- *The carrier Part B claim payment process indicator is other than A (allowed).*
- *For the carrier/DMERC claim only, the Part B claim contains only separately payable services per the files supplied to CWF in the annual and quarterly updates.*

110.2.4 – Edit for Ambulance Services

(Rev. 76, 02-06-04)

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

110.2.5 - Edit for Clinical Social Workers (CSWs)

(Rev. 76, 02-06-04)

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

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

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

RA

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

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

MSN

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

110.3 - CWF Override Codes

(Rev. 76, 02-06-04)

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

110.4 - Coding Files and Updates

(Rev. 76, 02-06-04)

To correspond with the annual and quarterly coding and payment updates, CWF will be provided with files of codes that are not included in consolidated billing and can be paid through the carrier or DMERC. These codes are available to the carriers, providers, and suppliers for informational purposes on the CMS Web site at www.cms.hhs.gov/medlearn/snfcode.asp. Changes in designation of codes from excluded to included (or vice versa) in consolidated billing will be considered corrections to align the codes with policy as opposed to changes in policy. Newly established Healthcare Common Procedure Coding System codes will be added to CWF edits to allow carriers to make appropriate payments.

110.4.1 - Annual Update Process

(Rev. 76, 02-06-04)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Medicare Claims Processing Manual

Chapter 7 - SNF Part B Billing (Including Inpatient Part B and Outpatient Fee Schedule)

Table of Contents

(Rev. 76, 02-06-04)

Crosswalk to Old Manuals

80 - Screening and Preventive Services

- 80.1 - Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines
- 80.2 - Mammography Screening
  - 80.2.1 - Diagnostic and Screening Mammograms Performed With New Technologies
- 80.3 - Screening Pap Smears
- 80.4 - Screening Pelvic Examinations
- 80.5 - Prostate Cancer Screening
- 80.6 - Colorectal Cancer Screening
- 80.7 - Glaucoma Screening

90 - Billing for Laboratory Tests Under Part B - General

- 90.1 - Glucose Monitoring

100 - Epoetin (EPO)

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

10 - Billing for Medical and Other Health Services

(Rev. 76, 02-06-04)

See Business Requirements at http://www.medicaid.com/manuals/pm_trans/R20CP.pdf

SNF-529

PM AB-02-157

There are three situations in which a SNF may submit a claim for Part B services. These are identified in subsections A through C below.

No bill is required when:

- The patient is not enrolled under Part B;
- 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.

A - Beneficiaries in a Part B Inpatient Stay (Part B Residents)

A Part B inpatient stay includes services furnished to inpatients whose benefit days are exhausted, or who are not entitled to have payment made for services under Part A. A more detailed description of services covered for beneficiaries in a Part B stay is founds at §10.1 – Billing for Inpatient Services Paid Under Part B.

B - Outpatient Services

Covered Part B services rendered to beneficiaries who are not inpatients of a SNF are considered SNF outpatient services. They include the services listed in §10.1 below as well as additional services described in the Medicare Benefit Policy Manual, Chapter 8, "Coverage of Extended Care (SNF) Services Under Hospital Insurance," §§80 and Medicare Benefit Policy Manual, Chapter 6, "Hospital Services Covered Under Part B." Detailed instructions for billing are located in §10.2 – Billing for Outpatient SNF Services.

C - Beneficiaries in a Part A Covered Stay

SNFs are required to consolidate billing to their intermediary for their covered Medicare inpatient services. However, certain services rendered to SNF inpatients are excluded from the SNF Prospective Payment System (PPS) reimbursement and are also excluded from consolidated billing by the SNF. Those services must be billed to Part B by the

rendering provider and not by the SNF (except screening and preventive services as described in the next paragraph.) A list of services excluded from consolidated billing is found in the Medicare Claims Processing Manual, Chapter 6, "SNF Inpatient Part A Billing," §§20 – 20.4.

Screening and preventive services are not included in the SNF PPS amount but may be paid separately under Part B for Part A patients who also have Part B coverage. Screening and preventive services are covered only under Part B. Only the SNF may bill for screening and preventive services under Part B for its covered Part A inpatients. Bill type 22X is used for beneficiaries in a covered Part A stay and for beneficiaries that are Part B residents. TOB 23x is used for SNF outpatients or for beneficiaries not in the SNF or DPU. The SNF must provide the service or obtain it under arrangements.

Coverage, billing and payment guidelines are found in the Medicare Claims Processing Manual, Chapter 18, "Preventive and Screening Services;" Chapter 17, "Drugs and Biologicals;" and the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §50.4.4.2.

In addition the SNF Help File provides guidance about these services to intermediaries, carriers, SNFs, and suppliers. The file lists services by HCPCS code and describes their status with respect to whether the service is included in SNF PPS or can be billed separately. For separately billable services the file also describes whether the SNF is required to bill or whether the rendering provider/supplier may or must bill.

There are certain medical and other health services for which payment may not be made to a SNF. Most of these are professional services performed by physicians and other practitioners. These services are always billed to the Medicare Part B Carrier. Others are services that have been determined to require a hospital setting to assure beneficiary safety. FI shared systems receive an annual file listing these non-payable HCPCS in November, and, if necessary, a quarterly update via a one time only notification.

Physicians, non-physician practitioners, and suppliers billing the carrier should consult the CMS Web site at *http://www.cms.hhs.gov/medlearn/snfcode.asp* ***for lists of separately billable services.***

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

(Rev. 76, 02-06-04)

For Medicare beneficiaries in a non-covered stay, only therapy services are subject to consolidated billing. All other covered SNF services must be separately billed to the carrier for payment consideration. Refer to section 110 in Chapter 6, SNF Inpatient Part A Billing for additional information on carrier claims processing. A list of therapy codes that are subject to consolidated billing for beneficiaries in a non-covered SNF stay can be found on the CMS Web site at cms.hhs.gov/medlearn/snfcode.asp.