CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 846

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: FEBRUARY 10, 2006

Change Request 4297

SUBJECT: New Skilled Nursing Facility (SNF) Consolidated Billing (CB) Web site Address

I. SUMMARY OF CHANGES: The purpose of this instruction is to replace the old SNF CB Web address with the new, updated SNF CB Web address into the Medicare Claims Processing Manual.

NEW/REVISED MATERIAL
EFFECTIVE DATE: *December 15, 2005
IMPLEMENTATION DATE: March 13, 2006

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. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / SubSection / Title
R	6/20.1/Services Beyond the Scope of the Part A SNF Benefit
R	6/20.6/SNF CB Annual Update Process for Fiscal Intermediaries (FIs)
R	6/110.2.6/Edit for Therapy Services Separately Payable When Furnished by a Physician
R	6/110.4.1/Annual Update Process
R	7/10/Billing for Medical and Other Health Services
R	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:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 846	Date: February 10, 2006	Change Request 4297

SUBJECT: New Skilled Nursing Facility (SNF) Consolidated Billing (CB) Web site Address

I. GENERAL INFORMATION

A. Background: The purpose of this CR is to place a new SNF CB Web site address into the IOM.

B. Policy: The purpose of this instruction is to place new information into the Medicare Claims Processing Manual.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4297.1	Carriers shall be in compliance with the instruction in Pub. 100-04, Medicare Claims Processing Manual, Chapter 6, Sections 20.1, 110.2.6, 110.4.1, and Chapter 7, Sections 10, and 110.			X						
4297.2	Fiscal Intermediaries shall be in compliance with the instruction in Pub. 100-04, Medicare Claims Processing Manual, Chapter 6, Sections 20.1 and 20.6 and Chapter 7, Section 10.	X								

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4297.3	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X						

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: December 15, 2005 **Implementation Date:** March 13, 2006 **Pre-Implementation Contact(s):** April Billingsley for carrier billing, April.Billingsley@cms.hhs.gov ; Jason Kerr for FI billing, Jason.Kerr@cms.hhs.gov **Post-Implementation Contact(s):** Regional Office	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

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

(Rev. 846, Issued: 02-10-06; Effective: 12-15-05; Implementation: 03-13-06)

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 for services billed to the *Carriers and* FIs are updated as frequently as quarterly on the CMS Web site at*:* *http://www.cms.hhs.gov/SNFConsolidatedBilling/* Physicians, non-physician practitioners, and suppliers billing the carrier should consult *the above link* for lists of separately billable services. ***Note****: There are separate Annual Update files for service billed to Carriers and services billed to FIs posted to the web site mentioned above.*

20.6 - SNF CB Annual Update Process for Fiscal Intermediaries (FIs)

(Rev. 846, Issued: 02-10-06; Effective: 12-15-05; Implementation: 03-13-06)

Barring any delay in the Medicare Physician Fee Schedule, CMS will provide the new Annual Update code file 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 Major Categories I through V to the codes in the current edits. Codes that appear on the new list, but not in the current edit, must be added to the edit.

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.
FIs must continue to respond to rejects and unsolicited responses received from CWF per current methodology. FIs 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. FIs need not search claims history to identify these claims. Prior to January 1 of each year, a new code file will be

posted to the CMS Web site at: *http://www.cms.hhs.gov/SNFConsolidatedBilling/* . Should this date change, FIs 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 file is posted to the CMS Web site, through their Web sites and list serves, FIs must notify providers of the availability of the new file.

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

(Rev. 846, Issued: 02-10-06; Effective: 12-15-05; Implementation: 03-13-06)

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

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

110.4.1 - Annual Update Process

(Rev. 846, Issued: 02-10-06; Effective: 12-15-05; Implementation: 03-13-06)

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 *http://www.cms.hhs.gov/SNFConsolidatedBilling/*. 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.

10 - Billing for Medical and Other Health Services

(Rev. 846, Issued: 02-10-06; Effective: 12-15-05; Implementation: 03-13-06)

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

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.

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, *and providers billing the FI* should consult the CMS Web site at *http://www.cms.hhs.gov/SNFConsolidatedBilling/* 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. 846, Issued: 02-10-06; Effective: 12-15-05; Implementation: 03-13-06)

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 *http://www.cms.hhs.gov/SNFConsolidatedBilling/*.