CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 767

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: DECEMBER 2, 2005

Change Request 4080

SUBJECT: SNF PPS Revisions to IOM 100-4--Manualization

I. SUMMARY OF CHANGES: Clarification is made with respect to the exclusion of certain RHC/FQHC services from Part A PPS Payment and the Consolidated Billing Requirement. Billing requirements for the new RUG categories set forth in the FY 2006 SNF PPS Final Rule, published on August 4, 2005 are revised to include the new groups. A SNF pricer update was issued through CR 3962 including the necessary system changes. Because a single hospital cannot have more than one SNF, the manual has been revised to discuss the billing requirements relating to composite distinct parts. Lastly, since SNF provider agreements are no longer time limited, manual instructions regarding the billing of services after termination of a provider agreement, or after payment is denied for new admissions have been revised to reflect this change.

MANUALIZATION/CLARIFICATION:
EFFECTIVE DATE: N/A
IMPLEMENTATION DATE: N/A

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/SNF Inpatient Part A Billing, Table of Contents
R	6/20.1.1/Physician's Services and Other Professional Services Excluded From Part A PPS Payment and the Consolidated Billing Requirement
R	6/30/Billing SNF PPS Services
R	6/60/Billing Procedures for a Composite SNF or a Change in Provider Number
R	6/70/Billing for Services After Termination of Provider Agreement, or After

	Payment is Denied for New Admission
R	6/70/70.1/General Rules
R	6/70/70.2/Billing for Covered Services
R	6/70/70.3/Part B Billing

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: 767	Date: December 2, 2005	Change Request 4080

SUBJECT: SNF PPS Revisions to IOM 100-4

I. GENERAL INFORMATION

We are updating the manual to include changes due to various legislative and regulatory changes.

A. Background: In the August 4, 2005 final rule CMS established 9 new RUG groups for purposes of payment under the SNF PPS. A SNF pricer update was issued through CR 3962 including the necessary system changes. Effective January 1, 2005, Section 410 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) amended the SNF consolidated billing law to specify that certain RHC/FQHC services are excluded from SNF PPS and the requirement for consolidated billing. On August 4, 2003, at 68 FR 46071, CMS set forth the definition of a distinct part SNF and a composite distinct part. The Omnibus Budget Reconciliation Act of 1981 (OBRA), Pub. L. 97-35, at section 2153, repealed section 1866(a)(1) of the Act, thereby removing the 12-month limit on provider agreements for SNFs participating in the Medicare program. Appropriate revisions have been made to reflect these changes.

B. Policy: N/A

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	
4080.1	Medicare contractors shall ensure that the 9 new RUG groups for payment under SNF PPS have been added to their claims processing system effective for claims with dates of service on or after January 1, 2006, consistent with the instructions set forth in CR 3962.	X								

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4080.2	Medicare contractors shall exclude the services included within the scope of RHC and FQHC services that are described in clause (ii) of section 1888(e)(2)(A) from the SNF consolidated billing provision consistent with the instructions set forth in CR 3575.	X								
4080.3	Contractors shall continue to ensure that upon a merger or consolidation of two or more hospitals into a single hospital each with a distinct part SNF and/or NF, the surviving SNF and/or NF has requested and been approved by the RO to operate as a single composite distinct part (i.e. where the second SNF and/or NF location continues to operate) that is assigned a single provider number, prior to making payment for SNF services rendered to Medicare beneficiaries consistent with the instructions set forth in the Joint Signature Memorandum issued on May 31, 1996.	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	
4080.4	None.									

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*: N/A. **Implementation Date:** N/A. **Pre-Implementation Contact(s):** Julie Stankivic (410) 786-5725 **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.**

Medicare Claims Processing Manual

Chapter 6 - SNF Inpatient Part A Billing

Table of Contents

(Rev.767, 12-02-05)

20.1.1 - Physician's Services and Other Professional Services Excluded From Part A PPS Payment and the Consolidated Billing Requirement

(Rev.767, Issued: 12-02-05, Effective: N/A, Implementation: N/A)

Except for the therapy services, the professional component of physician services and services of certain nonphysician providers listed below are excluded from Part A PPS payment and the requirement for consolidated billing, and must be billed separately by the practitioner to the carrier. *See below for Rural Health Clinic (RHC)/ Federally Qualified Health Center (FQHC) instructions.*

For this purpose "physician service" means the professional component of the service. The technical component, if any, must be billed by the SNF for its Part A inpatients. The carrier will pay only the professional component to the physician:

- Physician's services other than physical, occupational, and speech-language therapy services furnished to SNF residents;
- Physician assistants, not employed by the SNF, working under a physician's supervision;
- Nurse practitioners and clinical nurse specialists, not employed by the SNF, working in collaboration with a physician;
- Certified nurse-midwives;
- Qualified psychologists; and
- Certified registered nurse anesthetists.

Providers with the following specialty codes assigned by CMS upon enrollment with Medicare are considered physicians for this purpose. Some limitations are imposed by §§1861(q) and (r) of the Act. These providers may bill their carrier directly.

Physician Specialty Codes

01 General Practice	02 General Surgery
03 Allergy/Immunology	04 Otolaryngology
05 Anesthesiology	06 Cardiology
07 Dermatology	08 Family Practice
10 Gastroenterology	11 Internal Medicine
12 Osteopathic Manipulative Therapy	13 Neurology
14 Neurosurgery	16 Obstetrics Gynecology
18 Ophthalmology	19 Oral Surgery (Dentists only)

Physician Specialty Codes

20 Orthopedic Surgery	22 Pathology
24 Plastic and Reconstructive Surgery	25 Physical Medicine and Rehabilitation
26 Psychiatry	28 Colorectal Surgery (formerly Proctology)
29 Pulmonary Disease	30 Diagnostic Radiology
33 Thoracic Surgery	34 Urology
35 Chiropractic	36 Nuclear Medicine
37 Pediatric Medicine	38 Geriatric Medicine
39 Nephrology	40 Hand Surgery
41 Optometry	44 Infectious Disease
46 Endocrinology	48 Podiatry
66 Rheumatology	69 Independent Labs
70 Multi specialty Clinic or Group Practice	76 Peripheral Vascular Disease
77 Vascular Surgery	78 Cardiac Surgery
79 Addiction Medicine	81 Critical Care (Intensivists)
82 Hematology	83 Hematology/Oncology
84 Preventive Medicine	85 Maxillofacial Surgery
86 Neuropsychiatry	90 Medical Oncology
91 Surgical Oncology	92 Radiation Oncology
93 Emergency Medicine	94 Interventional Radiology
98 Gynecological/Oncology	99 Unknown Physician Specialty

Nonphysician Provider Specialty Codes

42 Certified Nurse Midwife	43 Certified Registered Nurse Anesthetist, Anesthesia Assistants (effective 1/1/89)

Physician Specialty Codes

50 Nurse Practitioner

62 Clinical Psychologist (billing independently)

68 Clinical Psychologist

89 Certified Clinical Nurse Specialist

97 Physician Assistant

NOTE: Some HCPCS codes are defined as all professional components in the fee schedule. Fee schedule definitions apply for this purpose.

Effective July 1, 2001, the Benefits Improvement and Protection Act (BIPA) established payment method II, in which CAHs can bill and be paid for physician services billed to their intermediary. CAHs must bill the professional fees using revenue codes 96x, 97x, or 98x on an 85x type of bill (TOB). Like professional services billed to the carrier, the specific line items containing these revenue codes for professional services are excluded from the requirement for consolidated billing.

RHC/FQHC Instructions:

Effective January 1, 2005, Section 410 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) amended the SNF consolidated billing law to specify that when a SNF's Part A resident receives the services of a physician (or another type of practitioner that the law identifies as being excluded from SNF consolidated billing) from a RHC or a Federally Qualified Health Center FQHC, those services *are* not subject to CB merely by virtue of being furnished under the auspices of the RHC or FQHC. *Accordingly, under section 410 of the MMA of 2003, services otherwise included within the scope of RHC and FQHC services that are also described in clause (ii) of section 1888(e)(2)(A) are excluded from consolidated billing, effective with services furnished on or after January 1, 2005. Only this subset of RHC/FQHC services may be covered and paid separately when furnished to SNF residents during a covered Part A stay. Use TOBs 71x and 73x, respectively, to bill for these RHC/FQHC services.*

30 - Billing SNF PPS Services

(Rev.767, Issued: 12-02-05, Effective: N/A, Implementation: N/A)

SNFs and hospital swing bed providers are required to report inpatient Part A PPS billing data as follows. Refer to the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-92 (CMS-1450) Data Set," for further information about billing, as it contains UB-92 data elements and the corresponding fields in the electronic record:

- In addition to the required fields identified in the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-92 (CMS-1450) Data Set," SNFs must also report occurrence span code "70" to indicate the dates of a qualifying hospital stay of at least three consecutive days which qualifies the beneficiary for SNF services.
- Separate bills are required for each Federal fiscal year for admissions that span the annual update effective date (October 1.)
- Use Type of Bill 21X for SNF inpatient services or 18X for hospital swing bed services.
- Revenue Code, Health Care Claim: ANSI X12N 837 I version 4010 SV201 must contain revenue code 0022. This code indicates that this claim is being paid under the SNF PPS. This revenue code can appear on a claim as often as necessary to indicate different HIPPS Rate Code(s) and assessment periods.
- There must be a line item on the claim for each assessment period represented on the claim with revenue code 0022. This code indicates that this claim is being paid under SNF PPS. This revenue code can appear on a claim as often as necessary to indicate different HIPPS rate code(s) and assessment periods.
- The line item date of service date must contain an assessment reference date (ARD) when FL 42 contains revenue code 0022 unless FL 44 contains HIPPS rate code AAA00. Assessment dates are reported on the ANSI X12N 837 I version 4010 using qualifier 866 in DTP01.
- HCPCS/Rates, Health Care Claim: Institutional ANSI X12N 837 I version 4010 SV202-01 must contain a ZZ qualifier and SV202-02 must contain a 5-digit "HIPPS Code" (AAA00-SSC79). The first three positions of the code contain the RUG III group and the last two positions of the code contain a 2-digit assessment indicator (AI) code. See Tables 1 and 2 below for valid RUG codes and AI codes.
- Service Units, Health Care Claim: Institutional 837 I version 4010 2400 SV205 must contain the number of covered days for each HIPPS rate code.

  NOTE: Fiscal Intermediary Shared System (FISS) requirement:

  The sum of all covered units reported on all revenue code 0022 lines should be equal to the covered days field less the number of days reported in an OSC 77. (Note: The covered units field is utilized in FISS and has no mapping to the 837 or paper claim).

- Total Charges, Health Care Claim: Institutional ANSI X12N 837 I version 4010 2400 SV203 should be zero total charges when the revenue code is 0022.
- When a HIPPS rate code of RUAxx, RUBxx , RUCxx, *RULxx and/or RUXxx* is present, a minimum of two rehabilitation therapy ancillary codes are required (revenue code 042x and/or, 043x and/or, 044x). When a HIPPS rate code of RHAxx, RHBxx, RHCxx, *RHLxx*, *RHXxx*, RLAxx, RLBxx, *RLXxx,* RMAxx, RMBxx, RMCxx, *RMLxx, RMXxx,* RVAxx, RVBxx, RVCxx, *RVLxx, and/or RVXxx* is present, a minimum of one rehabilitation therapy ancillary revenue code is required (revenue code 042x, 043x, or 044x. Bills that are missing required rehabilitation therapy ancillary revenue codes are to be returned to the SNF for resubmission.
- The accommodation revenue code 018x, leave of absence is reported when the beneficiary is on a leave of absence and is not present at the midnight census taking time.
- Principal Diagnosis Code - SNFs enter the ICD-9-CM code for the principal diagnosis in FL 67. The code must be reported according to Official ICD-9-CM Guidelines for Coding and Reporting, as required by the Health Insurance Portability and Accountability Act (HIPAA), including any applicable guidelines regarding the use of V codes. The code must be the full ICD-9-CM diagnosis code, including all five digits where applicable.
- Other Diagnosis Codes Required – The SNF enters the full ICD-9-CM codes for up to eight additional conditions in FLs 68-75. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in the ICD-9-CM guidelines.

60 - *Billing Procedures for a Composite SNF or a Change in Provider Number*

(Rev.767, Issued: 12-02-05, Effective: N/A, Implementation: N/A)

SNF-520, A3-3600.5

A hospital with a sub-provider that meets the criteria for a composite distinct part SNF defined in 42 CFR 483.5 is required to use the single SNF number assigned for all claims, beginning with the date the provider number is effective.

Where there is a change of ownership (CHOW), and the new owner refuses assignment of the existing provider agreement, the old owner submits all claims for periods prior to the CHOW using the old provider number. The new owner submits claims for services rendered after the date of the CHOW using the new provider number.

Also with respect to CHOWs, the SNF submits a bill with the old provider number for the period before the change and another with the new provider number for the period after the change. The date of discharge on the first bill and the date of admission on the second bill are the same, which is the effective date of the new provider number. All subsequent billings are submitted under the new provider number.

70 - *Billing for Services After Termination of Provider Agreement, or After Payment is Denied for New Admissions*

(Rev.767, Issued: 12-02-05, Effective: N/A, Implementation: N/A)

70.1 - General Rules

(Rev.767, Issued: 12-02-05, Effective: N/A, Implementation: N/A)

A SNF whose provider agreement terminates or that is denied payment for new admissions as an alternative to termination for noncompliance with one or more *requirements for* participation, may only be paid for covered Part A inpatient services under the following conditions:

Termination (Voluntary or Involuntary)

- Payment can continue to be made for up to 30 days for covered Part A inpatient services furnished **on and after** the effective date of termination for beneficiaries who were admitted **prior** to the termination date.
    - EXAMPLE: Termination date: 9/30/86
    - Beneficiary admitted: before 9/30/86
    - Payment can be made: *from* 9/30/86, up to and including 10/29/86

Denial of Payments for New Admissions (DPNA)

- Payment can continue to be made for covered Part A inpatient services furnished **on or after** the effective date of denial of payments for beneficiaries who were admitted **before** the effective date of denial of payments.

  EXAMPLE: Denial of payment date: 9/30/86

  - Beneficiary admitted before: 9/30/86
  - Payment can be made: Indefinitely

For detailed instructions on SNF payment bans, or denial of payment for new admission see IOM 100-4, Chapter 6, section 50.

NOTE: An inpatient, who goes on leave from the SNF before or after the effective date of denial of payments for new admissions is not considered a new admission when returning from leave.

70.2 - Billing for Covered Services

(Rev.767, Issued: 12-02-05, Effective: N/A, Implementation: N/A)

Upon cessation of a SNF's participation in the program, or when a SNF is not receiving payments for new admissions, the RO is supplied with the names and claim numbers of Medicare beneficiaries entitled to have payment made on their behalf for services in accordance with §80.1.

SNFs no longer participating in the program, or those under a denial of payment for new admissions, continue to bill for covered services per §80.l. They continue to submit "no-payment" death, discharge and reduction from SNF level of care bills for Medicare beneficiaries admitted prior to the termination of their agreement, or prior to the denial of payments for new admissions.

70.3 - Part B Billing

(Rev.767, Issued: 12-02-05, Effective: N/A, Implementation: N/A)

Following termination of its agreement, a SNF is considered to be a "nonparticipating provider." An inpatient of such a SNF who has Part B coverage, but for whom Part A benefits have been exhausted or are otherwise not available, is entitled to payment only for those services that are covered in a nonparticipating institution. Do not bill *Part A* services furnished **on or after** the effective date of termination.