Program Memorandum
Intermediaries/Carriers

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

Transmittal AB-02-043 **Date: APRIL 8, 2002**

CHANGE REQUEST 2035

SUBJECT: Corrections to Program Memorandum (PM) A-01-135 -- Codes Billable by SNFs and Suppliers for SNF Residents

This Program Memorandum is informational only for carriers. All actions are for intermediaries.

A - Clinical Diagnostic Lab Tests

PM A-01-135 incorrectly indicated that clinical diagnostic lab tests for SNF residents could be billed only by the entity that actually provided the test.

In fact §1833g(5)(A)iii of Title XVIII provides that "in the case of a clinical diagnostic laboratory test provided under an arrangement (as defined in §1861(w)(1)) made by a hospital, critical access hospital or skilled nursing facility, payment shall be made to the hospital or skilled nursing facility."

SNFs must make arrangements under Part A and may make arrangements under Part B under which the SNF bills the intermediary and receives payment from the program. Under this process the SNF pays the lab for services whatever amount the SNF and the lab agree on, and the beneficiary may not be charged by the lab.

Where the SNF and a lab have entered into such an arrangement, the arrangement may include Part A only or may include Part A and Part B. Such an arrangement is voluntary on the part of both the lab and the SNF for Part B services.

In the absence of such an arrangement under Part B, the lab may bill the program for lab services furnished to residents for whom Part A cannot be paid, and for SNF outpatients, and the SNF may not bill the program for these services. Hospital labs and labs in other SNFs would bill the intermediary. Independent labs would bill the carrier.

This correction applies to all clinical diagnostic lab HCPCS codes.

A revised Excel file is attached. Comments for codes in the clinical diagnostic lab code range, in the Excel file, have been changed to show that either the SNF may bill under arrangements or the rendering lab may bill, as agreed upon between the SNF and lab.

With respect to planning for SNF Part B fee schedule payments, intermediaries with SNF claims workloads should have fees loaded for payment to SNFs for all codes included in the clinical diagnostic lab fee schedule.

B - Other Corrections in the Revised File

1 - The following HCPCS codes are shown in two tables in the SNF manual, both as outpatient procedures that a SNF cannot bill and as rehab services that a SNF must bill. The comment field in the help file is changed to state the following: "Part B - Defined as therapy when rendered by therapist (revenue codes 042X, 043X, 044X) and SNFs must bill. Otherwise, defined as surgery and billed by rendering provider or SNF under arrangements." The code continues to be included in Part A SNF PPS. Physician charges for the surgery may be billed to the carrier.

Codes are:

29065	29125	29200	29280	29445	29550
29075	29126	29220	29345	29505	29580
29085	29130	29240	29365	29515	29590
29105	29131	29260	29405	29540	64550

2 - The following HCPCS codes are shown in two tables in the SNF Manual, both as chemotherapy administration codes that are excluded from SNF PPS and outpatient procedures that are included in SNF PPS. The codes and previous messages were:

36489 Part A resident- Rendering provider must bill. Part B - Non covered for SNF. Rendering provider must bill.

36491 Part A resident- Rendering provider must bill. Part B - Non covered for SNF. Rendering provider must bill.

These codes are included in Part A payment when performed alone or with other surgery, but are excluded if they occur with the same line item date of service as an excluded chemotherapy agent. The Help file now contains "COM" in the Included in Part A PPS column to direct the reader to the comment column. The comment column now reads: "Part A resident- included in Part A payment when done alone or with other surgery; excluded from Part A PPS rate if billed with separately billable chemotherapy agent. Part B - Noncovered for SNF. Rendering provider must bill."

3 - The following procedures are included in PPS; but for Part B, the HCPCS codes may be billed by the rendering provider or by the SNF under arrangements. Previously they were shown as " Part B - Non covered for SNF. Physician may bill."

The corrected message is "SNFs must use modifier TC. Physician may bill."

Intermediaries must pay these services when billed by the SNF with a TC modifier for Part B residents and outpatients.

51772	51792	54240	59025
51784	51795	54250	62367
51785	51797	59020	62368

For other procedures included in SNF PPS we changed the message from "Part B - Non covered for SNF. Physician may bill." To "Physician may bill." These are now shown as "SNFs cannot bill this service."

4 - HCPCS codes: 69090, 72159, 73225 are not covered by Medicare. Previously they were shown as "Hospital or CAH must bill."

The corrected message is "Non covered for Medicare. SNFs cannot bill this service.

Intermediaries may not pay for this service.

5 - HCPCS codes 76012, 76013 were previously shown as "physician billing to carrier"

The corrected message is "Rendering provider may bill or SNF may bill under arrangements." A TC modifier is required for SNF Part B.

Intermediaries must pay these services when billed by the SNF with a TC modifier for Part B residents and outpatients.

6 - HCPCS codes 96000, 96001, 96002, 96003 are therapy codes that must be billed by the SNF. The comment wording was changed for consistency. There is no change in application. The prior comment was "Code Effective 1/1/2002 Physical Therapy and SNFs must bill this service." The

corrected comment to be consistent with other rehab comments is "Code Effective 1/1/2002. SNFs must bill this therapy service."

No change in procedures. Intermediaries continue to pay when billed by a SNF and reject when billed by any other provider for a SNF resident (under Part A or Part B). This change is for consistency in presentation.

7 - HCPCS codes G0104, G0105 are colorectal cancer screening services which SNFs must bill under Part B for A residents.

Previously these were shown as " Physician billing to carrier." Corrected comment was changed to "Part A resident - SNFs must bill this service using 22x TOB. Part B resident – SNF or rendering provider may bill."

Intermediaries must accept claims for these services and process according to rules for colorectal cancer screening services.

8 - The description of HCPCS code G0179 is corrected and as a result the code has become classified as "Physician billing to carrier."

The previous incorrect description was for a service that could be billed under arrangements. Intermediaries are to deny HCPCS code G0179.

9 - Ambulance Fee Schedule

The following ambulance codes will be paid by fee schedule when implemented.

A0380	A0426	A0428	A0430	A0432	A0436
A0390	A0427	A0429	A0431	A0434	A0999

Ambulance code A0425 will be effective when the ambulance fee schedule is implemented.

C - Revised SNF Help File

A revised Excel file is attached. Intermediaries should discard the Excel file furnished with PM A-01-135. We are not reissuing PM A-01-135. Intermediaries are to make the changes shown above in your planning related to that PM.

D - Handling Claims Already Processed

Do not search for any claims processed incorrectly. Initiate adjustment processing for any errors called to your attention.

Attachment - **The Attachment is furnished with the electronic copy only. It can be accessed at** http://www.hcfa.gov/manuals**. Select Program Memos, then select file AB-02-027. Finally select the link to the Attachment.**

The *effective date* for this PM is April 1, 2002.

The *implementation date* for this PM is April 1, 2002.

These instructions should be implemented within your current operating budget.

This PM may be discarded after January 1, 2003.

If you have any questions contact Cindy Murphy at cmurphy1@cms.hhs.gov or call 410-786-5733.

To view the attachment associated with this PM, click here.