CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1757	**Date: June 19, 2009**
	Change Request 6521

SUBJECT: Claims Processing for Skilled Nursing Facility Consolidated Billing

I. SUMMARY OF CHANGES: This revision updates messages and adds references to MACs and DMEMACs.

NEW / REVISED MATERIAL
EFFECTIVE DATE: *July 20, 2009
IMPLEMENTATION DATE: July 20, 2009

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/Table of Contents
R	6/110/Carrier/Part B MAC/DMEMAC Claims Processing for Consolidated Billing for Physician and Non-Physician Practitioner Services Rendered to Beneficiaries in a SNF Part A Stay
R	6/110.2.1/Reject and Unsolicited Response Edits
R	6/110.2.2/A/B Crossover Edits
R	6/110.2.3/Duplicate Edits
R	6/110.2.4/Edit for Ambulance Services
R	6/110.2.5/Edit for Clinical Social Workers (CSWs)
R	6/110.2.6/Edit for Therapy Services Separately Payable When Furnished by a Physician
R	6/110.3/CWF Override Codes
R	6/110.4/Coding Files and Updates
R	6/110.4.1/Annual Update Process

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1757	Date: June 19, 2009	Change Request: 6521

SUBJECT: Claims Processing for Skilled Nursing Facility Consolidated Billing

EFFECTIVE DATE: July 20, 2009

IMPLEMENTATION DATE: July 20, 2009

I. GENERAL INFORMATION

A. Background: This CR revises the sections in Chapter 6 to update messages and to include references to the Medicare Administrative Contractors (MACs) and Durable Medical Equipment Medicare Administrative Contractors (DMEMACs).

B. Policy: There is no change to policy.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6521.1	Contractors shall note the revision to the Internet Only Manual.	X	X		X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact: Leslie Trazzi, leslie.trazzi@cms.hhs.gov.

Post-Implementation Contact: Appropriate Regional Office.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

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

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual

Chapter 6 - SNF Inpatient Part A Billing *and SNF Consolidated Billing*

Table of Contents
(Rev.1757, 06-19-09)

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

(Rev. 1757, Issued: 06-19-09, Effective: 07-20-09, Implementation: 07-20-09)

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

110.2.1 – Reject and Unsolicited Response Edits

(Rev. 1757, Issued: 06-19-09, Effective: 07-20-09, Implementation: 07-20-09)

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*/Part B MACs/DMEMACs* 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 *Part A MAC*. Appeals rights must be offered on all denials. Standard systems must develop, and along with carriers*/Part B MACs/DMEMACs* 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*/Part B MAC/DMEMAC.*

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*/Part B MAC/DMEMAC* 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 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*/Part B MACS/DMEMACs* 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*/Part B MAC/DMEMAC* in trailer 11. To recover any monies due back to Medicare resulting from these denials, carriers*/Part B MACs/DMEMACs* 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 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*/Part B MAC/DMEMAC* 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*/Part B MAC/DMEMAC* 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

Report *claim* adjustment reason code 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor; and

Remittance advice remark code (RARC) *MA101 - A Skilled Nursing Facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to its residents.*

If appropriate, use *RARC MA59 – Alert: The patient overpaid you for these services. You must issue the patient a refund within 30 days for the difference between his/her payment and the total amount shown as patient responsibility on this notice.*

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 *skilled nursing facility* on this date.

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 *($__)* 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 - A/B Crossover Edits

(Rev. 1757, Issued: 06-19-09, Effective: 07-20-09, Implementation: 07-20-09)

Effective April 1, 2002, CWF implemented the following crossover edits for carrier*/Part B MAC* submitted claims. Automated processes *were implemented* for the resolution of these edits based on the codes returned in the trailers from CWF.

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

Reject if a Part B claim is received containing physical therapy (type of service of W), occupational therapy, or speech-language pathology 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.

Effective for claims with dates of service on or after April 1, 2001, CWF implemented revisions on January 2, 2008 to bypass the edits 7258 and 7259 when a therapy claim with a date of service on or after April 1, 2001 is submitted and the date of service is within the From/Thru dates of an occurrence Span code date of 74 reported on a SNF inpatient claim 21x in history. This will allow for services to be separately payable outside of SNF consolidated billing during non-covered periods in the SNF.

Effective for claims with dates of service on or after April 1, 2001, CWF implemented revisions on April 7, 2008 to modify the existing therapy edit for Part B claims processing for non-covered SNF stays to read claims history to look for a 21x (SNF Inpatient) bill type that contains an Occurrence Code 22 (Date Active Care Ended) and a Patient Status Code 30 (Still patient or expected to return for outpatient services) where there is no subsequent 21x (SNF inpatient) bill type discharge claim from the same provider. As therapy services provided in a SNF must be consolidated when a beneficiary is in either a covered or non-covered stay, CWF will reject claims with dates of service after the posted SNF claim containing Occurrence Code 22 (Date Active Care Ended) and Patient Status 30 (Still patient or expected to return for outpatient services) until a 21x (SNF inpatient) bill type discharge claim is processed. The entity furnishing the therapy services must look to the SNF for reimbursement rather than the Medicare contractor. For claims processed on or after January 5, 2009, this edit shall no longer be functional. Contractors shall re-open and-re-process claims previously denied due to this edit when brought to their attention should they determine that the beneficiary was not in a SNF stay during the period the therapy service was rendered.

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

Reject if a 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.

Effective for claims with dates of service on or after April 1, 2001, CWF implemented revisions on January 2, 2008 to bypass the edits 7260 and 7261 when a claim with a date of service on or after April 1, 2001 is submitted and the date of service is within the From/Thru dates with an occurrence Span code date of 74, 76, 77, 79, or M1 reported on a SNF inpatient claim 21x in history or the date of service is greater than the occurrence date on a SNF inpatient claim 21x in history with an occurrence code date of A3, B3, or C3. This will allow for services to be separately payable outside of SNF consolidated billing during non-covered periods in the SNF.

110.2.3 - Duplicate Edits

(Rev. 1757, Issued: 06-19-09, Effective: 07-20-09, Implementation: 07-20-09)

Effective April 1, 2002, CWF implemented the following duplicate edits for carrier*/Part B MAC* submitted claims.

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

Reject if a 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*/Part B MAC/DMEMAC* or Intermediary Part B Claim Against An Inpatient B SNF (22x) Claim on History

Reject as a duplicate claim if a carrier*/Part B MAC/DMEMAC* 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 MAC* Part B claim payment process indicator is other than A (allowed).
- For the carrier*/Part B MAC/DMEMAC* 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. 1757, Issued: 06-19-09, Effective: 07-20-09, Implementation: 07-20-09)

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*/Part B MAC* must deny the service with appeals rights.

Effective for claims with dates of service on or after April 1, 2001, CWF implemented revisions on January 2, 2008 to bypass edit 7275 when a claim with a date of service on or after April 1, 2001 is submitted and the date of service is within the From/Thru dates with an occurrence Span code date of 74, 76, 77, 79, or M1 reported on a SNF inpatient claim 21x in history or the date of service is greater than the occurrence date on a SNF inpatient claim 21x in history with an occurrence code date of A3, B3, or C3. This will allow for services to be separately payable outside of SNF consolidated billing during non-covered periods in the SNF.

110.2.5 - Edit for Clinical Social Workers (CSWs)

(Rev. 1757, Issued: 06-19-09, Effective: 07-20-09, Implementation: 07-20-09)

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*/Part B MAC*. 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*/Part B MAC* or return an unsolicited response with new error code 7269. The carrier*/Part B MAC* will then take the same adjustment and recovery action as for other rejects and unsolicited responses.

When carriers*/Part B MACs* 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 charge*(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)*; 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 *S*killed *N*ursing *F*acility *(SNF)* 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 benefits in a skilled nursing facility on this date.

Effective for claims with dates of service on or after April 1, 2001, CWF implemented revisions on January 2, 2008 to bypass edit 7269 when a claim with a date of service on or after April 1, 2001 is submitted and the date of service is within the From/Thru dates with an occurrence Span code date of 74, 76, 77, 79, or M1 reported on a SNF inpatient claim 21x in history or the date of service is greater than the occurrence date on a SNF inpatient claim 21x in history with an occurrence code date of A3, B3, or C3. This will allow for services to be separately payable outside of SNF consolidated billing during non-covered periods in the SNF.

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

(Rev. 1757, Issued: 06-19-09, Effective: 07-20-09, Implementation: 07-20-09)

A number of therapy services are considered separately payable when provided by a physician and shall be paid separately by the Medicare carrier*/Part B MAC*. 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/.

110.3 - CWF Override Codes

(Rev. 1757, Issued: 06-19-09, Effective: 07-20-09, Implementation: 07-20-09)

A CWF override code has been developed for carrier*/Part B MAC/DMEMAC* 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*/Part B MAC/DMEMAC*. At the carrier*/Part B MAC/DMEMAC'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. 1757, Issued: 06-19-09, Effective: 07-20-09, Implementation: 07-20-09)

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*/Part B MAC* or DMEMAC. These codes are available 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*/Part B MACs/DMEMACs* to make appropriate payments.

110.4.1 - Annual Update Process

(Rev. 1757, Issued: 06-19-09, Effective: 07-20-09, Implementation: 07-20-09)

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.

CWF will be provided with 4 coding files (Physician Services, Professional Component of Physician Services to be Submitted with the 26 Modifier, Ambulance, and Therapy) that are effective based on dates of service January 1 through December 31 for that year. New files shall be provided for each calendar year. Quarterly updates to the four files will continue as usual.

Carriers*/Part B MACs/DMEMACs* must continue to respond to rejects and unsolicited responses received from CWF per current methodology.

Carriers*/Part B MACs/DMEMACs* 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*/Part B MACs/DMEMACs* 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*/Part B MACs/DMEMACs* 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*/Part B MACs/DMEMACs* must notify physician, non-physician practitioners, and suppliers of the availability of the files.