CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 740

Department of Health & Human Services (DHHS)

Center for Medicare & Medicaid Services (CMS)

Date: NOVEMBER 1, 2005

Change Request 3910

SUBJECT: Change to the Common Working File (CWF) Skilled Nursing Facility (SNF) Consolidated Billing (CB) Edits for Evaluation and Management (E&M) Services Billed to Fiscal Intermediaries (FIs) by Hospitals

I. SUMMARY OF CHANGES: These instructions revise the claims processing procedures to follow when a hospital bills for "facility charges" (overhead expenses) in connection with clinic services of hospital-based physicians. Existing SNF CB edits in the CWF shall be changed to allow the separate payment of E&M service HCPCS codes 99201-99245 which represents the "facility charge" for the associated hospital's overhead expense.

NEW/REVISED MATERIAL

EFFECTIVE DATE: January 01, 2006

IMPLEMENTATION DATE: April 03, 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/Table of Contents
N	6/20.1.1.2/Hospital's "Facility Charge" in Connection with Clinic Services of a Physician

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: 740	Date: November 1, 2005	Change Request: 3910

SUBJECT: Change to the Common Working File (CWF) Skilled Nursing Facility (SNF) Consolidated Billing (CB) Edits for Evaluation and Management (E&M) Services Billed to Fiscal Intermediaries (FIs) by Hospitals

I. GENERAL INFORMATION

A. Background: These instructions revise the claims processing procedures to follow when a hospital submits an outpatient claim containing "facility charges" (overhead expenses) in connection with hospital-based physicians. When the beneficiary receiving these clinic services performed by a physician is a Part A resident of a SNF, the associated hospital claim for a facility charge is currently being rejected, due to the SNF CB edits. (SNF CB is the provision that requires the SNF itself to assume the Medicare billing responsibility for all of the services that its Part A residents receive during the course of a covered stay, other than those services--such as physician services--that are specifically excluded from this provision.)

While the physician in this situation would bill his or her own professional services for the clinic visit directly to the Part B carrier, the physician would be reimbursed at the facility rate of the Medicare physician fee schedule-- which does not include overhead expenses. The hospital historically has submitted a separate Part B "facility charge" for the associated overhead expense to its fiscal intermediary (FI). The hospital's facility charge **does not** involve a separate service (such as a diagnostic test) being furnished **in addition to** the physician's clinic service; rather, it represents solely the overhead expense associated with furnishing the clinic service itself. Accordingly, hospitals bill for facility charges under the physician evaluation and management (E&M) HCPCS codes. As noted above, however, when the beneficiary who receives the physician clinic services is a Part A SNF resident, the associated hospital claim for a facility charge is currently being rejected, and SNFs have been responsible for these charges.

Accordingly, these instructions revise the existing procedures so that the SNF CB edits will no longer reject such claims. This change in policy is effective January 1, 2006, with an implementation date of April 3, 2006. Hospitals should refrain from submitting their claims, with the clinic visit charges identified below, to the FIs until the system is updated on April 3, 2006.

Hospital providers, including critical access hospitals, billing for the clinic visits identified above must submit the charges on 13x or 85x bill types. In addition, the CWF will bypass CB edits only when billed with revenue code 0510 (clinic visit) with an E&M HCPCS code in the range of 99201-99245.

NOTE: Unless otherwise excluded in one of the Five Major Categories for billing services to FIs, physician services codes are billed to the carrier by the physician. Facility charges associated with the physician's clinic visit must be reported as explained above and will be excluded from SNF CB edits.

B. Policy: The requirements below conform Medicare systems to the existing policy excluding physician services from SNF CB found in § 1888(e)(2)(A)(ii) of the Social Security Act.

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	
3910.1	Medicare systems shall bypass SNF CB edits for E&M HCPCS codes in the range of 99201-99245 when billed with a 0510 clinic visit revenue code on outpatient hospital bill types 13x or 85x.								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	
3910.2	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	X								

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

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*: January 1, 2006 **Implementation Date:** April 3, 2006 **Pre-Implementation Contact(s):** Jason Kerr (SNF claims processing), email Jason.Kerr@cms.hhs.gov or Bill Ullman (SNF Policy) email Bill.Ullman@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.**

Medicare Claims Processing Manual

Chapter 6 - SNF Inpatient Part A Billing

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(Rev.740, 11-01-05)

20.1.1.2 – Hospital's "Facility Charge" in Connection with Clinic Services of a Physician

(Rev. 740, Issued: 11-01-05, Effective: 01-01-06, Implementation: 04-03-06)

As noted above in section 20.1.1, physician services are excluded from Part A PPS payment and the requirement for consolidated billing. When a beneficiary receives clinic services from a hospital-based physician, the physician in this situation would bill his or her own professional services directly to the Part B carrier and would be reimbursed at the facility rate of the Medicare physician fee schedule-- which does not include overhead expenses. The hospital historically has submitted a separate Part B "facility charge" for the associated overhead expenses to its FI. The hospital's facility charge does not involve a separate service (such as a diagnostic test) furnished in addition to the physician's professional service; rather, it represents solely the overhead expenses associated with furnishing the professional service itself. Accordingly, hospitals bill for "facility charges" under the physician evaluation and management (E&M) codes in the range of 99201-99245.

E&M codes, representing the hospital's "facility charge" for the overhead expenses associated with furnishing the professional service itself, are excluded from SNF CB. Effective for claims with dates of service on or after January 1, 2006, hospital providers, including critical access hospitals, billing for such services identified above must submit the charges on 13x or 85x bill types respectively. In addition, the CWF will bypass CB edits only when billed with revenue code 0510 (clinic visit) with an E&M HCPCS code in the range of 99201-99245.

***NOTE:** Unless otherwise excluded in one of the Five Major Categories for billing services to FIs, physician services codes are to be billed to the carrier by the physician. Facility charges associated with the physician's clinic visit must be reported as explained above.*