Program Memorandum Intermediaries

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

Transmittal A-03-017 **Date: FEBRUARY 28, 2003**

CHANGE REQUEST 2541

SUBJECT: Payment for Services To Be Paid on a Fee Schedule But For Which There Is No Price--ACTION

In 2001, CMS issued Transmittals A-01-94 and A-01-119, Change Requests 1689 and 1878. These program memoranda informed intermediaries that any Part B services paid to a Skilled Nursing Facility (SNF) for which a fee schedule existed were to be paid on the fee schedule. The Agency also put files on its mainframe for intermediaries to pull down containing HCPCS codes and fee amounts.

A. Services Paid Through a Fee Schedule

Intermediaries regularly receive fee schedules in the last quarter of the calendar year (CY) for the following CY. In addition to the Therapy Fee Schedule, Durable Medical Equipment, Prosthetic, Orthotic and Supply (DMEPOS) Fee Schedule, Ambulance Fee Schedule and the Clinical Diagnostic Laboratory Fee Schedule, CMS makes an extract of the Medicare Physician Fee Schedule Database (MPFSDB) available to intermediaries for those services on that fee schedule that are payable to SNFs. Intermediaries should continue to pay on a fee basis using these files.

B. Services for Which the Fee Amount Is Not Present

CMS is aware that some services are listed on the fee schedules without payment amounts. The services listed without fees on the Clinical Diagnostic Fee Schedule will require gap-filling. All other services without fees should be paid on the basis of reasonable cost. In making payment to SNFs for Part B services, intermediaries are to use fee amounts whenever possible, and to make payment using reasonable cost methodology when non-laboratory fee amounts are missing.

C. Services Not Paid Through a Fee Schedules

Fee schedules have not yet been developed for all services. Payment is made using reasonable cost methodology for the following services:

- Some medical supplies;
- Dialysis supplies and equipment;
- Therapeutic shoes;
- Blood products;
- Transfusion medicine; and
- Drugs.

D. Payment Using Fee Schedules

Intermediaries must:

- Obtain fees for clinical diagnostic laboratory services, therapies, and DMEPOS items from the current laboratory, DMEPOS, or therapy fee schedules.

- Download fees for radiology services, other diagnostic services, and other services paid on the MPFSDB from the SNF extract file that will be placed on the CMS mainframe. This file is called the "SNF Extract from the MPFSDB" because at this time it is only to be used to pay Part B bills from SNFs. You will be notified via e-mail when the MPFSDB and extracts from it are available on the CMS mainframe for retrieval.

- Establish the approved amount as the lower of billed charges for the HCPCS code or the fee schedule amount.

- Calculate deductible and coinsurance for fee schedule payments based on the approved amount (not billed charges). Continue to calculate deductible and coinsurance for SNF services paid based on reasonable cost using billed charges. Deductible and coinsurance do not apply to:

    - Clinical diagnostic lab services; or

    - Pneumococcal pneumonia vaccine (PPV), influenza virus vaccines, or the administration of either.

For mammography screening services, the deductible is waived, but coinsurance does apply and should be calculated based on the payment amount.

Note that the SNF fee schedule amount is based on the "non-facility rate," which is the fee that physicians may receive if performing the service in the physician's office.

Fee schedule amounts for SNFs are based on the SNF's location within carrier locality where the current fee schedule is based on locality. Fee schedule amounts are based on Statewide amounts where the current fee schedule is Statewide. (Lab and DMEPOS are Statewide, and the others are locality based.)

Do not search out claims to adjust, but adjust any brought to your attention that are within the timely filing limit.

The *effective date* of this PM is April 1, 2001, and applies to claims received on or after January 1, 2003.

The *implementation date* of this PM is March 14, 2003.

These instructions should be implemented within your current budget.

This PM may be discarded after April 1, 2004.

Please contact your regional office with any questions.