CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 429 **Date: JANUARY 14, 2005**

CHANGE REQUEST 3561

SUBJECT: Change to the Common Working File (CWF) Skilled Nursing Facility (SNF) Consolidated Billing (CB) Edits for Critical Access Hospitals (CAHs) that have Elected Method II Payment Option and Bill Physician Services to their Fiscal Intermediaries (FIs)

I. SUMMARY OF CHANGES: This transmittal directs the CWF to bypass SNF CB edits for CAHs billing revenue codes 96x, 97x, or 98x to their fiscal intermediary on an 85x type of bill (TOB).

NEW/REVISED MATERIAL - EFFECTIVE DATE*: July 1, 2001
IMPLEMENTATION DATE: July 5, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	6/20.1.1/Physician's Services and Other Professional Services Excluded from Part A PPS Payment and the Consolidated Billing Requirement

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

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

Attachment - Business Requirements

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I. GENERAL INFORMATION

A. Background: Services specifically excluded from SNF CB include physicians' services as described at 1888(e)(2)(A)(ii) of the Social Security Act.

Effective July 1, 2001, the Benefits Improvement and Protection Act (BIPA) of 2000 established a new method II payment option for CAHs in which they could bill and be paid for physician services. Under this method II option, a CAH receives payment from their intermediary for professional services furnished in the CAH's outpatient department. Outpatient claims containing professional services are billed by CAHs on an 85x type of bill (TOB) to their intermediary. In addition, CAHs must use revenue codes 96x, 97x or 98x to identify the professional fees on the 85x TOB. Claims for CAH inpatient and swing bed services are not affected since these revenue codes, if they appeared on these claim types, do not receive separate payment.

B. Policy: This instruction requires the CWF to bypass SNB CB edits for line items containing 96x, 97x, or 98x on an 85x TOB. This bypass will ensure that physicians' services billed to intermediaries by CAHs will not receive incorrect SNF CB edits. Section 1888 of the Social Security Act codifies SNF PPS and CB.

C. Provider Education: A Medlearn Matters 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 1 week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. 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.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)					
		FI	RHH	Car	DME	Shared System Maintainers	Other

						FISS	MCS	VMS	CWF	
3561.1	The CWF shall bypass SNF CB edits for line items containing revenue codes 96x, 97x, or 98x on an 85x TOB.								X	
3561.2	For CAH claims addressed in this instruction beyond the timely filing period, the FIs shall override timely filing and allow the claims to process.	X								

III. 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

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: July 1, 2001 **Implementation Date:** July 5, 2005 **Pre-Implementation Contact(s):** Jason Kerr (410) 786-2123 or Jkerr3@cms.hhs.gov **Post-Implementation Contact(s):** Appropriate regional office	**Medicare contractors shall implement these instructions within their current operating budgets.**

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

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

(Rev. 429, Issued: 01-14-05, Effective: 07-01-01, Implementation: 07-05-05)

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.

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)
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

Physician Specialty Codes

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)
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.

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 Rural Health Clinic (RHC) or a Federally Qualified Health Center (FQHC), those services would not become subject to CB merely by virtue of being furnished under the auspices of the RHC or FQHC. In effect, the amendment enables such RHC and FQHC services to retain their separate identity as excluded "practitioner" services. As such, these services remain separately billable to the FI when furnished to an SNF resident during a covered Part A stay. Since these entities provide professional services only, all services billed on their dedicated TOB are excluded. This includes 71x TOBs for RHCs and 73x TOBs for FQHCs.