



# MEMBERSHIP ALERT

(Posted 3/29/99)

<b>PROGRAM MEMORANDUM INTERMEDIARIES</b>	<b>Department of Health and Human Services</b>  <b>Health Care Financing Administration</b>
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**Transmittal No. A-98-37 Date NOVEMBER 1998**

## CHANGE REQUEST #711

**SUBJECT: Consolidated Billing for Skilled Nursing Facility (SNF) Patients When Receiving Outpatient/Emergency Care in a Medicare-Participating Hospital or Critical Access Hospital (CAH)**

### **Background**

Consolidated billing for SNF residents in a Part B stay and for residents in a Part A stay not yet on PPS is still delayed until further notice (PM-AB-98-35). However, this delay in no way affects any reporting requirements for therapies as stated in PM A-98-8 or subsequent therapy instructions. Consolidated billing continues to apply to all the services and supplies that a SNF resident receives while in a SNF PPS Part A stay.

Under the regulations at 42CFR §483.20, the beneficiary's status as a SNF resident ends when the beneficiary receives outpatient services from a Medicare-participating hospital or CAH (but only with respect to those services that are not furnished pursuant to the SNF's required resident assessment or comprehensive care plan). The purpose of citing the SNF care plan in the context of an outpatient hospital visit is to clarify that the SNF retains the overall billing responsibility for essentially the entire package of care furnished during the outpatient visit, other than certain specifically excluded services. In the outpatient hospital context, this exclusion applies to a small number of exceptionally intensive services that lie well beyond the scope of the care that SNFs would ordinarily furnish (and, thus, beyond the scope of the care plan itself), as well as emergency services (which, by their nature, cannot be anticipated and planned for in advance). Under the regulations at 42CFR §424.101, outpatient hospital emergency services are defined as services that are necessary to prevent death or serious impairment of health and, because of the danger to life or health, require use of the most accessible hospital available and equipped to furnish those services.

Further, this exclusion is not invoked merely because a particular outpatient hospital service does not appear in

the individual SNF care plan of the person receiving the service; rather, the exclusion applies only to those specified categories of service that, by definition, lie well beyond the scope of SNF care plans generally. Currently, only the following categories of services (including the five services that are specifically cited as examples in the preamble to the interim final rule (63 FR 26298- 99)) are excluded. These five services are cardiac catheterization, computerized axial tomography (CT) scans, magnetic resonance imaging (MRIs), ambulatory surgery involving the use of an operating room, and emergency services. In addition, based upon consultation with providers, we have added a new category of excluded services; radiation therapy. Like the above categories, these are relatively costly services which are beyond the scope of care in SNFs. Even though it may be medically appropriate for a beneficiary to be cared for in a SNF while receiving radiation therapy, we do not believe that the SNF should be responsible for paying for radiation therapy that a beneficiary receives. Similarly, we have added angiography codes and codes for lymphatic and venous procedures to the list of services that are beyond the scope of services delivered by SNFs.

### **Claims Processing**

This PM gives additional information as to the billing requirements for an outpatient department of a hospital in situations where a Part A SNF PPS beneficiary receives outpatient services or emergency room care from a Medicare participating hospital or CAH while temporarily absent from the SNF. The outpatient department/emergency room of a hospital independently bills you on Form HCFA- 1450 for these excluded services and will be reimbursed accordingly outside the SNF PPS rate. In addition, instruct your hospitals that they may also bill only for those services and supplies that are directly related and required to complete the procedure or treat the emergency condition for which the beneficiary came to the hospital, e.g., anesthesia when used during ambulatory surgery involving the use of an operating room. All other services and supplies must be bundled back to the SNF and the hospital must look to the SNF for payment.

### **Bill Type**

Instruct your hospitals to report the appropriate bill type (13X - Hospital Outpatient) or (83X - Hospital ASC surgery) in FL 4 on Form HCFA-1450.

### **Revenue Codes**

Hospitals are to report the applicable revenue codes in FL 42. Revenue code 45X is coded in FL 42 to designate emergency room.

### **Hospital Outpatient Department HCPCS Codes**

Hospitals are to report the appropriate HCFA Common Procedure Coding System (HCPCS) code from the list below in FL 44, "HCPCS/Rates." (See § 3627 of the Medicare Intermediary Manual, Part 3, for an explanation of the HCPCS coding system, and §§ 3627.1 and 3627.5 for instructions for informing/educating your providers regarding HCPCS reporting.) This requirement enables you to identify individual items and services more readily on the claim and to limit the amount you pay the hospital to any applicable payment limits.

The applicable HCPCS codes that a Medicare-participating hospital or CAH can report for outpatient CT scans are:

<b>70450</b>	<b>70487</b>	<b>71270</b>	<b>72131</b>	<b>73201</b>	<b>74170</b>	<b>76380</b>
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MEMBERSHIP ALERT - HCFA Transmittal A-98-37

70460	70488	72125	72132	73202	XXXX	G0131
70470	70490	72126	72133	73700	76355	G0132
70480	70491	72127	72192	73701	76360	
70481	70492	72128	72193	73702	76365	
70482	71250	72129	72194	74150	76370	
70486	71260	72130	73200	74160	76375	

The applicable HCPCS codes that a Medicare-participating hospital of CAH can report for outpatient cardiac catheterization are:

<b>93501</b>	<b>93510</b>	<b>93526</b>	<b>93530</b>	<b>93536</b>	<b>93542</b>	<b>93555</b>
93503	93511	93527	93531	93539	93543	93556
93505	93514	93528	93532	93540	93544	93561
93508	93524	93529	93533	93541	93545	93562

NOTE: Add HCPCS code 93571 and HCPCS code 93572 to the above list effective 1/1/99

The applicable HCPCS codes that a Medicare-participating hospital of CAH can report for outpatient MRI are:

<b>70336</b>	<b>71550</b>	<b>72148</b>	<b>72196</b>	<b>73721</b>	<b>75554</b>	<b>76400</b>
70540	71555	72149	72198	73725	75555	
70541	72141	72156	73220	74181	75556	
70551	72142	72157	73221	74185	76093	
70552	72146	72158	73225	75552	76094	
70553	72147	72159	73720	75553	76390	

The applicable HCPCS codes that a Medicare-participating hospital of CAH can report for outpatient radiation therapy are:

<b>77261</b>	<b>77310</b>	<b>77336</b>	<b>77409</b>	<b>77430</b>	<b>77750</b>	<b>77784</b>
77262	77315	77370	77411	77431	77761	77789
77263	77321	77399	77412	77432	77762	77790
77280	77326	77401	77413	77470	77763	77799
77285	77327	77402	77414	77499	77776	
77290	77328	77403	77416	77600	77777	<td valign