



*Medicare Part A  
Skilled Nursing Facility Billing  
Final Rule*

EMPIRE MEDICARE SERVICES  
*HCFA Medicare Part A and Part B Contracted Agent*





***Skilled Nursing Facility Prospective Payment System***  
***The Final Rule***

This training manual provides the major aspects of the Skilled Nursing Facility (SNF) Prospective Payment System (PPS). The intent is to provide skilled nursing facilities with the information that they will need to know in order to implement the new payment system according to the Final Rule.

Please refer to all intermediary bulletins to update this material and incorporate all changes when they are made public by Empire Medicare Services.

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# Skilled Nursing Facility Prospective Payment System Final Rule

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## OVERVIEW

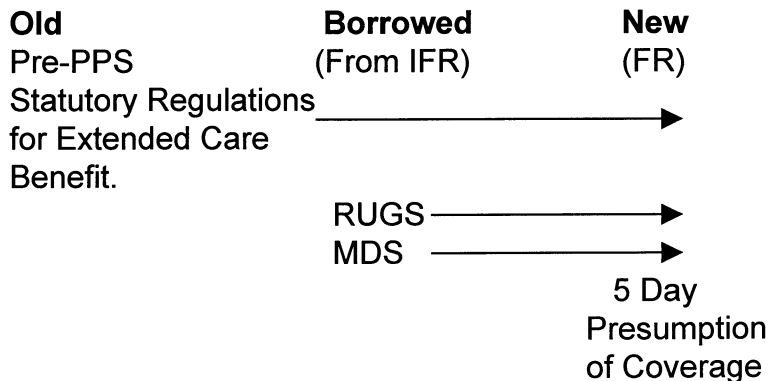
### PPS Final Rule

- **Effective Service dates on and after 10/1/99**

The Final Rule (FR) for SNF PPS is effective for services dates on or after 10/1/99. While the FR represents some additional changes to the SNF Extended Care Benefit, with respect to eligibility and clinical criteria it provides a greater degree of clarity and interpretation of the requirements it set forth. The following pages represent an explanation of the changes that have occurred in both the long-standing criteria and that of the FR.

## THE MARRIAGE OF THE OLD AND THE NEW

The FR represents a “marriage” of the Pre PPS Extended Care Benefit requirements with the Interim Final Rule (IFR) into one final document that represents the SNF Extended Care Benefit in its entirety under the Perspective Payment System FR. The chart below illustrates the transition of such regulations.



## ELIGIBILITY CRITERIA

The long-standing administrative criteria for coverage under the Extended Care Benefit remains. Under the FR and addition to the definition of a skilled level of care has been made.

### Technical Eligibility Requirements

Technical eligibility remains per HCFA Pub. (MIM 13-3) and Skilled Nursing Facility Manual (HIM 12)

- Enrolled in Medicare Part A and has days available To use
- Three Day Qualifying Stay Prior Hospital Stay
- Thirty Day Transfer

<b>Eligibility Criteria</b>
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### Clinical Eligibility Requirements

A beneficiary is eligible for post hospital extended care if the following requirements are meet:

- Individual needs or needed skilled care on a daily basis provided by or under the direct supervision of skilled nursing or rehabilitation services
- As a practical matter can only be provided in a SNF
- Services must be needed for a condition which was treated during the patient's qualifying stay  
or  
for a condition which arose while in the provider for treatment of a condition for which the beneficiary was previously treated in a hospital

## PHYSICIANS CERTIFICATION

### Physician Certification

- **Required**
- **Has no bearing on certifications required for therapy plans of treatment**

A Physician, Clinical Nurse Specialist or Nurse Practitioner must certify and re-certify where such services are furnished over a period of time the need for extended care services in the SNF.

The initial certification may be to one of the following:

- Certify in the existing context found in Section 424.20 of the regulation that the resident meets the existing SNF level of care definition
- OR
- Simply state that the resident's assignment to one of the Upper RUG-III (Top 26) groups is correct.

**Re-certifications** are to the continued need for extended care services only.

***\*These certification statements have no correlation to requirements specifically related to the plan of treatment for therapy that is required for purposes of coverage.***

## SPELL OF ILLNESS

### Spell Of Illness

- **No break in a spell of illness if resident is in Top 26 RUG-III groups**

A SNF resident who has exhausted Part A benefits continues to meet the skilled level of care definition when placing in the TOP 26 RUG-III groups. As a result there is no break in the spell of illness.

## THE BASIC COMPONENTS OF SNF PPS-THE MINIMUM DATA SET (MDS) AND THE RUG-III GROUPS

### MDS and RUG-III GROUPS

- **No alteration in the MDS completion requirements**  
Or
- **The composition of the RUG-III Groups**
- **Clarifications on:**
  - **Grace Days**
  - **Completion/Locking**
  - **Section U**
  - **OMRAs**

The FR has not changed the requirements for the completion of the MDS or to the make-up of the RUG-III clinical groups, but **merely clarified** them based on comments given to the IFR

### THE MINIMUM DATA SET (MDS) VERSION 2.0 1-30-98 AND THE RUG-III GROUPS

As stated in the IFR, the MDS is a clinical assessment tool, representing the primary source of quality indicators and provides the basis for The RUG-III classification system and the PPS. Detailed MDS information, as it applies to its role under the Medicare SNF benefit, is contained in the Empire Medicare Services SNF PPS Training Manual for the IFR.

***The final rule has not altered the meaning of the MDS nor the requirement for its completion on a designated schedule.*** However the following areas have been clarified:

- Grace days
- Completion and Locking Requirements
- Section U
- Other Medicare Required Assessments (OMRA)

### Grace Days

Under the requirements of the IFR a specific number of grace days were allowed per each scheduled Medicare assessment. (Refer to MDS Assessment Schedule). ***The final rule has not altered the number or use of grace days but has clarified their use and application.*** The use of grace days is acceptable and permitted for patients with any condition.

### Grace Days

- **Remain per IFR**
- **Acceptable and permitted**

## The Medicare 5-Day Assessment and the Use of Grace Days

Days one through five are optimal Assessment Reference Dates (ARD), however days six through eight are also acceptable and for some residents the most appropriate, e.g., Rehabilitation Services.

### Grace Days and Rehabilitation

Grace days are allowable as there is an expectation that many beneficiaries who classified into the rehabilitation category will have 5-day ARDs that fall within the grace days.

There are three principle reasons for this to occur:

1. The beneficiary is not physically able to begin therapy, due to an unstable condition and does not begin receiving a therapy program until days 5, 6, or 7. This effectively sets a ARD on a grace day, allowing the facility to capture an adequate number of days and minutes to enter on section P of the MDS.
2. Allows for the classification into the two highest RUG-III groups of ULTRA HIGH and VERY HIGH by capturing the minimum level of services received by the beneficiary in the first seven days of his or her stay.
3. The use of grace days in this manner minimizes the risk to the beneficiary receiving a therapy program that is to intense during this potentially unstable period.
4. Allows clinical flexibility in setting ARDs

**\*Reminder:**

***IF a facility chooses to routinely use grace days they may be subject to audit to determine if indeed the assessment reference dates are accurately reflected.***

### Grace Days and Rehabilitation

- **Acceptable for 5 Day ARD to fall within the grace days**

### Section U

- **Deferred Until 10/1/2000**

### Section U

As noted under the IFR the requirements for completion of Section U (Medications) was deferred until 10/1/99. This requirement continues to be deferred until 10/1/2000.

### Completion and Locking

Any assessment for Medicare Payment including the Medicare 5-Day must be completed (signed by all team members) within 14 days of the ARD indicated in section A3a.

### Completion and Locking

- **MDS must be signed by all team members within 14 days of the ARD**
- **A Medicare claim may not be submitted until after the MDS has been locked**

- The completion date indicated in section R2b must be within 14 days of the date entered in A3a.
- The assessment must be locked within 7 days of the date indicated in section R2b
- Transmitted to the state within 31 days of the final lock date.

Example: ARD = 10/6/99

Completion Date = 10/19/99

Locked By 10/25/99

#### ***\*Reminder:***

***Only those assessments that have been locked may have a bill prepared and submitted for payment to the Fiscal Intermediary for Medicare payment.***

### MDS Corrections

Corrections Policy is set forth in the MDS 2.0 User Guide and the Medicare Reimbursement Manual Pub. 13-3.

## THE OTHER MEDICARE REQUIRED ASSESSMENT (OMRA)

### The Other Medicare Required Assessment

- **Must be completed if a skilled level of care is ongoing**
- **The ARD must be set between days 8, 9 or 10**
- **Rehabilitation RUG rate continues from therapy end to OMRA ARD**

The OMRA **must be completed only if the beneficiary continues to have a skilled level of care** requirement after the discontinuation of therapy. The OMRA assessment reference date must be set on day 8, 9, 10 after the last day of all rehabilitation.

- Coverage continues at the Rehabilitation rate to which he or she classifies from the end of therapy until the OMRA assessment reference date.
- If the beneficiary is discharged or moved to a non-certified bed before the eighth day following the end of therapy no OMRA is required.

### ***\*Reminder***

***Always waiting to verify the stability of the beneficiary in the absence of a skilled nursing or rehabilitation is inappropriate.***

## MAKING A LEVEL OF CARE DETERMINATION

### Skilled Level of Care

A pre-requisite for coverage under the extended care benefit is the beneficiary's need and receipt of a skilled level of care and the fact that all services must be reasonable and necessary to diagnosis or treat the beneficiary's condition.

### The IFR

The IFR designated a beneficiary's correct assignment to one of the upper 26 RUG-III groups as representing a SNF level of care. *"However, this designation was never intended to supersede any of the coverage requirements related to a particular service or the overall requirement that services provided to the beneficiary be reasonable and necessary for the diagnosis or treatment of the beneficiaries illness or injury or to improve functioning of a ma formed body member."* (Transmittal 405 July 1998)

When making a coverage determination during the IFR, a clinician would make a determination as to the beneficiary's eligibility for a covered stay using the following rationale:

- The services to be initiated or to be continued are medically reasonable and necessary.
- The skilled therapy or skilled rehabilitation are ordered by a physician and rendered on a daily basis.

#### \* *Reminder*

***The requirement for daily skilled services should not be applied so strictly that it would not be met merely because there is a brief, isolated absence from the facility in a situation where discharge is not practicable e.g., holidays.***

#### **Skilled Level of Care and the IFR**

- **Correct assignment to one of the TOP 26 RUG-III Groups**
- **Receipt of reasonable and necessary services on a daily basis**

### Skilled Level of Care and the FR

- Establishes 5-Day Presumption for meeting a Skilled Level of Care

## Final Rule

The FR re-defines and further clarifies the definition of skilled care by establishing a 5-day Presumption of Coverage. It is at this period of post hospitalization when a beneficiary's condition is most unstable. This is a period of time that allows for:

- Initiation of skilled nursing or rehabilitation
- Complete assessment of the beneficiary's clinical characteristics and care needs

However, this presumption of coverage only applies if the beneficiary is receiving services that are reasonable and necessary to diagnosis or treat the beneficiary's condition.

## Definition of a 5-Day Presumption

### 5-Day Presumption

- Requires placement in Top 26 RUG-III groups
- Services must be reasonable and necessary
- Applies to Medicare 5-Day Assessment Only
- Extends from admission up to and including the ARD and grace days if utilized

"When the initial Medicare (5-Day) required assessment results in a beneficiary being correctly assigned to one of the upper 26 RUG-III groups, this effectively creates *a presumption of coverage for the period from admission up to and including the assessment reference date for that assessment.* (This presumption is valid days 1-8 (includes 3 grace days))

The coverage that arises from this presumption *remains in effect for as long thereafter as it continues to be supported by the actual facts of the beneficiary's condition or care needs, thus meeting the skilled care definition. If the services are not medically necessary a decision of non-coverage should be made.*" (HCFA 1913-F III M)

### **Determination of Skilled Care Beyond the 5 Day Presumption**

Continuation of coverage once established by the RUG-III presumption is dependent upon:

- The subsequent course of the resident's actual condition and care needs as documented in the medical record.

### **THE ADMINISTRATIVE CRITERIA AND DIRECT SKILLED SERVICE**

IFR Coverage Criteria is effective for Service Dates from 7/1/98-9/30/99

- The coverage criteria became effective on the date the individual SNF entered PPS, defined as, the SNF's first cost reporting period beginning on or after 7/1/98 through 10/1/99.

**IFR  
Coverage Criteria**

- **Applies to dates of service 7/1/98 through 9/30/99**

**Elimination's to Existing Administrative Criteria**

- **Subcutaneous Injections**
- **Hypodermoclysis**
- **Management and Evaluation of A Care Plan**
- **Observation and Assessment**

**IFR****Eliminations to the Existing Administrative Criteria:**

- Subcutaneous Injections
- Hypodermoclysis
- Overall Management and Evaluation of a Plan of Care
- Observation and Assessment of a Patient's Condition

**Modifications to Existing Criteria**

- **Levin/gastrostomy feeds require 26% daily caloric intake and min 501 ml fluid per day**
- **Patient education re-defined**

**Modifications to the Existing Administrative Criteria:**

- Use of levin tubes (e.g., naso-gastric) and gastrostomy feedings is limited to those instances where the resident receives at least 26% of their daily caloric intake requirements and at least 501 ml of fluid per day
- Patient Education Services will be re-defined under Nursing

**FR Coverage Criteria is effective for Service Dates on or after 10/1/99**

**Additions** to the Amended Administrative Criteria under the IFR:

**Additions to Existing Administrative Criteria**

- **Management and Evaluation of A Care Plan**
- **Observation and Assessment**

- Overall Management and Evaluation of a Plan of Care
- Observation and Assessment of a Patient's Condition

**Clarifications**

- The qualification of Catheters as meeting the definition of direct skilled services has been modified to Suprapubic Catheters only.

**\* Reminder**

***All other changes remain under the IFR.***

***\*See Coverage Criteria Comparison Chart.***

**Modifications to Existing Criteria**

- **Catheters have been modified to Suprapubic Catheters only**
- **Patient Education to be re-defined**

## SKILLED OBSERVATION AND ASSESSMENT OF THE RESIDENT'S CHANGING CONDITION

“Observation and assessment constitutes skilled services when the skills of a technical or professional person are required to identify and evaluate the patient’s need for modifications of treatment or for additional medical procedures until his or her condition is stabilized.” (CFR 409.33)

### Skilled Observation and Assessment

- Identification and evaluation for treatment plan modifications
- Requires skills technical or professional

#### Example A

Beneficiary with diagnosis of CHF may require continuous close observation for:

- Signs and symptoms of decompensation
- Abnormal fluid balance
- Medication side effects signaling the need for an adjustment in the medical treatment

#### Example B

Beneficiary with diagnosis of surgical hip replacement may require observation and assessment for:

- Post operative complications
- Presence of co-morbid conditions/physical problems
- Acute psychological symptoms such as depression, anxiety or agitation
- To ensure safety of resident in the case of suicidal or homicidal behaviors. *The need for these services must be documented by physicians orders or nursing/ therapy notes.*

## OVERALL MANAGEMENT OF/OR EVALUATION OF A CARE PLAN

### Management and Evaluation of a Care Plan

- **Based on a physician's order**
- **Requires management by technical or professional personnel**
- **Overall patient condition must be documented in the medical record to support the need**

The development, management and evaluation of a patient care plan based on physician orders constitutes skilled services when:

- Due to the beneficiary's physical and mental condition those activities require the involvement of technical or professional personnel to safely promote the patient's needs and promote recovery.
- Management of multiple personal care services is required when the patient's condition requires the involvement of technical or professional personnel. (Aggregate of Care)

Although a properly instructed person could perform these services the ability to understand the relationship between services and the ultimate effect of one upon the others is essential. In this circumstance the skills of a nurse are required even though the individual services themselves may not be skilled.

#### *\*Reminder*

*The overall condition must be documented in the medical record to support the finding that recovery and safety can be ensured only if the total care is planned, managed and evaluated by technical or professional personnel.*

#### Example A

Beneficiary with history Diabetes Mellitus and Angina Pectoris is recovering from an open reduction of a FX Femur requiring:

- Skin care per diabetic protocol
- Appropriate oral medications
- Diabetic diet
- Exercise program to preserve muscle tone and body condition
- Observation of signs and symptoms of complication and or deterioration as a result of restricted activity

**Patient Education**

- **For the teaching of a self-maintenance program**
- **Requires technical or professional staff**

**Patient Education Services**

Patient education services are skilled when and if the services of a technical or professional is required to teach a patient a self-maintenance program.

**Example**

Recent amputee needs skilled rehabilitative services provided by technical or professional personnel to provide the necessary gait training and prosthetic care.

## COVERAGE CLARIFICATIONS

The FR addresses general concerns and provides clarification or re-statement of the policy set-forth in the IFR. The following topics have been clarified:

### Coverage Clarifications

- **MDS Assessments**
- **Rehabilitation Services**
- **Coverage and LOC Determinations**

- MDS Assessments
- Certifications and Re-certifications
- Rehabilitation Services
- Coverage and Level of Care Determinations

## Physician Visits and Order Changes

Physician order changes and visits are indicators of a beneficiaries clinical instability.

## Physician Order Changes

The following **are not** order changes:

- Continuation or Renewal of existing orders
- Clarifications of existing orders
- Sliding scale administrations

**Physician Visits**

- **Full or partial exam at the SNF or physician's office**

**Physician Visits**

A physician visit is defined as a partial or full exam at the facility or in physician's office by the following professionals:

- MD, Osteopath, Podiatrist or Dentist
- Primary Physician or Consultant
- Authorized Physician's Assistant
- Nurse Practitioner working in collaboration with the Physician

**Rehabilitative Services**

Rehabilitative services may begin as early as day one of the Beneficiary's Part A stay. All therapeutic services must meet the following criteria to be coded in the MDS as "minutes of therapy":

- Ordered by a Physician
- Relate directly and specifically to an active written plan of treatment
- Reasonable and necessary
- Provided directly or under direct supervision of a licensed professional
- Coordinated with nursing services

**Faxed Signatures**

- **Acceptable**

**Rehabilitative Services and Faxed Signatures**

A plan of treatment signed by a physician is acceptable when faxed to the SNF. Any modifications to the original plan must be made in writing, and if done by a therapist, initialed/ signed by the ordering physician.

**Initial Evaluations**

- **Completed during Part A stay**
- **May not be counted on MDS**
- **Cost captured in the PPS Rate**

**Initial Evaluations**

The initial evaluation performed by a licensed therapist must be completed while the beneficiary is in a SNF Part A stay **and not** be an evaluation that was performed while in the inpatient facility. The time to perform such a formal evaluation and to develop treatment goals and a formalized plan may not be counted and subsequently recorded as mins of therapy on the MDS. The facility cost of doing the initial evaluation is captured in the SNF PPS rate.

**Re-evaluations** (hands on exam) that are not reflective of care plan revisions or updates performed after therapy has begun are counted in section of the MDS.

### Therapy Supervision

- **Provided by licensed staff**
- **PTA and COTA under general supervision**
- **Therapy Aides require sight of service supervision**

### Therapy Supervision

Licensed or certified therapists must provide or supervise the therapeutic service and coordinate the intervention with Nursing. PTAs (Physical Therapy Assistant) and COTAs (Certified Occupational Therapy Assistant) may provide such services under the general supervision of the professional who must be accessible while they are providing the therapeutic service.

- All supervision must be provided by a licensed professional rather than a PTA or COTA.
- A Therapy Aide must be under direct personal supervision or “in a manner which allows for visual contact at all times.”

### Therapy Minutes

- **Therapy received on seven or less days**
- **Therapy does not have to be on consecutive days**
- **RUGs represent minimum requirements**
- **Must be documented on daily attendance log**
- **A minute reflects actual treatment time**

### Minutes of Therapy

The minutes of therapy received on seven or less consecutive days must be captured for entry on the MDS and must be supported in the medical record either in the therapy progress notes and/or on the therapy daily attendance log. *Therapy days are consecutive calendar days.*

- There are no limits to be placed on services provided to a beneficiary due to the facility’s interpretations of minutes allowed by a particular RUG-III group.
- RUG-III Therapy group “minute requirements” reflects the minimum number of minutes required.

**A therapy minute** reflects actual treatment beginning with the first treatment activity or task and ends with the last procedure/apparatus completion.

- Therapeutic services performed by students are not counted.

The above stipulation was rescinded per FR on 11/04/99, effective as of 7/30/99. The following applies: Providers should record the number of minutes provided by therapy students in accordance with MDS 2.0 User Guide instructions.

- Only minutes of actual treatment received (including set-up) are counted and recorded over the “last seven days” beginning with admission from the SNF forward. If admission was less than 7 days you may not capture therapy treatments during the inpatient stay.
- Treatment minutes need not be consecutive days. Example: beneficiary received therapy 50 minutes on 2<sup>nd</sup> and the 5<sup>th</sup> day of the stay. Record this as 2 Days of PT for 100 minutes.
- Minutes recorded are “actual time” and are not to be rounded up or in increments of 10 or 15 minutes.
- PT, OT, ST provided outside the SNF may be counted and recorded on the MDS **if provided by qualified staff**. Transportation time to and from the beneficiary’s home before discharge is acceptable if the time in transport is utilized for education or discussion of the beneficiaries treatment and or goals and for beneficiary/family conferences. ( Per State Operations Manual HCFA Pub. 7, Transmittal #272 pp. R64)

### **Group Therapy**

- **4 or fewer beneficiaries**
- **May only equal 25% of weekly therapy**
- **25% applicable per discipline, e.g., ST**

### **Group Therapy**

Group therapy is clarified in the MDS 2.0, as a group of four or fewer participants per supervising therapist or therapy assistant under general supervision. The total number of minutes spent is captured individually on each group members MDS. In addition the following criteria apply:

- Group may only equal 25 % of the beneficiary's weekly therapy program
- The 25% limit is applied to each individual discipline e.g., PT, OT, ST
- Supervising Therapist may not oversee/supervise any other beneficiaries while providing group supervision.
- Section T on the MDS "Anticipated Therapy in first 14 days"

However, if the order for therapy is 10 days the minutes are captured over 10 days. In the absence of time utilize 14 days.

### **RESPIRATORY THERAPY**

The rules governing the provision of respiratory treatment were not altered by PPS implementation and are described SNF Pub. 12 Section 230.10 C.

## NOTICES OF NON-COVERAGE

A resident's acuity level may change/ decrease to where it may fall below a covered level of care even though it may not trigger a Significant Change. Once it becomes known that skilled care is no longer required, a Notice of Non-coverage must be issued, effective the following day.

This is based upon the custodial care exclusion form coverage, and takes precedence over other program provisions including any presumptions made regarding coverage.

### **Notices of Non-coverage**

- **Required When Services Are No Longer Skilled and/or Reasonable and Necessary**
- **Effective Immediately**
- **Payment Ends the Following Day**

## DEMAND BILLS

A beneficiary has the right to request a Demand Bill for services that the SNF has determined to be non-covered, by indicating his or her wish to do so on the Notice of Non-coverage issued to them. (HCFA Pub. 12, Section 356.1)

### Demand Bills

- **Required Review**
  - **Prior 7/1/98 coverage determined by Existing Administrative Criteria**
  - **After 7/1/98 coverage determined by Revised Administrative Criteria**
  - **10/1/99 and after coverage is according to the FR**
- Prior to 7/1/98, coverage is determined under the existing administrative criteria
  - 7/1/98 through 9/30/99 and upon facility entrance into PPS, coverage is determined according to the **revised** Criteria in MIM 13-3, Section 3130-3132.
  - For service dates on or after 10/1/99 coverage is determined according to the FR

#### **\*Reminder**

***There is no requirement to complete a Medicare MDS when a resident has been cut from covered care. However, ongoing monitoring should continue to assess for a change in resident condition and potential resumption in coverage if within 30 days of the last covered day. This change in condition may or may not result in a significant change.***

Detailed claim coding requirements may be found in the chapter on "Billing Principles for the FR"

## MEDICAL REVIEW PROCESS UNDER PPS

### Medical Review Coverage Criteria

- Per MIM 13-3
- HIM 12
- Program Memoranda

Medical Review of SNF PPS claims will be done in accordance with Medicare Intermediary Manual (MIM 13-3), HCFA Health Insurance Manual, Pub.12, and Program Memoranda. Until further notification medical review will be:

- Post pay
- Demand bills will continue as a Pre-Pay Review.
- Based on a **Random** and **Focused** claim selection

### Medical Record Documentation Requirements

In response to an Additional Record Request (ADR) the following documentation is required:

- All applicable Minimum Data Sets for the claim period billed
- All medical records for 30 days prior to each assessment reference date applicable to this billing period including:

Hospital Discharge Summary  
 Admission Assessment  
 Care Plans  
 Progress Notes (Nursing, Rehabilitation)  
 Intake and Output Log  
 Vital Sign Log  
 Weight Records  
 Treatment and Medication Sheets  
 and

Providers written notice(s) of denial to the beneficiary and any reinstatement notices. Include dated verification that the beneficiary or representative received notification or documentation that telephone contact was attempted.

### Medical Record Time Frame

- 30 Days Prior to Each ARD and the claim period billed

## Requirements for Coverage

In order for a claim to be covered a service must meet all three criteria below:

- |  |
|--|
| <p style="text-align: center;"><b>Medical Record</b></p> <p><b>Must Support the Following:</b></p> <ul style="list-style-type: none"><li>• <b>Level of Care requirement</b></li><li>• <b>Services documented on the MDS were delivered</b></li><li>• <b>Services delivered were Reasonable and Necessary</b></li></ul> |
|--|

- Level of care requirement as defined by the Final Rule
- Services must not be statutorily excluded
- Services must be reasonable and necessary

***\*Reminder***

***It is important to remember that the medical record must support that:***

- ***Services documented on the MDS were actually delivered***
- ***Services delivered/provided were Reasonable and Necessary for the relevant assessment period.***

## Review of the 5-Day Presumptive Period

The services provided and received during this initial presumptive period must be as follows:

- Reasonable and necessary to diagnose and or treat the beneficiary's condition
- Meet level of care requirements

### **Continued Coverage Decisions (After the 5-Day Presumption)**

Continued coverage after the 5-Day Presumption is based on the determination of the continued need for, and receipt of, a skilled level of care. This will be based on the following:

- Beneficiary's overall clinical status and needs for the dates of service in review.

### **Medical Review Decisions**

All medical review decisions are made on the basis of medical documentation from the provider. The provider must demonstrate in their documentation the medical necessity of the services provided. There are 4 potential decisions listed below.

1. Services were documented and medically reasonable and necessary.

***The claim is approved for payment.***

2. Rehabilitation RUG-III Groups

- If Rehabilitation is Reasonable and Necessary but, not at the level billed, the claim will be adjusted according to a decision matrix (see appendix "MR Decision Matrix")
- If Rehabilitation services are not Reasonable and Necessary, the clinical group is determined by assessing the presence of clinical conditions and or services and adjusted according to the decision matrix.

***Provider is held liable in both cases***

#### **Medical Review Decisions**

- **Based on Provider documentation**
- **Must demonstrate medical necessity**

3. No Documentation of Services being Rendered

***Claim is denied in Full or part of the entire payment period***

***Provider is held liable***

4. Lower 18 RUG-III Groups

- If they meet SNF Level of Care

***The claim is approved for payment***

- If they **do not meet** the SNF level of care

***The claim is denied for the entire assessment payment period***

***Provider is held liable.***

**Notices of Non-coverage**

- **Issued on the date the medical record no longer supports a skilled level of care**  
OR
- **When the services rendered do not meet the medical necessity criteria**

**NOTICES OF NON-COVERAGE**

Under the FR when the documentation no longer supports the need for and receipt of a skilled level of care a decision of non-coverage is made and applied as of that date.

## MEDICARE SUMMARY NOTICES (MSN)

The following chart represents the Beneficiary's message on the MSN, and the applicable provider ANSI Reason Code on the Remittance Advice

<b>Insufficient Information Denial</b>	<b>MSN 9.2</b> "The item/service was denied because information required to make payment was missing"	<b>ANSI B12</b> "Claim denied charges" and "Services not documented in patient's medical records"
<b>Partial Payment at Reduced Rate(Matrix)</b>	<b>MSN 15.8</b> "The information provided does not support the level of service as shown on the claim."	<b>ANSI 57</b> " Claim denied charges" and "the claim/service denied/reduced because the payor deems the information submitted does not support this level of service/this many services/this length of service or this dosage."
<b>Full Denial as Not Medically Reasonable and Necessary</b>	<b>MSN 13.3 or 13.4</b> "Information provided does not support the need for skilled nursing facility care" or "Information provided does not support the need for continued care in a skilled nursing facility."	<b>ANSI 50</b> "Claim charges denied" and "These are non-covered services because this is not deemed a medical necessity by the payor."
<b>Demand Bill Agrees With Provider's Determination of Non-coverage</b>	<b>MSN 16.42</b> "The provider's determination of non-coverage is correct."	<b>ANSI 50</b> "These are non-covered services because this is not deemed a medical necessity by the payor."
<b>Agree With Non-coverage But the Provider Failed to Issue Proper or Timely Notice</b>	<b>MSN 36.2</b> "It appears that you did not know that we would not pay for this service, so you are not liable. Do not pay your provider for this service. If you have paid your provider for this service, you should submit to this office three things: a copy of this notice, your provider's bill, a receipt or proof that you have paid the bill."	<b>ANSI 116</b> "Claim/service denied. The advance indemnification notice signed by the patient did not comply with requirements."
<b>Improper Placement in a Non-Certified Bed</b>	<b>MSN 13.7</b> "Normally, care is not covered when provided in a bed that is not certified by Medicare. However, since you received covered care, we have decided that you will not have to pay the facility for anything more than Medicare coinsurance and non-covered items."	<b>ANSI 116</b> "Claim /service denied. The advance indemnification notice signed by the patient did not comply with requirements."
<b>Billing Error</b>	<b>MSN 9.4</b> "This item or service was denied because information required to make payment was incorrect."	<b>ANSI A1</b> "Claim Denied Charges"

## MEDICAL REVIEW DECISION MATRIX

### MATRIX A

RUG Category Billed:	Adjust To:
Rehabilitation RUC, RVC, RHC	RMC
Rehabilitation RUB, RVB, RHB	RMB
Rehabilitation RUA, RVA, RHA	RMA
Rehabilitation RMC	RLB
Rehabilitation RMB, RMA	RLA

Note: The adjusted RUG codes in the above matrix, were determined by selecting the RUG code in the medium rehabilitation service category that most clearly matched the billed ADLs. Services billed in the Medium Rehabilitation category were reduced to Low Rehabilitation.

### MATRIX B

RUG Category Billed:	Adjust To:				
	Extensive Services	Special Care	Clinically Complex	Lower 18	Not R and N and NO Qualifying Clinical Condition
Rehabilitation RUC,RVC,RHC,RMC,RBL	SE1	SSC	CC1	PA1	DENY
Rehabilitation RUB,RVB,RHB,RMB	SE1	SSA	CB1	PA1	DENY
Rehabilitation RUA,RVA,RHA,RMA,RLA	X	SSA	CA1	PA1	DENY
EXTENSIVE SERVICES SE3,SE2,SE1	X	SSA	CA1	PA1	DENY
SPECIAL CARE SSC	X	X	CC1	PA1	DENY
SPECIAL CARE SSB	X	X	CB1	PA1	DENY
SPECIAL CARE SSA	X	X	CA1	PA1	DENY
CLINICALLY COMPLEX CCE,CC1,CB2,CB1CA2, CA1	X	X	X	PA1	DENY
ALL LOWER 18 RUG-III GROUPS	X	X	X	PA1	DENY

Note: The adjusted RUG codes in the above matrix were determined by selecting the rug code for each category that closely matched the ADL index of the billed rug code. When the ADL index was the same for the entire category the lowest RUG code in the category was selected. In some cases, the adjusted RUG code may fall into a different category than was selected when using the MDS 2.0 RUG-III Codes.

## MEDICARE ASSESSMENT SCHEDULE

DAY 1= Admission or Re-Admission

<b>Medicare Assessment Schedule</b>	<b>Assessment Reference Date</b>	<b>Reason For Assessment #AA8b MDS 2.0 Users Guide</b>	<b>Applicable Medicare Payment Days</b>
DAY 5 Comprehensive* <b><i>May be completed OR at day 14</i></b>	Days 1-5	1 Medicare 5-Day Assessment	1-14
DAY 14 Comprehensive	Days 11-14	7 Medicare 14 Day	15-30
DAY 30 Full	Days 21-29	2 Medicare 30 Day	31-60
DAY 60 Full	Days 50-59	3 Medicare 60 Day	61-90
DAY 90 Full	Days 80-89	4 Medicare 90 Day	91-100

**\*If a resident expires or transfers to another facility before day 8 an MDS is prepared as completely as possible allowing for RUG classification and Medicare payment purposes.**

- \* Full Assessment = Entire MDS
- \* Comprehensive Assessment = MDS + RAPs

## MDS2.0 RUG III Codes

CATEGORY	ADL INDEX	END SPLITS	MDS RUG III CODES
<b>REHABILITATION</b>			
<b>ULTRA HIGH</b> Rx 720 minutes a week minimum At least 2 disciplines, 1st -5 days, 2nd - at least 3 days	16-18 9-15 4-8	NOT USED NOT USED NOT USED	RUC RUB RUA
<b>VERY HIGH</b> Rx 500 minutes a week minimum At least 1 discipline - 5 days	16-18 9-15 4-8	NOT USED NOT USED NOT USED	RVC RVB RVA
<b>HIGH</b> Rx 325 minutes a week minimum 1 discipline 5 days a week	13-18 8-12 4-7	NOT USED NOT USED NOT USED	RHC RHB RHA
<b>MEDIUM</b> Rx 150 minutes a week minimum 5 days across 1, 2 or 3 disciplines	15-18 8-14 4-7	NOT USED NOT USED NOT USED	RMC RMB RMA
<b>LOW Nrsng. Rehab 6 days</b> in at least 2 activities and Rehabilitation therapy Rx 3 days/ 45 minutes a week minimum	14-18 4-13	NOT USED NOT USED	RLB RLA
<b>EXTENSIVE SERVICES</b> - (if ADL <7 classifies to Special Care) IV feeding in the past 7 days (K5a) IV medications in the past 14 days (P1ac) Suctioning in the past 14 days (P1ai) Tracheostomy care in the last 14 days (P1aj) Ventilator/respirator in the last 14 days (P1ai)	7-18 7-18 7-18	new grouping: count of other categories code into plus IV Meds + Feed	SE3 SE2 SE1
<b>SPECIAL CARE</b> -- (if ADL <7 classifies to Clinically Complex) Multiple Sclerosis (I1w) and an ADL score of 10 or higher Quadriplegia (I2z) and an ADL score of 10 or higher Cerebral Palsy (I2s) and an ADL score of 10 or higher Respiratory therapy (P1bdA must = 7 days) Ulcers, pressure or stasis; 2 or more of any stage (M1a,b,c,d) and treatment (M5a, b,c,d,e,g,h) Ulcers, pressure; any stage 3 or 4 (M2a) and treatment (M5a,b,c,d,e,g,h) Radiation therapy (P1ah) Surgical, Wounds (M4g) and treatment (M5f,g,h) Open Lesions (M4c) and treatment (M5f,g,h) Tube Fed (K5b) and Aphasia (I1r) and feeding accounts for at least 51 percent of daily calories (K6a=3 or 4) OR at least 26 percent of daily calories and 501cc daily intake (K6b=2,3,4 or 5) Fever (J1h) with Dehydration (J1c), Pneumonia (Ie2), Vomiting (J1o) or Weight loss (K 3a) Fever (J1h) with Tube Feeding (K5b) and, as above, (K6a=3 or 4) and/or (K6b = 2,3,4,or 5)	17-18 15-16  7-14	NOT USED NOT USED  NOT USED	SSC SSB  SSA

CATEGORY	ADL INDEX	END SPLITS	MDS RUG III CODES
<b>CLINICALLY COMPLEX --</b> Burns (M4b) Coma (B1) <u>and</u> Not awake (N1 = d) <u>and</u> completely ADL dependent (G1aa, G1ba, G1ha, G1ia = 4 or 8) Septicemia (I2g) Pneumonia (I2e) Foot / Wounds (M6b,c) <u>and</u> treatment (M6f) Internal Bleed (J1j) Dialysis (P1ab) Tube Fed (K5b) and feeding accounts for: at least 51% of daily calories (K6a = 3 or 4) OR 26% of daily calories and 501cc daily intake (K6b = 2, 3, 4 or 5) Dehydration (J1c) Oxygen therapy (P1ag) Transfusions (P1ak) Hemiplegia (I1v) and an ADL score or 10 or higher Chemotherapy (P1aa) Physician Visits and order changes (No. Of Days in last 14 that they occurred visits >=1 days and order changes >=4 days; or visits >=2 days and order changes on >=2 days) Diabetes mellitus (I1a) and injections on 7 days (O3 >= 7) <u>and</u> order changes >=2 days (P8 >= 2)	17-18D 17-18 12-16D 12-16 4-11D 4-11		CC2 CC1 CB2 CB1 CA2 CA1
<b>IMPAIRED COGNITION</b> Score on MDS2.0 Cognitive Performance Scale >= 3	6-10 6-10 4-5 4-5	Nursing Rehabilitation* not receiving Nursing Rehabilitation not receiving	IB2 IB1 IA2 IA1
<b>BEHAVIOR ONLY</b> Coded on MDS 2.0 items: 4+ days a week - wandering, physical or verbal abuse, inappropriate behavior or resists care; or hallucinations, or delusions checked	6-10 6-10 4-5 4-5	Nursing Rehabilitation* not receiving Nursing Rehabilitation not receiving	BB2 BB1 BA2 BA1
<b>PHYSICAL FUNCTION REDUCED</b> No clinical conditions used	16-18 16-18 11-15 11-15 9-10 9-10 6-8  6-8 4-5 4-5	Nursing Rehabilitation* not receiving Nursing Rehabilitation not receiving Nursing Rehabilitation not receiving Nursing Rehabilitation not receiving Nursing Rehabilitation not receiving Nursing Rehabilitation not receiving	PE2 PE1 PD2 PD1 PC2 PC1 PB2  PB1 PA2 PA1
			Default

\*To qualify as receiving Nursing Rehabilitation, the rehabilitation must be in at least 2 activities, at least 6 days a week. As defined in the Long Term Care RAI Users Manual, Version 2 activities include: Passive or Active ROM, amputation care, splint or brace assistance and care, training in dressing or grooming, eating or swallowing, transfer, bed mobility or walking, communication, scheduled toileting program or bladder retraining



COMPARISON AND RATIONALE FOR ELIGIBILITY AND COVERAGE CHANGES

TECHNICAL ELIGIBILITY

PRIOR TO 7/1/98	IFR 7/1/98-9/30/99	FR 10/1/99 and After
3 Day Qualifying Stay	----->	----->
Transferred Within 30 Days of Hospital Stay of 3 Consecutive days	----->	----->
Physician Certification Need Skilled Care (Admission/by Day 14& q30 days thereafter)	Physician, Nurse Practitioner or Clinical Nurse Specialist <i>may initially</i> Certify to the Need for Skilled Care <i>or</i> Correctness of the RUG III <b>Re-certifications</b> are for the ongoing need skilled services ----->	----->
Medical Predictability (Continuation Rx is inappropriate from a Medical perspective	----->	----->
Treated for a condition which was treated during qualified stay <i>or</i> ...which arose while in a SNF for a treatment of condition for which the beneficiary previously was treated in a hospital	----->	----->

Eligibility Chart

**COVERAGE ELIGIBILITY**

<p><b>SKILLED NURSING OR SKILLED REHABILITATION ON A DAILY BASIS</b></p>	<p>-----&gt;</p>	<p>-----&gt;</p>
<p><b>PERFORMED BY OR UNDER DIRECT MDSUPERVISION</b></p>	<p>-----&gt;</p>	<p>-----&gt;</p>
<p><b>MANAGEMENT EVALUATION PLAN OF CARE</b></p>	<p>-----&gt;</p>	<p>-----&gt;</p>
<p><b>OBSERVATION AND ASSESSMENT PLAN OF CARE</b></p>	<p>-----&gt;</p>	<p>-----&gt;</p>
<p><b>TEACHING AND TRAINING ACTIVITIES</b> <i>To teach self maintenance</i></p> <ul style="list-style-type: none"> <li>• Self Injection</li> <li>• Newly Diagnosed Diabetic Insulin INJ/Diet/Observation Foot Care Precautions</li> <li>• Gait Training and Prosthesis Care</li> <li>• Recent colostomy/ileostomy care</li> <li>• Self Catheterization and Self GT feedings Care and Maintenance CVP's/Hickman Catheters</li> <li>• Care of Braces, Splints, Orthotics Associated Skin Care</li> <li>• Specialized dressings or skin treatment</li> </ul>	<p>-----&gt;</p>	<p>-----&gt;</p> <p>Requires Skills of a Technical/Professional for the teaching of a self maintenance program</p>

**COVERAGE ELIGIBILITY (continued)**

DIRECT SKILLED SERVICES		
<ul style="list-style-type: none"> <li>• IV, IM, SC Injections</li> </ul>	<p>MODIFIED TO : IV, IM Injections ELIMINATED: SC</p>	<p>IV, IM Injections</p>
<ul style="list-style-type: none"> <li>• Hypodermoclysis, IV feedings</li> </ul>	<p><b>MODIFIED: IV Feedings ELIMINATED:</b> <b>Hypodermoclysis</b></p>	<p>IV Feedings</p>
<ul style="list-style-type: none"> <li>• NG tube, Gastrostomy, Jejunostomy</li> <li>• Naso-Pharyngeal Tracheotomy aspiration</li> </ul>	<p><b>MODIFIED TO: Feedings 26% of QD calories and minimum of 501 ml fluid per day</b></p>	<p>Feedings 26% of QD calories and Minimum of 501 ml fluid per day</p>
<ul style="list-style-type: none"> <li>• Insertion, sterile irrigation, replacement catheters/care of suprapubic catheter and insertion /care of catheter adjunct to active rx of a disease</li> <li>• Application of Dressings with Prescription Meds and Aseptic Techniques</li> <li>• Treatment decubitus ulcers. Severity grade 3 or worse or wide spread skin disorder</li> <li>• Heat RX's ordered by MD requiring skilled observation</li> <li>• Rehabilitation Nursing procedures includes related teaching adaptive aspects of nursing and part of active treatment necessitating skilled nursing e.g., institution bowel and bladder training programs</li> <li>• Initial regimen involving administration medical gases such as bronchodilator therapy</li> <li>• Care of a colostomy /early post-op phase with associated complications</li> </ul>	<p>MODIFIED TO: Suprapubic Catheters Only</p>	<p>MODIFIED TO: Suprapubic Catheters Only</p>

**SKILLED REHABILITATION**

<p><b>SKILLED PHYSICAL THERAPY</b></p> <ul style="list-style-type: none"> <li>• Directly related written plan of treatment</li> <li>• Requires knowledge/skills/ judgment of qualified professional</li> <li>• Services must be considered under acceptable standards clinical practice</li> <li>• Expectation of improvement of restorative potential in a reasonable and predictable period of time.....or.....</li> <li>• Establishment of a safe and effective maintenance program</li> </ul> <p><b>Applications</b></p> <ul style="list-style-type: none"> <li>• Hot Packs Hydrocollator infra red, Paraffin Baths</li> <li>• Only in presence complicating condition e.g., open wounds</li> <li>• Gait Training</li> <li>• Ultrasound, Short-wave, Diathermy</li> <li>• ROM Tests</li> <li>• Therapeutic exercises</li> </ul>	<p>Skilled Rehabilitation Services are captured within the RUG III Rehabilitation groups</p> <p>-----&gt;</p>	<p>-----&gt;</p>
<p><b>SKILLED OCCUPATIONAL THERAPY</b></p> <ul style="list-style-type: none"> <li>• Ordered by a Physician</li> <li>• Improve or Restore Function</li> </ul> <p><b>Applications</b></p> <ul style="list-style-type: none"> <li>• Eval/ Re-Eval of Function</li> <li>• Teaching task oriented therapeutic activities</li> <li>• Plan/ Implement/Supervise individualized therapeutic activities and sensory integration functions</li> <li>• Testing of compensatory techniques</li> <li>• Design/fabrication and fitting orthotic or self help devices</li> <li>• Vocational Pre-vocational Assessment and training</li> </ul>	<p>Skilled Rehabilitation Services are captured within the RUG III Rehabilitation groups</p> <p>-----&gt;</p>	<p>-----&gt;</p>

**SKILLED REHABILITATION (continued)**

<p><b>SPEECH THERAPY</b></p> <ul style="list-style-type: none"> <li>• Directly related written plan of treatment</li> <li>• Requires knowledge/skills/ judgment of qualified professional</li> <li>• Services must be considered under acceptable standards clinical practice</li> <li>• Expectation of improvement restorative potential in a reasonable and predictable period of time</li> </ul> <p style="text-align: center;">or</p> <ul style="list-style-type: none"> <li>• establishment of a safe and effective maintenance program</li> <li>• Services necessary for diagnosis and treatment speech and language disorders</li> </ul> <p><b>Applications</b></p> <ul style="list-style-type: none"> <li>• Restoration therapy</li> <li>• Establishment Maintenance program</li> <li>• Diagnostic and Evaluation services</li> <li>• Therapeutic Services</li> <li>• Services treatment dysphagia</li> </ul>	<p style="text-align: center;"><i>Skilled Rehabilitation Services are captured within the RUG III Rehabilitation groups</i></p> <p style="text-align: center;">-----&gt;</p>	<p style="text-align: center;">-----&gt;</p>
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# Skilled Nursing Facility Prospective Payment System Billing Principles Per Final Rule

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## BILLING PRINCIPLES PER FINAL RULE

Billing guidelines for SNF PPS modify the existing rules in the SNF manual (HCFA PUB. 12) Section 500 – 600 to meet requirements of the Balanced Budget Act of 1997. The Final Rule (FR) which was published on August 28, 1999 clarified the coverage and billing criteria for SNF PPS.

### Payment and Billing Changes Per FR

<b>Financial and billing changes per final rule</b>
---

- New PRICER effective 10/1/99
  - federal rates modified
  - wage indexes modified
- Recalculate Payment Sheets
  - ALL SNFs should recalculate payment masters for reimbursement for dates of service 10/1/99 – 12/31/99
    - Use current provider specific rate, with new federal rates
- New fee schedule for therapy services 01/01/00
- BBRA (11/99) provided a Part B “add on” for demo facilities
- New blend year begins with new cost report year on or after 7/1/99
- New facility specific rate issued at the start of each new cost report year during the PPS transition
- **No** major changes in the billing instructions per the FR, but several clarifications were made for the billing of demand bills, MSP, Leave of Absence, HMO, and Hospice claims

**Traditional claim coding requirements unchanged by PPS**

**Claim Coding Requirements That Remain Unchanged by the Final Rule**

- HCFA 1450 claims are submitted to the FI on a 30 day schedule (monthly billing)
- Part A claims must be submitted in sequential order per each admission date **including no pay discharge claims**
- Maximum number of covered Part A SNF days in a benefit period is 100
- Field assignments on HCFA 1450 have not been modified in length
- HCPCS are **not** required on Part A claims for ancillary services
- When a beneficiary is no longer covered by Part A benefits in the SNF, Part B claims may be submitted to FI for ancillary services per SNF manual (HCFA PUB. 12) Section 260

**SNF PPS coding requirements**

**PPS Required Billing Codes**

- **Revenue Code 0022** for each assessment affecting the billing period
- **HIPPS** (health insurance prospective payment rate) code in field locator (FL) 44
- **Assessment Reference Date (ARD)** of the MDS in FL 45
- **Number of Covered Days (Units)** in FL 46 for each HIPPS code billed
- **Accommodation information** (revenue code + rate x days =charges)

## FACTORS WHICH EFFECT THE BILLING OF SNF PPS CLAIMS

### Relationship Between the Assessment and the Claim

SNF PPS establishes a schedule of Medicare assessments. The schedule is followed throughout a beneficiary's stay and is interrupted only by discharge, a change in level of care or the end of technical eligibility. The Medicare assessment chart indicates the maximum number of days that can be billed per each assessment.

### Timing of the Assessments

An assessment schedule for each eligible Medicare resident begins with each:

- On admission
- On readmission
- On **day one of Medicare coverage** (following an MSP period, following a “**cut**” period of less than 30 days, following a physician's **hold** period due to medical predictability)

**When to begin a Medicare assessment schedule**

### ASSESSMENT REFERENCE DATES (ARD)

- The ARD is the end of the observation period for scoring clinical information on the MDS 2.0. The date is set by the clinical staff and entered on line A3 of the MDS.
- The ARD must be accurately conveyed to the billing staff in order to correctly complete a UB-92 for the service period.

**ARD and the claim**

**Reporting the Assessment Reference Date (ARD) on the Claim**

- Each assessment **must** have an ARD
- The **ARD** reported on the claim in FL 45 **must match** the date on the MDS document  
**SECTION A3**
  - If it does **not** match, the FI may return the claim to provider (on prepay demand bills) or cancel payment (on a post pay review).
  - Failure to code this date correctly results in an improperly billed claim and **no** Medicare payment may be made.
  - ARD is **required** on all HIPPS lines **except** when billing the default code (AAA00).

**Regular Medicare assessment schedule**

**The Regular Assessment Schedule and Billable Days for Resident with Full Benefits in an Uninterrupted Stay**

- Day 5 assessment provides a billing code for day 1 – 14
- Day 14 assessment provides a billing code for day 15 – 30
- Day 30 assessment provides a billing code for day 31 – 60
- Day 60 assessment provides a billing code for day 61 – 90
- Day 90 assessment provides a billing code for day 91 – 100

**See Assessment Schedule Table**

## PAYMENT SCHEDULE

### Correct Coding of Claims Based on Payment Schedule

**Billing the payment blocks**

- Bill for **entire block** of payment period **unless**:
  - benefits exhaust
  - patient discharges/dies/transfers
  - there is a change in level of care to
  - non-skilled
  - there is a change in medical condition requiring an OMRA or SCSA
  
- **Split** bills based on calendar month, not on payment blocks
  
- **Change** HIPPS codes for each regular assessment at the **beginning of the payment block** , unless it is an **OMRA** or **SCSA** – these HIPPS codes **change with the ARD** of that special assessment
  
- Remember to **“restart”** the assessment schedule for readmits and for beneficiaries who return to skilled care following a “cut”
  - use the proper modifier to reflect which assessment is being billed
  
  - When the schedule starts over, the benefit period does not start anew unless there has been a break in spell of illness

## MODIFIERS

**Nineteen (19) valid modifiers** define the type of Medicare assessment completed (see chart). Modifiers must accurately reflect which assessment is being used to bill the RUG group for Medicare reimbursement. The modifier will validate the **type of assessment** and the **length of time (days) allowed for payment** under SNF PPS for that assessment.

**Modifiers – the right information for the claim**

### Correct Claim Coding Using Modifiers

- **Clinical** staff must determine the modifier and pass this information to the billing staff.
- Any **incorrectly** assigned modifier can result in an incorrectly billed claim.
  - Incorrectly billed claims will either be RTP'd (on prepay demand bill review) or payment canceled (on postpay medical review).
  - **Future edits** will RTP claims with incorrect modifiers.
- Modifiers (selected from allowed listing) **must match** the reason for Medicare assessment in **AA8b of MDS** even though the modifier is not chosen from that MDS section.
  - **Do not add AA8a + AA8b** (from MDS) together to get modifier code.
  - **Do** take the **reason for assessment in AA8b** and select the proper code for the claim **from the Medicare list of approved modifiers**.

## 5-DAY PRESUMPTION OF COVERAGE

### Billing for “ Presumption of Coverage” at Day 5 Assessment

**Billing under  
presumption of  
coverage on the 5-day  
assessment**

- FR establishes “presumption of coverage” through the **ARD** of the 5-day assessment
- The clinical staff must make the coverage decision by the 5-day ARD
- Clinical staff will determine if notice of non-coverage if necessary
- **Provide the billing department** with the HIPPS code and dates of service that may be billed to Medicare
- If SNF resident is **no longer receiving skilled care** by ARD of day 5 assessment, Medicare can only be billed from admit date through ARD
  - Code claim with Occurrence Code 22 = to the ARD

Example 1: Patient admitted on 11/1/99

- ARD set for 11/6
- RUG code from assessment = CC1
- Per clinical perspective, resident is **no** longer receiving skilled services on ARD
- Bill 6 covered days (11/1 – 11/6)
- Occurrence Code 22 = 11/6

Example 2: Patient admitted on 11/1/99

- ARD set for 11/6
- RUG code from assessment = CC1
- Per clinical perspective, resident **is** receiving daily skilled services Bill 14 covered days (11/1 – 11/14)

2 <b>Skilled Nursing Facility</b>		3 PATIENT CONTROL NO. <b>12345</b>										C4 TYPE OF BILL <b>212</b>											
		5 FED. TAX NO.		8 STATEMENT COVERS PERIOD FROM: <b>110199</b> THROUGH: <b>110699</b>		7 COV D. <b>6</b>	8 N-C.D.	9 C-I.D.	10 L-R.D.	11													
12 PATIENT NAME <b>Barbara A. Griffin</b>												13 PATIENT ADDRESS <b>400 S. Salina St. Syracuse, N.Y. 13221</b>											
14 BIRTHDATE <b>02251925</b>		15 SEX <b>F</b>	16 MS	17 DATE <b>110199</b>		ADMISSION 18 HR: 19 TYPE: 20 SRC:		21 D HR	22 STAT	23 MEDICAL RECORD NO. <b>123456</b>			24-30 CONDITION CODES			31							
32 OCCURRENCE CODE: <b>22</b> DATE: <b>110699</b>		33 OCCURRENCE CODE: DATE:		34 OCCURRENCE CODE: DATE:		35 OCCURRENCE CODE: DATE:		36 OCCURRENCE SPAN CODE: FROM: <b>70</b> THROUGH: <b>110199</b>		37			A			B:	C:						
38												39 VALUE CODE CODE: AMOUNT:		40 VALUE CODES CODE: AMOUNT:		41 VALUE CODES CODE: AMOUNT:		a	b	c	d		
42 REV. CD.	43 DESCRIPTION			44 HCPCS/RATES		45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES		49											
<b>0022</b>				<b>CC101</b>		<b>1106</b>	<b>6</b>	<b>0</b>															
<b>0120</b>				<b>25000</b>			<b>6</b>	<b>1200 00</b>															
<b>0250</b>								<b>150 00</b>															
<b>0001</b>								<b>1350 00</b>															
50 PAYER <b>Medicare</b>				51 PROVIDER NO. <b>XX5XXX</b>				52 REL INFO	53 ASG BRN	54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56									
57 <b>DUE FROM PATIENT ▶</b>																							
58 INSURED'S NAME <b>Griffin, Barbara</b>				59 P REL <b>01</b>	60 CERT.-SSN-HIC-ID NO. <b>123456789A</b>				61 GROUP NAME		62 INSURANCE GROUP NO												
63 TREATMENT AUTHORIZATION CODES			64 ESC	65 EMPLOYER NAME				66 EMPLOYER LOCATION															
67 PRIN. DIAG. CD. <b>480.9</b>	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78												
79 P.C.	80 PRINCIPAL PROCEDURE CODE: DATE:		81 OTHER PROCEDURE CODE: DATE:		OTHER PROCEDURE CODE: DATE:		82 ATTENDING PHYSICIAN <b>812345 GUDDEN G</b>																
	OTHER PROCEDURE CODE: DATE:		OTHER PROCEDURE CODE: DATE:		OTHER PROCEDURE CODE: DATE:		83 OTHER PHYSICIAN																
84 REMARKS <b>Presumption of Coverage - Beneficiary "non-skilled" by ARD of 5 Day Assessment</b>												85 PROVIDER REPRESENTATIVE	86 DATE										

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I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART

## DEMAND BILLS

Demand bills must be sent to the FI **any** time the beneficiary requests the SNF to do so. The beneficiary makes this request by marking the box on the notice of non-coverage that requires a claim to be billed. Demand bills must be submitted even in cases of technical ineligibility. The FI will handle those cases differently because **no** medical review is necessary when the patient is not technically eligible for Part A reimbursement.

**Coding for demand bills**

### Claim Coding for Demand Bills

- There must be a **valid HIPPS code** on the claim.
- For SNF residents that have Part A days available to use, there must be a separate HIPPS code on the claim for **each block of time** that would have been represented by a new Medicare required assessment.
  - For a **technically ineligible beneficiary** (no qualifying hospital stay, benefits exhaust, etc.) you may use the default code **AAA00**.
- The minimum requirement is to bill from the first non-covered day to the end of the billing period.
- Medical review will be **pre-pay** for beneficiaries who have Part A days to use (see clinical chapter for documentation requirements).
- Do **not** attach medical information to the paper claim or enter clinical information on page 7 of the electronic.
- Submit the claim with non-covered days, non-covered charges, and HIPPS code line units = 0.

**Use default code ONLY when NO MDS was completed**

## Demand Bills Following MR Review to Uphold SNF Decision of Non-coverage

- **Beneficiary Liability Assigned**
  - Beneficiary must make payment for continued stay even if appeal is filed
  - Subsequent requests for demand bills must be sent and SNF should notify FI if the patient is now technically ineligible due to 30 days of non-coverage (use remarks screen)
  - If non-coverage on previous demand bill is less than 30 days, the subsequent demand bill must be reviewed according to normal procedure for technically qualified resident
- **Provider Liability Assigned**
  - Decision may be appealed
  - Provider may **not** bill the resident for dates of provider liability

**What next?  
Billing when FI upholds  
SNF decision of  
non-coverage**

## Demand Bills Following MR Review to Overturn and Pay SNF for Covered Care on a Demand Bill

- Submit subsequent claims **non-covered** following all the billing requirements (HIPPS Codes, ARD, etc.).
- For technically eligible residents (with benefit days available), SNF may **not** bill the resident until the medical review decision is made.

**What next?  
Billing when FI  
overturns SNF decision  
of non-coverage and  
pays the claim**

2														3 PATIENT CONTROL NO.				04 TYPE OF BILL				
Skilled Nursing Facility														12345				212				
5 FED. TAX NO.				6 STATEMENT COVERS PERIOD FROM				7 COV D.		8 N-C-D.	9 C-I-D.	10 L-R-D.	11									
				090199 093099						30												
12 PATIENT NAME										13 PATIENT ADDRESS												
Baarbara A. Griffin										400 S. Salina St. Syracuse, N.Y. 13221												
14 BIRTHDATE		15 SEX	16 MS	17 DATE		18 HR	19 TYPE	20 SRC	21 D HR		22 STAT	23 MEDICAL RECORD NO.			24	25	26	27	28	29	30	31
02251925		F		090199					30			123456			20							
32 OCCURRENCE CODE		33 OCCURRENCE DATE		34 OCCURRENCE CODE		35 OCCURRENCE DATE		36 OCCURRENCE CODE		36 OCCURRENCE THROUGH		37										
70								082599		090199		A										
												B										
												C										
38										39 VALUE CODE CODE		40 VALUE CODES CODE		41 VALUE CODES CODE								
										a		b		c		d						
42 REV. CD.	43 DESCRIPTION										44 HCPCS/RATES		45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES		49			
0022											BA101		090599	0	0							
0022											BA107		091499	0	0							
0120											25000			30	7500 00		7500 00					
0001															7500 00		7500 00					
50 PAYER					51 PROVIDER NO.					52 REL INFO		53 ASG BEV	54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56					
Medicare					XX5XXX																	
57										DUE FROM PATIENT ▶												
58 INSURED'S NAME					59 P. REL	60 CERT. -SSN-HIC-ID NO.					61 GROUP NAME			62 INSURANCE GROUP NO								
Griffin, Barbara					01	123456789A																
63 TREATMENT AUTHORIZATION CODES			64 ESC	65 EMPLOYER NAME					66 EMPLOYER LOCATION													
67 PRIN. DIAG. CD.	68 code	69 code	70 code	71 code	72 code	73 code	74 code	75 code	76 ADM. DIAG.	77 E-CODE	78											
331.0																						
79 P.C.	80 PRINCIPAL PROCEDURE CODE		81 OTHER PROCEDURE CODE		OTHER PROCEDURE CODE		OTHER PROCEDURE CODE		82 ATTENDING PHYS. ID													
									B12345 GLIDDEN G													
									83 OTHER PHYS. ID													
									84 OTHER PHY													
84 REMARKS										85 PROVIDER REPRESENTATIVE		86 DATE										
DEMAND BILL - Beneficiary is Eligible But Does Not Meet Medical Level of Care for Coverage										X												

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I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART

Empire Medicare Services Addendum to Blue Cross Blue Shield Association SNF PPS Manual October 1999

2		3 PATIENT CONTROL NO.										03 TYPE OF BILL		
Skilled Nursing Facility		12345										212		
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM		THROUGH		7 COV D.	8 N-C.D.	9 C-I.D.	10 L-R.D.	11				
		090199		093099			30							
12 PATIENT NAME						13 PATIENT ADDRESS								
Baarbara A. Griffin						400 S. Salina St. Syracuse, N.Y. 13221								
14 BIRTHDATE	15 SEX	16 MS	17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24 CONDITION CODES				
02251925	F		090199				30		123456	20				
32 OCCURRENCE CODE		33 OCCURRENCE DATE		34 OCCURRENCE CODE		35 OCCURRENCE DATE		36 OCCURRENCE SPAN FROM		THROUGH				
								70		082599 090199				
38						39 VALUE CODE		40 VALUE CODES		41 VALUE CODES				
						CODE AMOUNT		CODE AMOUNT		CODE AMOUNT				
						a		b		c				
						d								
42 REV. CD.	43 DESCRIPTION			44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49					
0022				AAA00		0	0							
0120				25000		30	7500.00	7500.00						
0001							7500.00	7500.00						
50 PAYER				51 PROVIDER NO.		52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS		55 EST. AMOUNT DUE				
Medicare				XX5XXX										
57						DUE FROM PATIENT ▶								
58 INSURED'S NAME				59 P.REL	60 CERT.-SSN-HIC-ID NO.		61 GROUP NAME		62 INSURANCE GROUP NO					
Griffin, Barbara				01	123456789A									
63 TREATMENT AUTHORIZATION CODES			64 ESC	65 EMPLOYER NAME			66 EMPLOYER LOCATION							
67 PRIN.DIAG.CD.		68 CODE	69 CODE	70 CODE	OTHER DIAG. CODES		71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78
436														
79 P.C.	80 PRINCIPAL PROCEDURE CODE		DATE		81 OTHER PROCEDURE CODE		DATE		OTHER PROCEDURE CODE		DATE		82 ATTENDING PHYS:ID	
													812345 GUDEN G	
	OTHER PROCEDURE CODE		DATE		OTHER PROCEDURE CODE		DATE		OTHER PROCEDURE CODE		DATE		83 OTHER PHYS:ID	
84 REMARKS												85 PROVIDER REPRESENTATIVE		86 DATE
DEMAND BILL - Patient Benefits Exhaust on Prior Stay												X		
Use of DEFAULT Code - When Resident is Technically Ineligible														

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I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART

## LATE OR MISSED ASSESSMENTS

SNF PPS allows for a window of time in which the assessment is started and completed. The regulation includes the possibility of adding extra days (late days) for the completion of each MDS2.0 without a penalty.

### Late days allowed for completing the assessments

- Use of default HIPPS code

- Billing the default code signifies that the SNF considers the resident to be at a **skilled level of care**, but no assessment was completed to classify him/her into a RUG III group

### Billing Claims For Late Assessments

- Default code **must** be used in all cases when the ARD of the required assessment was not set timely
- Default code is applied for **all** days until the ARD is set for the late assessment
- HIPPS code from late assessment becomes effective with ARD
- HIPPS code is valid until the next regularly scheduled assessment
- Late assessments **never** replace the next regularly scheduled assessment

### Example

- Patient admitted 12/1/99
- ARD for 14 day should be set between 12/11 – 12/19
- **ARD set on 12/23**
- bill default (AAA00) 12/15 – 12/22
- bill HIPPS code from late assessment for days 12/23 – 12/30
- **modifier is 07** (modifier is always for the assessment which is currently due)

### 30-day assessment is due on schedule

<b>Skilled Nursing Facility</b>		2										3 PATIENT CONTROL NO.				1 TYPE OF BILL							
												12345				212							
		5 FED. TAX NO.					6 STATEMENT COVERS PERIOD		7 COV D.	8 N-C-D.	9 C-I-D.	10 L-R-D.		11									
					120199 123199		31		11														
12 PATIENT NAME												13 PATIENT ADDRESS											
Barbara A. Griffin												400 S. Safina St. Syracuse, N.Y. 13221											
14 BIRTHDATE		15 SEX	16 MS	17 DATE		18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.				24 CONDITION CODES				31				
02251925		F		120199					30		123456												
32 OCCURRENCE		33 OCCURRENCE		34 OCCURRENCE		35 OCCURRENCE		36 OCCURRENCE SPAN		37													
CODE DATE		CODE DATE		CODE DATE		CODE DATE		CODE FROM THROUGH		A				B									
								70 112599 120199															
38										39 VALUE CODE		40 VALUE CODES		41 VALUE CODES									
										a CODE AMOUNT		CODE AMOUNT		CODE AMOUNT									
										09 1056.00													
										b													
										c													
										d													
42 REV. CD.	43 DESCRIPTION				44 HCPCS/RATES		45 SERV. DATE		46 SERV. UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES		49									
0022					RVA01		120599		14	0													
0022					AAA00				8	0													
0022					RVB07		122399		8	0													
0022					RVB02		122999		7	0													
0120					25000				31	7750.00													
0420									120	2400.00													
0424									1	200.00													
0001										10350.00													
50 PAYER					51 PROVIDER NO.					52 REL. 53 ASG		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56							
Medicare					xx5xxx																		
<b>DUE FROM PATIENT ▶</b>																							
57					58 INSURED'S NAME					59 P. REL.		60 CERT. -SSN-HIC-ID NO.		61 GROUP NAME		62 INSURANCE GROUP NO.							
					Griffin, Barbara					01		123456789A											
63 TREATMENT AUTHORIZATION CODES				64 ESC	65 EMPLOYER NAME				66 EMPLOYER LOCATION														
67 PRIN. DIAG. CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.		77 E-CODE		78										
436																							
79 P. C.	80 PRINCIPAL PROCEDURE		81 OTHER PROCEDURE		OTHER PROCEDURE		82 ATTENDING PHYS. ID																
	CODE DATE		CODE DATE		CODE DATE		812345 Glidden G																
	OTHER PROCEDURE		OTHER PROCEDURE		OTHER PROCEDURE		83 OTHER PHYS. ID																
	CODE DATE		CODE DATE		CODE DATE																		
84 REMARKS	85 PROVIDER REPRESENTATIVE											86 DATE											
DEFAULT CODE - Used When SNF Failed to Set Assessment Reference Date Within the Time Frame Allowed by PPS Schedule	X																						

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## SPECIALITY CLAIMS BILLING

### Residents Who Are Not Effected by SNF PPS Schedule

PPS regulations do not apply to all Medicare beneficiaries in a SNF. When it is determined that the beneficiary's care is reimbursed under a different payment source, the PPS assessment schedule need not be followed.

### Medicare Beneficiaries Enrolled In HMOs

A Medicare beneficiary in a **Risk HMO (Option C)** will be covered (or not) based on the policies of the insurer; however the HMO insurance may never offer the beneficiary anything less than what is provided to the fee-for-service beneficiary

#### SNF PPS affect on HMO beneficiaries

- Risk HMOs
- Cost HMOs

- Bill the HMO according to contract terms
- Assessment schedule does not need to be followed for Medicare billing purposes
- HCFA 1450 **must** be submitted to the FI for **benefit management** (the default code AAA00 may be used)
- Residents receiving HMO denials must file an appeal **with the HMO**. Do **not** send a demand bill to the FI.

A Medicare beneficiary in a **Cost HMO (Option 1)** has a choice of where to receive services. All claims for Cost HMO beneficiaries in a Medicare certified SNF are **sent to the FI for processing**

- **Follow the SNF PPS assessment schedule**
- Submit a HCFA 1450 to the FI using the HIPPS rate code for each required Medicare assessment

2 <b>Skilled Nursing Facility</b>		3 PATIENT CONTROL NO.										04 TYPE OF BILL			
		12345										212			
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM		THROUGH		7 COV D.	8 N-C-D.	9 C-I-D.	10 L-R-D.			11			
		090199		093099		30		10							
12 PATIENT NAME						13 PATIENT ADDRESS									
Baarbara A. Griffin						400 S. Salina St. Syracuse, N.Y. 13221									
14 BIRTHDATE	15 SEX	16 MS	17 DATE	ADMISSION		21 D HR	22 STAT	23 MEDICAL RECORD NO.		24-30 CONDITION CODES					
02251925	F		090199	18 HR	19 TYPE	20 SRC	30	123456		04					
32 OCCURRENCE CODE		33 OCCURRENCE DATE		34 OCCURRENCE CODE		35 OCCURRENCE DATE		36 OCCURRENCE SPAN		37					
70		082599		090199		FROM		THROUGH		A					
										B					
										C					
38				39 VALUE CODE		40 VALUE CODES		41 VALUE CODES							
a		b		c		d									
42 REV. CD.	43 DESCRIPTION			44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49						
0022				AAA00		30	0								
0120				25000		30	7500.00								
0001							7500.00								
50 PAYER				51 PROVIDER NO.		52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56			
Medicare				XX5XXX											
57				DUE FROM PATIENT ▶											
58 INSURED'S NAME				59 P.REL	60 CERT.-SSN-HIC.-ID NO.		61 GROUP NAME		62 INSURANCE GROUP NO						
Griffin, Barbara				01	123456789A										
63 TREATMENT AUTHORIZATION CODES			64 ESC	65 EMPLOYER NAME			66 EMPLOYER LOCATION								
67 PRIN. DIAG. CD.	88 CODE		69 CODE	70 CODE	OTHER DIAG. CODES		71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78	
436															
79 P.C.	80 PRINCIPAL PROCEDURE		81 OTHER PROCEDURE		OTHER PROCEDURE		82 ATTENDING PHYS. ID								
	CODE DATE		CODE DATE		CODE DATE		R12345 GLIDDEN G								
	OTHER PROCEDURE		OTHER PROCEDURE		OTHER PROCEDURE		83 OTHER PHYS. ID								
	CODE DATE		CODE DATE		CODE DATE										
84 REMARKS													85 PROVIDER REPRESENTATIVE		86 DATE
HMO - OPTION Code C - Claim for Benefit Utilization													X		

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## Medicare Beneficiaries Who Are In Hospice

Medicare beneficiaries enrolled in the hospice program who are admitted to the SNF for their terminal illness are **not covered** by inpatient Part A SNF benefit.

### SNF PPS affect on hospice beneficiaries

- **Hospice beneficiaries admitted to SNF for their terminal illness**
- **Hospice beneficiaries admitted to SNF for a non-hospice related illness**

- Do not follow the PPS assessment schedule
- No discharge claim is necessary
- Be alert for beneficiaries who opt out of the hospice program and revert to traditional Medicare coverage

Medicare beneficiaries enrolled in hospice who are admitted to a SNF for a condition unrelated to their terminal illness **are** governed by PPS regulations.

- Follow the PPS assessment schedule
- Bill covered claims with valid HIPPS codes
  - **Condition Code 07** must be present on the claim

2 <b>Skilled Nursing Facility</b>		3 PATIENT CONTROL NO. <b>12345</b>										04 TYPE OF BILL <b>212</b>									
		5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM <b>110199</b>		THROUGH <b>113099</b>		7 COV D. <b>30</b>	8 N-C.D.	9 C-I.D. <b>10</b>	10 L-R.D.	11									
12 PATIENT NAME <b>Barbara A. Griffin</b>						13 PATIENT ADDRESS <b>400 S. Salina St. Syracuse, N.Y. 13221</b>															
14 BIRTHDATE <b>02251925</b>	15 SEX <b>F</b>	16 MS	17 DATE <b>110199</b>	ADMISSION 18 HR <b>30</b>		19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO. <b>123456</b>	24	25	26	27	28	29	30	31			
32 OCCURRENCE CODE <b>70</b>		33 OCCURRENCE DATE <b>102599</b>		34 OCCURRENCE CODE <b>110199</b>		35 OCCURRENCE DATE		36 OCCURRENCE SPAN FROM <b>110199</b>		THROUGH		37 A									
38		39 VALUE CODE AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT		a		b		c		d							
42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES		45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES		49											
<b>0022</b>		<b>RHB01</b>		<b>110899</b>	<b>14</b>	<b>0</b>															
<b>0022</b>		<b>RHB07</b>		<b>111299</b>	<b>16</b>	<b>0</b>															
<b>0120</b>		<b>25000</b>			<b>30</b>	<b>7500 00</b>															
<b>0420</b>					<b>84</b>	<b>1020 00</b>															
<b>0424</b>					<b>1</b>	<b>200 00</b>															
<b>0001</b>						<b>8720 00</b>															
50 PAYER <b>Medicare</b>				51 PROVIDER NO. <b>XX5XXX</b>		52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56									
57 <b>DUE FROM PATIENT</b>																					
58 INSURED'S NAME <b>Griffin, Barbara</b>				59 P.REL <b>01</b>	60 CERT.-SSN-HIC.-ID NO. <b>123456789A</b>				61 GROUP NAME		62 INSURANCE GROUP NO										
63 TREATMENT AUTHORIZATION CODES				64 ESC	65 EMPLOYER NAME				66 EMPLOYER LOCATION												
67 PRIN. DIAG. CD. <b>824.5</b>		68 CODE <b>150.9</b>		69 CODE		70 CODE		71 CODE		72 CODE		73 CODE		74 CODE		75 CODE		76 ADM. DIAG.	77 E-CODE	78	
79 P.C.	80 PRINCIPAL PROCEDURE CODE <b>824.5</b>		81 OTHER PROCEDURE CODE <b>150.9</b>		OTHER PROCEDURE CODE		OTHER PROCEDURE CODE		OTHER PROCEDURE CODE		OTHER PROCEDURE CODE		OTHER PROCEDURE CODE		OTHER PROCEDURE CODE		82 ATTENDING PHYS. ID <b>812345 GLIDDEN G</b>				
84 REMARKS <b>HOSPICE BENEFICIARY - Admitted for Condition Unrelated to Terminal Illness</b>												83 OTHER PHYS. ID		OTHER PHYS.		85 PROVIDER REPRESENTATIVE		86 DATE			

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I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART

## Beneficiaries With Other Insurance Coverage

Medicare regulations require SNFs to follow admission practices which include a survey for coverage by another insurer. If another insurance company is responsible for the payment of the SNF stay, the SNF will bill that insurer according to the rules of the insurance company. **Medicare Secondary Payer (MSP)** rules will effect the use of the SNF PPS assessment schedule and use of RUG III codes.

### Affect of other insurance on SNF PPS assessment schedule

- MSP categories
- Beginning an assessment schedule when other insurance ends or denies
- Submission of MSP claims

## 8 Categories of MSP Coverage

- Working Aged
- ESRD
- Auto/No Fault
- Liability
- Workers Compensation
- Disability
- Federal Black Lung
- VA Benefits

## When Assessments Are Done

- When a **specific** time period is guaranteed by another insurer (usually by an employer group health plan) , the **assessment schedule begins when the primary insurer's coverage ends.**
- When the other insurer is **indefinite** in the amount of days to be paid, we recommend that you follow the assessment schedule from day of admission.

### Billing Claims During a MSP Period

- **All** Part A MSP claims **must** be submitted to the FI to satisfy the sequential claims processing requirements prior to billing Medicare days
  - Bill claims with covered days and charges
  - Use condition code 77 if payment is accepted as 'payment in full'
  - SNF PPS coding must be present on the claim including HIPPS codes and ARD
  - Default code **AAA00** may be used if no Medicare Secondary payment is sought
  - All applicable MSP billing requirements must be met

#### Coding for MSP claims

### Billing Claims After Other Insurance Ends

- Part A Medicare primary claims follow the MSP period if the beneficiary continues to meet skilled level of care criteria
- Begin the MDS schedule on first day that Medicare becomes primary
  - First day of Medicare coverage is day one of the Medicare schedule
  - First assessment would use 01 modifier for Medicare billing (5-day assessment)
  - Use the modifier 01 (5 day) regardless of where the patient was in the schedule, and bill for all of the days until the next assessment is scheduled
- If primary insurance file is still "open," code your claim with occurrence code 24 date other insurance company denied payment

#### When to begin a Medicare assessment schedule

### Leave of Absence (LOA) Rules

1 SKILLED NURSING FACILITY											3 PATIENT CONTROL NO.				OF BILL 273
5 FED. TAX NO.					6 STATEMENT COVERS PERIOD FROM 080199 THROUGH 083199			7 COV D. 31	8 N-C D.	9 C-I D. 11	10 L-R D.	11			
12 PATIENT NAME GLIDDEN G						13 PATIENT ADDRESS 400 S. SALINA ST SYRACUSE NY 13221									
14 BIRTH DATE 08301925	15 SEX M	16 MS	17 DATE 070199	18 ADMISSION HR		19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.			24 CONDITION CODES 25 26 27 28 29 30		31
32 OCCURREN CODE		33 OCCURREN DATE		34 OCCURREN CODE		35 OCCURREN DATE		36 OCCURREN CODE		37 OCCURREN DATE		38		39 VALUE CODE	
01		062599		24		073199		70		062599		0701989		a 09	
														b 105	
														c 00	
														d	
42 REV.CD.	43 DESCRIPTION			44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES		49					
0022				RMB01	080699	14	00 00								
0022				RMB07	081399	16	00 00								
0022				RLA02	082899	1	00 00								
0120				25000		31	7500 00								
0420						84	1200 00								
0001							8700 00								
50 PAYER MEDICARE				51 PROVIDER NO. XX5XXX		52 REL INFO	53 BEN	54 PRIOR PAYMENTS		55 EST. AMOUNT DUE	56				
57 DUE FROM PATIENT															
58 INSURED'S NAME GLIDDEN G				59 P-PT	60 CERT.-SSN-HIC-ID NO. 987654121A			61 GROUP NAME		62 INSURANCE GROUP NO.					
63 TREATMENT AUTHORIZATION CODES			64 ESC	65 EMPLOYER NAME				66 EMPLOYER LOCATION							
67 PRIN.DIAG.CD. 82110															
68 CODE 69 CODE 70 CODE 71 CODE 72 CODE 73 CODE 74 CODE 75 CODE 76 ADM. DIAG. 77 E-CODE 78															
79	80 PRINCIPAL PROCEDURE CODE DATE		81 OTHER PROCEDURE CODE DATE		OTHER PROCEDURE CODE DATE		82 ATTENDING PHYS. ID B12345 GRIFFIN B								
							83 OTHER PHYS. ID								
84 REMARKS REMARKS REQUIRED - NO FAULT BENEFITS EXHAUST 7/31/99 DAY ONE OF MEDICARE COVERAGE = 8/1/99															
85 PROVIDER REPRESENTATIVE X															

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1 CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART HEREOF.

<b>SKILLED NURSING FACILITY</b>		2		3 PATIENT CONTROL NO.				4 TYPE OF BILL <b>213</b>									
		5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM: <b>080199</b> THROUGH: <b>083199</b>		7 COV D. <b>31</b>	8 N-C D.	9 C-I D. <b>11</b>	10 L-R D.	11							
12 PATIENT NAME <b>GLIDDEN G</b>					13 PATIENT ADDRESS <b>400 S. SALINA ST SYRACUSE NY 13221</b>												
14 BIRTHDATE <b>08301925</b>	15 SEX <b>M</b>	16 MS	17 DATE <b>070199</b>	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24	25	26	27	28	29	30	31
32 OCCURRENCE CODE <b>01</b>	33 OCCURRENCE DATE <b>062599</b>	34 OCCURRENCE CODE <b>24</b>	35 OCCURRENCE DATE <b>073199</b>	36 OCCURRENCE CODE <b>70</b>	37 OCCURRENCE SPAN FROM <b>062599</b>	37 OCCURRENCE SPAN THROUGH <b>0701989</b>	38	39 VALUE CODE CODE <b>a 09</b>	39 VALUE CODE AMOUNT <b>1056.00</b>	40 VALUE CODES CODE	40 VALUE CODES AMOUNT	41 VALUE CODES CODE	41 VALUE CODES AMOUNT				
42 REV.CD. <b>0022</b>	43 DESCRIPTION			44 HCPCS/RATES <b>RMB01</b>	45 SERV.DATE <b>080699</b>	46 SERV.UNITS <b>14</b>	47 TOTAL CHARGES <b>0</b>	48 NON-COVERED	49								
<b>0022</b>				<b>RMB07</b>	<b>081399</b>	<b>16</b>	<b>0</b>										
<b>0222</b>				<b>RLA02</b>	<b>082899</b>	<b>1</b>	<b>0</b>										
<b>0120</b>				<b>25000</b>		<b>31</b>	<b>7500.00</b>										
<b>0420</b>						<b>84</b>	<b>1200.00</b>										
<b>0001</b>							<b>8700.00</b>										
50 PAYER <b>MEDICARE</b>			51 PROVIDER NO. <b>XX5XXX</b>		52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56								
57 <b>DUE FROM PATIENT</b>																	
58 INSURED'S NAME <b>GLIDDEN G</b>			59 P.REL <b>01</b>	60 CERT.-SSN-HIC.-ID NO. <b>987654121A</b>		61 GROUP NAME		62 INSURANCE GROUP NO.									
63 TREATMENT AUTHORIZATION CODES		64 ESC	65 EMPLOYER NAME			66 EMPLOYER LOCATION											
67 PRIN.DIAG.CD. <b>82110</b>	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78						
79 P.C.	80 PRINCIPAL PROCEDURE CODE <b>82110</b>	80 PRINCIPAL PROCEDURE DATE	81 OTHER PROCEDURE CODE	81 OTHER PROCEDURE DATE	82 ATTENDING PHYS: ID <b>R12345</b>	82 ATTENDING PHYS: ID <b>GRIFFIN B</b>	83 OTHER PHYS: ID	83 OTHER PHYS: ID	83 OTHER PHYS: ID	83 OTHER PHYS: ID							
84 REMARKS <b>REMARKS REQUIRED - NO FAULT BENEFITS EXHAUST 7/31/99</b> <b>DAY ONE OF MEDICARE COVERAGE = 8/1/99</b>																	
85 PROVIDER REPRESENTATIVE <b>X</b>								86 DATE									

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1 CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART HEREOF.

<b>SKILLED NURSING FACILITY</b>	3 PATIENT CONTROL NO.										4 TYPE OF BILL <b>213</b>						
	5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM: <b>070499</b> THROUGH: <b>073199</b>		7 COV D. <b>28</b>	8 N-C D.	9 C-I D. <b>8</b>	10 L-R D.		11							
	12 PATIENT NAME <b>GLIDDEN G</b>																
13 PATIENT ADDRESS <b>400 S. SALINA ST SYRACUSE NY 13221</b>																	
14 BIRTHDATE <b>08301925</b>	15 SEX <b>M</b>	16 MS	17 DATE <b>060199</b>	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24	25	26	27	28	29	30	31
32 OCCURRENCE CODE <b>01</b>	OCCURRENCE DATE <b>052599</b>	33 OCCURRENCE CODE <b>24</b>	OCCURRENCE DATE <b>070399</b>	34 OCCURRENCE CODE	OCCURRENCE DATE	35 OCCURRENCE CODE	OCCURRENCE DATE	36 OCCURRENCE CODE <b>70</b>	OCCURRENCE FROM <b>052599</b>	OCCURRENCE THROUGH <b>0601989</b>	37 A	B	C				
38	39 VALUE CODE a <b>09</b>	AMOUNT <b>864.00</b>	40 VALUE CODES b	AMOUNT	41 VALUE CODES c	AMOUNT	d										
42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	48 NON-COVERED	49										
<b>0022</b>		<b>RMB01</b>	<b>0629</b>	<b>27</b>	<b>0</b>												
<b>0022</b>		<b>RMB07</b>	<b>0728</b>	<b>1</b>	<b>0</b>												
<b>0120</b>		<b>25000</b>		<b>28</b>	<b>7000.00</b>												
<b>0274</b>				<b>1</b>	<b>125.00</b>												
<b>0420</b>				<b>84</b>	<b>1200.00</b>												
<b>0001</b>					<b>8325.00</b>												
50 PAYER <b>MEDICARE</b>			51 PROVIDER NO. <b>XX5XXX</b>		52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56								
57 <b>DUE FROM PATIENT</b>																	
58 INSURED'S NAME <b>GLIDDEN G</b>			59 P.REL <b>01</b>	60 CERT.-SSN-HIC.-ID NO. <b>987654121A</b>			61 GROUP NAME	62 INSURANCE GROUP NO.									
63 TREATMENT AUTHORIZATION CODES		64 ESC	65 EMPLOYER NAME			66 EMPLOYER LOCATION											
67 PRIN.DIAG.CD. <b>82110</b>	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.	77 E-CODE	78						
79 P.C.	80 PRINCIPAL PROCEDURE CODE <b>82110</b>	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS: ID <b>B12345 GRIFFIN B</b>									
OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS: ID									
OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	84 OTHER PHYS: ID									
84 REMARKS <b>NO FAULT BENEFITS EXHAUST 7/3/99 - Facility had been following the Regular SNF PPS Schedule....Facility Applies 5 Day Modifier to 30 day (ARD 6/29) and Bills All Days until Assessment Schedule is Re-established on 7/31</b>								85 PROVIDER REPRESENTATIVE <b>X</b>	86 DATE								

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I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART HEREOF.

<b>Leave of absence</b>
-------------------------

Leave of absence criteria has not changed for SNF PPS. Any time a resident does not meet midnight census taking, he is considered to be on a leave of absence. There are two types of LOA situations.

- **Medical LOA** – resident is in emergency room of hospital but has not been admitted as an inpatient
  - Absences exceeding 24 hours constitutes a “discharge” for the purposes of consolidated billing
- **Therapeutic (Social) LOA** – resident has gone home with family

### **Coding Requirements for Leave of Absence**

- Occurrence Span Code 74 and dates
- Revenue code 018X in FL 42
- Number of days on LOA in FL 46
- 0 (zero) charges in FL 47

### **Effect of LOA on Benefit Days and Assessment Schedule**

- Medicare Part A benefit days are **not** taken
- Do not code non-covered charges on LOA days
- **LOA days do not** interrupt the assessment schedule and are **not** counted on the MDS when scoring the patient’s next assessment

***Outside services rendered to the SNF patient on a LOA day are not bundled to the SNF, but may be billed directly to Medicare by the entity performing the service.***

### **NEW SPELL OF ILLNESS**

There is no limit to the number of benefit periods

2 <b>Skilled Nursing Facility</b>		3 PATIENT CONTROL NO. <b>12345</b>										4 TYPE OF BILL <b>212</b>						
		5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM: <b>120199</b> THROUGH: <b>123199</b>		7 COV D. <b>29</b>	8 N-C-D. <b>2</b>	9 C-I-D. <b>8</b>	10 L-R-D. <b>11</b>									
		12 PATIENT NAME <b>Barbara A. Griffin</b>											13 PATIENT ADDRESS <b>400 S. Salina St. Syracuse, N.Y. 13221</b>					
14 BIRTHDATE <b>02251925</b>		15 SEX <b>F</b>	16 MS	17 DATE <b>120199</b>		ADMISSION 18 HR 19 TYPE 20 SRC		21 D HR		22 STAT		23 MEDICAL RECORD NO. <b>123456</b>		24-30 CONDITION CODES				31
32 OCCURRENCE CODE DATE		33 OCCURRENCE CODE DATE		34 OCCURRENCE CODE DATE		35 OCCURRENCE CODE DATE		36 OCCURRENCE CODE DATE		36 OCCURRENCE SPAN FROM THROUGH		37						
										<b>70 112599 120199</b>		A						
										<b>74 122499 122599</b>		B						
												C						
38										39 VALUE CODE CODE AMOUNT		40 VALUE CODES CODE AMOUNT		41 VALUE CODES CODE AMOUNT				
										a <b>09 76800</b>								
										b								
										c								
										d								
42 REV. CD.	43 DESCRIPTION			44 HCPCS/RATES		45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES		49						
<b>0022</b>				<b>RVA01</b>		<b>120599</b>	<b>14</b>	<b>0</b>										
<b>0022</b>				<b>RVB07</b>		<b>121499</b>	<b>15</b>	<b>0</b>										
<b>0022</b>				<b>RVB02</b>		<b>122999</b>	<b>1</b>	<b>0</b>										
<b>0120</b>				<b>25000</b>			<b>29</b>	<b>7250 00</b>										
<b>0180</b>							<b>2</b>	<b>0</b>										
<b>0420</b>							<b>120</b>	<b>2400 00</b>										
<b>0424</b>							<b>1</b>	<b>200 00</b>										
<b>0001</b>								<b>9858 00</b>										
50 PAYER <b>Medicare</b>				51 PROVIDER NO. <b>xx5xxx</b>				52 REL INFO BEN		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56				
57 <b>DUE FROM PATIENT ▶</b>																		
58 INSURED'S NAME <b>Griffin, Barbara</b>				59 P. REL <b>01</b>		60 CERT. -SSN-HIC. ID NO. <b>123456789A</b>				61 GROUP NAME		62 INSURANCE GROUP NO.						
63 TREATMENT AUTHORIZATION CODES				64 ESC		65 EMPLOYER NAME				66 EMPLOYER LOCATION								
67 PRIN. DIAG. CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG.		77 E-CODE		78					
<b>436</b>																		
79 P.C.	80 PRINCIPAL PROCEDURE CODE DATE		81 OTHER PROCEDURE CODE DATE		OTHER PROCEDURE CODE DATE		82 ATTENDING PHYS. ID <b>R12345 Giffden G</b>											
	OTHER PROCEDURE CODE DATE		OTHER PROCEDURE CODE DATE		OTHER PROCEDURE CODE DATE		83 OTHER PHYS. ID											
84 REMARKS <b>Beneficiary on Leave of Absence (LOA) 12/24 &amp; 12/25/99</b>																		
										85 PROVIDER REPRESENTATIVE		86 DATE						
										<b>X</b>								

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CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO TYPE BILL AND ARE MADE A PART

a beneficiary may have as long as he/she meets the criteria for ending a current spell of illness.

### Criteria For Breaking The Current Spell of Illness

- 60 consecutive days facility free
- or
- 60 consecutive days in a SNF at a non-skilled level of care

### Coding For Continuing Stay Residents

- Prior to benefits exhaust, occurrence code 22 is coded on the claim as the last medically skilled day
- This is a **covered** day on the claim
- This is the same day as the date of the notice of non-coverage
  - Days following occurrence code 22 are non-covered and should be submitted on a separate claim if the resident asks for a demand bill
- Benefits exhaust code (**A3**) does **not** impact benefit periods – it does **not** break spells
  - Occurrence code 22 and A3 should not appear on the same claim

#### Spell of illness

- **Criteria for breaking current spell of illness**
- **Use of occ. code 22**
- **Use of occ. code A3**
- **Discharge bills**

## Effect of Discharge Bills on Benefit Periods

Medicare regulations outlined in Section 517 of the HCFA PUB 12 describe the requirement for all SNFS to track the days beneficiaries live in a SNF.

- SNFs **must** submit a discharge bill for all residents who are enrolled in Part A (unless that resident is being covered by the Hospice)
- Discharge claims should be submitted at the time of transfer, death, discharge to home or another facility
- Claims should close a sequence (TOB 214) or **may** be submitted as a TOB 210
- A single discharge claim is all that is required (unless you are crossing the start date of PPS) from the first day of non-coverage until the date of discharge
  - Apply occurrence code 22 and date to the discharge claim if a **change to non-skilled level of care** has occurred **since the last covered day**
  - Do **not** apply occurrence code 22 to the discharge claim if the beneficiary has remained skilled
- Facilities may also bill a single claim through change of level of care or a move to a non-certified bed
  - Claims billed in this manner **must** have occurrence code 22 and date = to the 'through date' of the claim

### Discharge bills

***Failure to submit discharge bills creates an artificial gap in service on CWF and establishes a new benefit periods inappropriately.***

***Intentional failure to submit discharge bills for the purpose of creating a new benefit period is FRAUD.***

## CODING

### Billing Requirements for HCPCS/Rate (FL 44)

- When billing for accommodations, code your customary charge in the FL 44.
- When billing revenue code 0022, code the HIPPS rate code in FL 44.
- Part A claims do **not** require HCPCS codes for ancillary services.

### Billing Requirements For Service Date (FL 45)

- Required field on revenue code 0022 line for reporting ARD
- No other revenue line requires a service date on a Part A claim

### Billing Requirements for Units (FL 46)

- When billing accommodations, units are **days**.
- When billing HIPPS codes, units represent **days covered by a specific assessment**.
- When billing therapy ancillary services, units represent **number of times therapy procedures were performed**.
- When there is no specific time frame to be reported, **the number 1 must be coded in the units field**.

### Billing Requirements for Charges (FL 47)

- **Required** on all revenue code lines except 0022 (PPS code) and 0180 (LOA)

#### SNF PPS field requirements

- **HCPCS**
- **Service date**
- **Units**
- **Total charges**

## THERAPY EDITS

### Edits For Therapy Ancillary Charges

SNF PPS requires the billing of ancillary charges for residents who score in a RUG III Rehab Group.

System edits have been developed to insure that the Rehabilitation RUG III groups are not billed unless therapy ancillaries appear on the claim.

- Therapy Ancillary Edits**
- **Required if billing any of the RUG III REHABILITATION groups**
  - **Ultra High REHAB groups require 2 therapy ancillary revenue codes on claim**
  - **All other REHAB groups require 1 therapy ancillary on claim**

- Residents in the highest Rehabilitation groups (RUA, RUB and RUC) require ancillary revenue codes for two therapy disciplines
- Residents in the lower Rehabilitation groups (RLA–RVC) require ancillary revenue codes for one therapy discipline
- Claims that fail system edits will be returned to provider for corrected submission

### Therapy Processing Problems

Medicare does not require an OMRA be done **unless** all therapy has ended. When a resident in an ultra-high therapy RUG III Group decreases therapy, there is no mechanism to obtain a new HIPPS code for continued billing. SNFs are permitted to code the existing HIPPS code from the last assessment until the next assessment is due.

Continued billing of an ultra-high rehabilitation HIPPS code without two therapy ancillaries to support the group will fail system edits.

### Work-a-round for Therapy Edit Problem

- Enter a single line of coding to represent the therapy which has been discontinued
  - 429 for discontinued PT
  - 439 for discontinued OT
  - 449 for discontinued ST
- Enter a unit of 1
- Enter charges of .01

### EDIT PROBLEM

**Therapy work-a-round**

## REIMBURSEMENT UNDER SNF PPS

Medicare Part A claims will be run through a PRICER software program provided to the FI by HCFA. The software contains the reimbursement amounts (rates) for each RUG III group. In combination with the rate information from each individual provider file, the FI computer will be able to calculate payment for each claim regardless of the number of different RUG III codes present.

<b>Changes in reimbursement rates</b>
---

### **Changes to Reimbursement Rates Under SNF PPS**

- **Provider Specific rates** are assigned at the beginning of each new cost reporting period
- **Federal Rates** change on 10/1 of each year and affect all SNFs who receive blended payment
- **Blend ratios** during the three year transition to PPS change at the beginning of each SNF's individual cost report year
- **Final Settlement** may result in a change to provider specific rate or the Part B rate
  - Audit and Reimbursement department sends a new rate sheet **each** time a facility has a change in payment

## Reimbursement Data on Part A Claim

The RUG III reimbursement rate will overlay the zero charge in FL 47 for each line of data submitted with a revenue code 0022 and a HIPPS rate code

- |   |  |
|---|--|
| <p style="text-align: center;"><b>Reimbursement</b></p> <ul style="list-style-type: none"> <li>• <b>Separate calculation for each HIPPS code entered on a claim</b></li> <li>• <b>Beneficiary co-insurance remains as is currently calculated</b></li> <li>• <b>Payment = total of each HIPPS payment minus beneficiary co-insurance responsibility</b></li> <li>• <b>Payment for ancillary services on claim is factored into HIPPS reimbursement</b></li> </ul> | <ul style="list-style-type: none"> <li>• The total charges field will <b>not</b> be altered on any other line of data and total charges will go to the PS&amp;R report as submitted by provider.</li> <li>• Each RUG III group on the claim will be calculated separately, then totaled to determine reimbursement.</li> <li>• Beneficiary co-insurance responsibility is calculated and subtracted from total reimbursement to establish the payment amount.</li> </ul> |
|---|--|

## Withholding Issues

The Medicare FI may create a withholding (of payment) for SNFs in the following circumstances:

- |   |   |
|---|---|
| <p style="text-align: center;"><b>Withholding</b></p> | <ul style="list-style-type: none"> <li>• Failure to file cost report by required deadline             <ul style="list-style-type: none"> <li>- 100% withholding remains in place until cost report is submitted and accepted</li> </ul> </li> <li>• Overpayment on final settlement             <ul style="list-style-type: none"> <li>- 100% unless payment arrangements are made on amount of overpayment or if payment arrangements are not met</li> </ul> </li> <li>• Credit Balance</li> <li>• Adjustments             <ul style="list-style-type: none"> <li>- Withholding resulting from claims processing occurs when an adjustment cancel original claim pending the reprocessing of the corrected claim</li> <li>- When the adjusted claim is finalized, the correct payment is restored</li> </ul> </li> </ul> |
|---|---|

<b>Adjustments</b>
--------------------

## THE ADJUSTMENT PROCESS UNDER PPS

The claim adjustment process has not been changed for SNF PPS. Follow your normal procedures to adjust any claim in which data elements need to be corrected.

### Provider Adjustments

- Adjustment claims are submitted with type of bill 217
- Condition code ( D0 – E0) in FL 24 must be coded to provide reason for adjustment
- **Remarks** are required in when using D8 and D9 as reasons for adjustments
- Provide **cross reference DCN** of original claim
- All adjustments to the MDS document must follow the MDS instruction manual

### Intermediary Adjustments

- Alerts from **Common Working File (CWF)** regarding a change in benefit days may result in a full or partial adjustment
- **PRO review** may result in their request for our office to do adjustments
- Adjustments to facilitate **Appeal decisions**
- Adjustments to RUG category following **Medical Review decision**
- **Mass** adjustments following a policy or reimbursement change



# Skilled Nursing Facility Prospective Payment System Consolidated Billing

## Table of Contents

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Special Circumstances Requiring Application of Consolidated Billing Principles.....	7
SNF Responsibility Under Consolidated Billing .....	14
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## CONSOLIDATED BILLING REQUIREMENTS

### **BBA Regulations Effecting Part A and Part B Billing**

Section 4432 (b) of the Balance Budget Act (BBA) of 1997 contains the requirement that SNFs must submit **all** Medicare claims for **all** the services provided to its residents with the exception of statutory exclusions beginning July 1, 1998.

### **Who is Governed by Consolidated Billing**

Consolidated billing requirements govern all Medicare fee-for-service beneficiaries residing in a participating SNF, or in the nonparticipating remainder of a nursing home (NH) that also includes a participating distinct part SNF.

**Who is governed by consolidated billing?**

- Consolidated billing began for the Part A resident at the beginning of the SNF's new cost report year on or after 7/1/98.
- **Part B consolidated billing has been postponed until further notice.**
  - Residents in non-certified beds will not be affected by consolidated billing until it is implemented for Part B services.

### **Services Not Included in the Extended Care Benefit**

Services not included in the extended care benefit for Part A residents of a SNF will be **excluded** from the consolidating billing requirements.

- **Flu shots** are an example of Part B services not required on a Part A claim, and **not** bound by consolidated billing regulations.

## Inpatient Defined

For the purposes of consolidated billing, a Medicare beneficiary who resides in a SNF is considered to be an **inpatient of a SNF** until which time the resident changes his status by the following action:

### Who is an Inpatient?

- Consolidated billing rules
- Status codes of residents leaving the SNF and the how it affects a resident's "inpatient" status

- discharged to home  
(status **01** in FL 22)
- discharged and admitted to a hospital  
(status **02** in FL 22)
- transferred to another SNF  
(status **03** in FL 22)
- discharged to another inpatient facility  
(status **05** in FL 22)
- discharged to home under HHA care  
(status **06** in FL 22)
- left against medical advice  
(status **07** in FL 22)
- discharge to home under home IV provider  
(status **08** in FL 22)
- expired  
(status **20** in FL 22)
- discharged to hospice - medical facility  
(status **51** in FL 22)
- discharged to hospice - home  
(status **50** in FL 22)

Consolidated billing requires that charges for outside services must be charged back to the SNF if the beneficiary is covered under Medicare Part A and the SNF is receiving SNF PPS reimbursement for that day.

- *Services provided outside the SNF on date of beneficiary's discharge or on LOA days do **not** have to be charged back to the SNF for payment because the resident is **not** considered to be an "inpatient" of the SNF on those days and the SNF is not receiving Part A reimbursement.*

## COMPONENTS OF CONSOLIDATED BILLING

### Services Billed on Part A claim (21X) Include:

**Requirements for  
Part A claims**

- All services allowed under Part A stay per Section 230 of the SNF manual (HCFA Pub 12) must be reported on a UB92 using a line item ancillary revenue code and total charges for that service.
- Services required to be included on the Part A claim are those rendered within the facility (either directly or under arrangement) and those rendered “off-site” (with the exception of those services excluded by BBA).

### Services Billed on Part B Claim (22X) will be Subject to Consolidated Billing Regulations in the Future

**Services billed on a  
Part B (22X) claim**

- Per Section 260 of the SNF Manual (HCFA PUB 12) and the requirements of BBA, the following services are billable on a Part B claim (22X).
  - Diagnostic X-ray tests
  - Diagnostic laboratory tests
  - X-rays, radiological services, radium and radioactive isotope therapy
  - Surgical dressings, splints, casts and other devices used for the reduction of fractures and dislocations
  - Leg, arm, back and neck braces, trusses, and artificial legs, arms and eyes (including adjustment, repairs and replacements)
  - Vaccinations or inoculations specifically for flu, PPV and hepatitis B
  - Approved oral cancer and anti-emetic drugs
  - Hemophilia clotting factor
  - Ambulance
  - Physical, occupational and speech therapy

Currently, the SNF must submit 22X claims for those services provided within their facility.

## Services Exempt from Consolidated Billing

HCFA has provided a list of those services not normally within the SNF purview to provide and therefore **not** bound by consolidated billing rules.

### Excluded Services:

Exclusions originally listed in Interim Final Rule (IFR)

<b>Excluded Services Per IFR</b>
--------------------------------------

- physicians
- physician assistants working under a physician's supervision
- nurse practitioners and clinical nurse specialists working in collaboration with a physician
- certified nurse-midwives
- qualified psychologists
- certified registered nurse anesthetists
- home dialysis supplies and equipment, self-care home dialysis support services and institutional dialysis services and supplies
- Erythropoietin (EPO) for certain dialysis patients
- hospice care related to a beneficiary's terminal condition
- an ambulance trip that transports a beneficiary to the SNF for the initial admission or from the SNF following a final discharge
- **for 1998 only** - transportation costs of EKG equipment for electrocardiogram test services (HCPC R7006) rendered during 1998

<b>Additional exclusions</b>
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**Exclusions From Federal Register/Vol. 63 No. 91**

- Cardiac catheterization
- CT scans (provided by a hospital)
- MRI (provided by a hospital)
- Ambulatory surgery involving the use of an operating room
- Emergency room services

**Additional Exclusions per HCFA Transmittal No. A-98-37**

- Radiation therapy
- Angiography
- Lymphathatic and venous procedure

**Additional Exclusions per BBTRA (11/99 Effective 4/01/00)**

- Chemotherapy items
- Chemotherapy administration services
- Radioisotope services
- Customized prosthetic devices
- Ambulance transport for renal dialysis services

See attached chart for HCPCS definitions of services that included in these exclusions. Services on this list may be billed directly to Medicare by the entity providing the service.

**Bundling of Charges**

The IFR and FR both refer to the “bundling of charges”. This means that under consolidated billing provisions, ***the costs for rendering services (other than those excluded) to a SNF Part A resident must be charged back to the SNF for payment.*** Because HCFA has determined that the SNF reimbursement rates contain payment for all of these services, separate claims may not be submitted to Medicare.

## SPECIAL CIRCUMSTANCES REQUIRING APPLICATION OF CONSOLIDATED BILLING PRINCIPLES

### Leave of Absence (LOA)

Medicare beneficiaries absent from the SNF at midnight 'census taking' time must be considered to be on a leave of absence.

#### **A Resident on a LOA at Midnight Cannot Use a Part A Benefit Day.**

- Benefit days are not applied, nor is Part A reimbursement made if the beneficiary is absent at midnight.
- Consolidated billing rules do **not** apply if the SNF is not receiving Part A PPS reimbursement

Leave of absence

A SNF Part A resident who is absent for more than 24 hours receiving outpatient services is no longer considered an "inpatient" for consolidated billing purposes.

- During medical absences of more than 24 hours, the charges for services rendered **may be billed directly to Medicare by the entity performing the service.**
- Absences of greater than 24 hours (on a medical leave) require SNFs to consider the patient "discharged."
  - Beneficiaries may be on social leave for more than 24 hours and do not need to be considered "discharged."

## Services and Treatments Provided “Under Arrangement”

Consolidated billing requires that services provided by individuals or companies other than the employees of the SNF must be billed to the FI on the HCFA 1450 for Medicare beneficiaries under Part A.

## Items Provided by Outside Suppliers/Contracted Staff to SNF Part A Residents

- orthotics/prosthetics
- ostomy/colostomy supplies
- sterile dressings/surgical dressings and supplies
- enteral/parenteral nutrition and supplies
- independent laboratories
- portable X-ray companies
- therapy professionals rendering PT, OT, SP

### Changes to billing for “under arrangement” services

- DMERC billing
- Carrier billing

## Services Provided to SNF Residents Outside the SNF Facility

In addition to services rendered to a patient within the SNF, certain other services provided to a Medicare beneficiary **outside** of the facility must be charged back to the SNF by the outside provider and billed on the SNF claim to the Fiscal Intermediary including:

- all services, unless excluded by statute, must be bundled back to the SNF for payment and for reporting to the FI on a HCFA 1450 (UB-92).
- ambulance services for medically necessary transport (as defined by Carrier criteria) of SNF INPATIENTS to outside services unless excluded by statute.

### Billing for services rendered out of the SNF

***SNFs are free to choose vendors and providers for contractual agreements as long as those agreements do not violate the existing anti-kickback statutes.***

**Plan of care**

### Plan of Care

The Final Rule makes the following two clarifications regarding plan of care and consolidated billing provisions.

- If a service is excluded by statute (i.e., CT scan), that service is **always** excluded from consolidated billing, even if that service is a part of the residents plan of care.
- Outside services are not automatically excluded from consolidated billing because they are not in a ***specific patient's plan of care***; but must be defined on the broader level of services beyond the pervue of the SNF to provide ***in general*** .

### Enteral and Parenteral Nutrition

#### Medicare Part A :

**Medicare Part A**

- Parenteral nutrition is considered a drug and is billed under revenue code 0260 (IV drugs), and supplies to administer the nutrition are billed under revenue code 0270 (medical/surgical supplies) or revenue code 0264 (IV therapy supplies).
- Enteral nutrition is considered "routine" under Medicare Part A and is not billable to the FI or to the DMERC by the SNF.

#### Medicare Part B:

**Medicare Part B**

- Parenteral and enteral nutrition formula and supplies may be billed to the DMERC by the SNF if the SNF has a DMERC provider number, or
- May be billed by the supplier directly to the DMERC if the SNF wishes to have the vendor do the billing on behalf of the Part B beneficiary.

**Services in the  
emergency room**

### **Emergency Room Services**

Emergency room services are exempt from consolidated billing provisions if:

- Treatment is for a “life or death” situation, or one involving “serious impairment of health.”

Any other routine services provided to the patient while they are in the emergency room **must** be charged back to the SNF.

**Services in an operating  
room**

### **Use of the Operating Room**

- Ambulatory surgery services must be rendered in an operating room in order to be exempt from consolidated billing provisions.
- With respect to **PEG tubes procedures**, HCFA considers the use of the GI suite or endoscopy suite as equivalent to the use of the operating for the purpose of this exclusion.

**Services “incident to” a  
professional service**

### **Services Furnished “Incident To” A Professional Service**

The fees of physicians and other professionals (see BBA list of those medical personnel excluded from bundling) are billed directly to the Part B Carrier.

- Services “incident to” the professional service must be billed on the SNF Part A claim to the FI.

Examples of services “incident to” are surgical dressings when ordered by the physician.

- The technical component of a visit with a professional is **not** exempt from consolidated billing and must be bundled back to the SNF.

## Dialysis Services for Part A Beneficiaries

Dialysis services **are excluded** from the consolidated billing provision if:

- Services are rendered to the beneficiary on the site of a Medicare certified ESRD facility or a hospital certified by Medicare to render outpatient dialysis.
- Supplies and equipment are provided to a beneficiary in a SNF who has been trained perform *self dialysis* (home dialysis).

### Dialysis in a SNF

Dialysis services **are not excluded** from the consolidated billing provision if:

- Services are provided to the beneficiary at the SNF by staff from an ESRD facility or hospital under arrangement.
  - Services provided on the site of the SNF are included in the daily SNF PPS rate.
  - The SNF must pay the ESRD or hospital and report these charges on the SNF claim to the FI.

## Home Dialysis Beneficiaries

- “Home” dialysis beneficiaries residing in the SNF qualify to have their supplies and equipment excluded from consolidated billing provisions.
  - Equipment and supplies may not be shared with other residents.
  - Nursing staff assistance to perform home dialysis in the SNF may not be billed to Medicare

***Freestanding ESRD facilities and hospitals may apply to the State and HCFA to establish separate certification of an ESRD unit within a SNF.***

<b>Billing of ancillaries</b>
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## Lab and X-ray Services

Lab and X-ray charges should be billed to the SNF by entity performing the service for Part A beneficiaries.

- If the facility has its own lab and radiology units, the claims are billed directly to the FI by the SNF.
- If services are performed by portable Xray companies, independent labs, or hospitals, the claims are sent by these providers to the SNF for payment. The SNF must report these services on their Part A claim.

***Until consolidated billing becomes effective for Part B beneficiaries, facilities performing lab and Xray services may bill to Medicare using current practices.***

## Orthotics and Prosthetics

Orthotics and prosthetics supplies and equipment are governed by the consolidated billing provisions of BBA.

- Supplies and equipment received by the beneficiary during a Part A stay are financial responsibility of the SNF.

## Drugs and Biologicals

Drugs and biologicals are a covered service under Part A in a SNF and are included in the PPS payment.

- Drugs obtained from an outside source are the financial responsibility of the SNF.
- Beneficiary's supplemental insurance (RX policy) should not be used when obtaining prescriptions until his/her Part A stay ends.

<b>Ambulance rules</b>
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### **Consolidated Billing Special Rules for Ambulance Transport of SNF Residents**

Medicare payment can be made for medically necessary ambulance services for a Part A and Part B beneficiaries. Currently consolidated billing provisions apply to SNF Part A beneficiaries.

**SNFs** are **not** responsible to make payment for Part A residents if an ambulance transports the beneficiary for:

- initial admission to a SNF
- final discharge to home
- hospital inpatient admission
- to and from an excluded service (except dialysis)

**SNFs** are responsible to make direct payment to an ambulance company whenever the SNF resident is transported by ambulance for:

- outpatient hospital services (except for exclusions)
- dialysis services
- transfers to another SNF

NOTE: Medicare does **not** cover transportation via ambulette, wheelchair van, taxi, or public transportation.

***Consolidated Billing has been postponed until further notice for SNF Part B residents. If a Part B resident requires ambulance transport, the ambulance company would bill the carrier (not the SNF) using their current billing practices.***

## SNF RESPONSIBILITY UNDER CONSOLIDATED BILLING

### Non-Billing Responsibilities

In addition to preparing accurate, complete claims on a HCFA 1450 for processing by the FI, SNFs are required to monitor and regulate all patient care (including those rendered under arrangement ).

***You must notify any outside provider if they are treating a SNF Part A beneficiary in order for that provider to correctly direct the charges back to the SNF for payment (unless they are providing an excluded service).***

### Other Responsibilities

- Medical necessity of services
- Contracts with outside suppliers
- Certificates of Medical Necessity (CMN) from suppliers
- Payment to contractors for services rendered “under arrangement”

**Non-Billing responsibilities**

### Actions NOT Required by Consolidated Billing

Some of the current requirements imposed on contractors providing services to SNF residents will **not** be carried over to become a SNF mandate.

- SNFs do **not** have to obtain a bond to bill durable medical equipment (DME is not billable if place of service is a SNF).
- SNFs do **not** have to enroll with the National Supplier Clearinghouse (NSC) to bill the DMERC.
- SNFs do **not** have to obtain a CLIA Number unless you have a lab on premises.

**Coding Part A claims  
per consolidated  
billing requirements**

### **Billing Responsibilities on Part A Claims**

- Part A claims (21X bill type) **must** contain ( in addition to the HIPPS code for the RUG III group in which the resident was classified) a line item listing (by revenue code) of **all services** rendered to the SNF INPATIENT resident during the dates of service on the claim.
- Adjustments must be sent to the FI if the SNF receives bills from outside suppliers or other providers of service whose charges should have been applied to an original SNF claim.
  - SNFs are responsible for billing the claim, and make payment to those contractors who have provided services to their Part A beneficiaries.

***SNFs may contract with billing agencies for preparation and submission of claims to the FI, but may not “assign” to any other entity the legal responsibility for the claim or the right to receive Medicare payment***

### **Billing Responsibilities on Part B Claims**

**HCPCS coding  
requirements on Part B  
claims**

- Part B claims (22X bill type) will require **HCPCS** for all services when consolidated billing becomes effective for Part B.
- Services billed to the FI by SNFs will continue to be billed in the current manner until HCFA implements consolidated billing for Part B.

**Payment for ancillaries on a Part A claim are factored into the SNF PPS reimbursement**

**Payment for ancillaries on a Part B claim :**

- **Fee schedule**
- **Percentage of charges**

## **REIMBURSEMENT UNDER CONSOLIDATED BILLING**

- Reimbursement for ancillaries that are billed on a Part A claim are **factored into** the RUG III rate for each category in which the resident is classified.
  - Payment includes all reimbursement for services: routine/capital/ancillary.
  - Total payment will be a blend of the provider-specific rate and the national PPS rate.
- Part B claims are reimbursed according to fee schedule for those services in which HCFA has an established fee schedule in place.
  - All others will be paid based on percentage of charges rule until a fee schedule is developed for that service.

### **Financial Issues Regarding Payment for Part A Stays**

Based on their participating agreements, SNFs may not charge beneficiary the difference between the Medicare payment and the charges on the claim.

- Beneficiaries are financially responsible only for co-insurance amounts and services non-covered by Medicare for which a written notice of non-coverage has been issued.

***SNFs will be in violation of their participating agreements if they discriminate against the Medicare beneficiary in their admission practices or in delivery of medically necessary services due to the discrepancy in cost vs. reimbursement.***



# HCPCS

## Codes and Narratives

### Billing for SNF Patients Receiving Services Excluded From the Consolidated Billing Provision of SNF PPS

Service	Effective Date	Page
CT SCANS	July 1, 1998	1
CARDIAC CATHETERIZATION	July 1, 1998	3
MRI	July 1, 1998	5
RADIATION THERAPY	July 1, 1998	7
ANGIOGRAPHY	July 1, 1998	10
OUTPATIENT SURGERY (WITH SOME EXCEPTIONS)	July 1, 1998	14
CHEMOTHERAPY ITEMS	April 1, 2000	18
CHEMOTHERAPY ADMINISTRATION	April 1, 2000	20
RADIOISOTOPE SERVICES	April 1, 2000	22
CUSTOMIZED PROSTHETIC DEVICES	April 1, 2000	23

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

<b>HCPCS</b>	<b>Explanation</b>
70450	computerized axial tomography, head or brain; without contrast material
70460	computerized axial tomography, head or brain; with contrast material(s)
70470	computerized axial tomography, head or brain; without contrast material, followed by contrast material(s) and further sections
70480	computerized axial tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material
70481	computerized axial tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s)
70482	computerized axial tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material, followed by contrast material(s) and further sections
70486	computerized axial tomography, maxillofacial area; without contrast material
70487	computerized axial tomography, maxillofacial area; with contrast material(s)
70488	computerized axial tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections
70490	computerized axial tomography, soft tissue neck; without contrast material
70491	computerized axial tomography, soft tissue neck; with contrast material(s)
70492	computerized axial tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections
71250	computerized axial tomography, thorax; without contrast material
71260	computerized axial tomography, thorax; with contrast material(s)
71270	computerized axial tomography, thorax; without contrast material, followed by contrast material(s) and further sections
72125	computerized axial tomography, cervical spine; without contrast material
72126	computerized axial tomography, cervical spine; with contrast material
72127	computerized axial tomography, cervical spine; without contrast material, followed by contrast material(s) and further sections
72128	computerized axial tomography, thoracic spine; without contrast material
72129	computerized axial tomography, thoracic spine; with contrast material
72130	computerized axial tomography, thoracic spine; without contrast material, followed by contrast material(s) and further sections
72131	computerized axial tomography, lumbar spine; without contrast material
72132	computerized axial tomography, lumbar spine; with contrast material
72133	computerized axial tomography, lumbar spine; without contrast material, followed by contrast material(s) and further sections
72192	computerized axial tomography, pelvis; without contrast material
72193	computerized axial tomography, pelvis; with contrast material(s)
72194	computerized axial tomography, pelvis; without contrast material, followed by contrast material(s) and further sections
73200	computerized axial tomography, upper extremity; without contrast material
73201	computerized axial tomography, upper extremity; with contrast material(s)

<b>HCPCS</b>	<b>Explanation</b>
73202	computerized axial tomography, upper extremity; without contrast material, followed by contrast material(s) and further sections
73700	computerized axial tomography, lower extremity; without contrast material
73701	computerized axial tomography, lower extremity; with contrast material(s)
73702	computerized axial tomography, lower extremity; without contrast material, followed by contrast material(s) and further sections
74150	computerized axial tomography, abdomen; without contrast material
74160	computerized axial tomography, abdomen; with contrast material(s)
74170	computerized axial tomography, abdomen; without contrast material, followed by contrast material(s) and further sections
76355	computerized tomography guidance for stereotactic localization
76360	computerized tomography guidance for needle biopsy, radiological supervision and interpretation
76365	computerized tomography guidance for cyst aspiration, radiological supervision and interpretation
76370	computerized tomography guidance for placement of radiation therapy fields
76375	coronal, sagittal, multiplanar, oblique, 3-dimensional and/or holographic reconstruction of computerized tomography, magnetic resonance imaging, or other tomographic modality
76380	computerized tomography, limited or localized follow-up study
G1031	computerized tomography bone mineral density study, one or more sites; axial skeleton (e.g., hips, pelvis, spine)
G1032	computerized tomography bone mineral density study, one or more sites; appendicular skeleton (peripheral) e.g., radius, wrist, heel)

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

<b>HCPCS</b>	<b>Explanation</b>
93501	right heart catheterization
93503	insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes
93505	endomyocardial biopsy
93508	Catheter placement in coronary artery(s), arterial coronary conduit(s), and/or venous coronary bypass graft(s) for coronary angiography without concomitant left heart catheterization
93510	left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; percutaneous
93511	left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; by cutdown
93514	left heart catheterization by left ventricular puncture
93524	combined transeptal and retrograde left heart catheterization
93526	combined right heart catheterization and retrograde left heart catheterization
93527	combined right heart catheterization and transeptal left heart catheterization through intact septum (with or without retrograde left heart catheterization)
93528	combined right heart catheterization with left ventricular puncture (with or without retrograde left heart catheterization)
93529	combined right heart catheterization and left heart catheterization through existing septal opening (with or without retrograde left heart catheterization)
93530	Right heart catheterization, for congenital cardiac anomalies
93531	Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies
93532	Combined right heart catheterization and transeptal left heart catheterization through intact septum with or without retrograde left heart catheterization, for congenital cardiac anomalies
93533	Combined right heart catheterization and transeptal left heart catheterization through existing septal opening, with or without retrograde left heart catheterization, for congenital cardiac anomalies
93536	percutaneous insertion of intra-aortic balloon catheter
93539	injection procedure during cardiac catheterization; for selective opacification of arterial conduits (eg, internal mammary), whether native or used for bypass
93540	injection procedure during cardiac catheterization; for selective opacification of aortocoronary venous bypass grafts, one or more coronary arteries
93541	injection procedure during cardiac catheterization; for pulmonary angiography
93542	injection procedure during cardiac catheterization; for selective right ventricular or right atrial angiography
93543	injection procedure during cardiac catheterization; for selective left ventricular or left atrial angiography
93544	injection procedure during cardiac catheterization; for aortography

HCPCS	Explanation
93545	injection procedure during cardiac catheterization; for selective coronary angiography (injection of radiopaque material may be by hand)
93555	imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; ventricular and/or atrial angiography
93556	imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; pulmonary angiography, aortography, and/or selective coronary angiography including venous bypass grafts and arterial conduits (whether native or used in bypass)
93561	indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)
93562	indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization; subsequent measurement of cardiac output
93571	Intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel
93572	Intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel

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

<b>HCPCS</b>	<b>Explanation</b>
70336	magnetic resonance (eg, proton) imaging, temporomandibular joint
70540	magnetic resonance (eg, proton) imaging, orbit, face, and neck
70541	magnetic resonance angiography, head and/or neck, with or without contrast material(s)
70551	magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material
70552	magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)
70553	magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences
71550	magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy)
71555	magnetic resonance angiography, chest (excluding myocardium), with or without contrast material(s)
72141	magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material
72142	magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s)
72146	magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material
72147	magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s)
72148	magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material
72149	magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s)
72156	magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical
72157	magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic
72158	magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar
72159	magnetic resonance angiography, spinal canal and contents, with or without contrast material(s)
72196	magnetic resonance (eg, proton) imaging, pelvis
72198	magnetic resonance angiography, pelvis, with or without contrast material(s)
73220	magnetic resonance (eg, proton) imaging, upper extremity, other than joint
73221	magnetic resonance (eg, proton) imaging, any joint of upper extremity

<b>HCPCS</b>	<b>Explanation</b>
73225	magnetic resonance angiography, upper extremity, with or without contrast material(s)
73720	magnetic resonance (eg, proton) imaging, lower extremity, other than joint
73721	magnetic resonance (eg, proton) imaging, any joint of lower extremity
73725	magnetic resonance angiography, lower extremity, with or without contrast material(s)
74181	magnetic resonance (eg, proton) imaging, abdomen
74185	magnetic resonance angiography, abdomen, with or without contrast material(s)
75552	cardiac magnetic resonance imaging for morphology; without contrast material
75553	cardiac magnetic resonance imaging for morphology; with contrast material
75554	cardiac magnetic resonance imaging for function, with or without morphology; complete study
75555	cardiac magnetic resonance imaging for function, with or without morphology; limited study
75556	cardiac magnetic resonance imaging for velocity flow mapping
76093	magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral
76094	magnetic resonance imaging, breast, without and/or with contrast material(s); bilateral
76390	Magnetic resonance spectroscopy
76400	magnetic resonance (eg, proton) imaging, bone marrow blood supply

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

HCPCS	Explanation
77261	therapeutic radiology treatment planning; simple
77262	therapeutic radiology treatment planning; intermediate
77263	therapeutic radiology treatment planning; complex
77280	therapeutic radiology simulation-aided field setting; simple
77285	therapeutic radiology simulation-aided field setting; intermediate
77290	therapeutic radiology simulation-aided field setting; complex
77295	therapeutic radiology simulation-aided field setting; three-dimensional
77299	unlisted procedure, therapeutic radiology clinical treatment planning
77300	basic radiation dosimetry calculation, central axis depth dose, TDF, NSD gap calculation, off axis factor, tissue inhomogeneity factors, as required during course of treatment, only when prescribed by the treating physician
77305	teletherapy, isodose plan (whether hand or computer calculated); simple (one or two parallel opposed unmodified ports directed to a single area of interest)
77310	teletherapy, isodose plan (whether hand or computer calculated); intermediate (three or more treatment ports directed to a single area of interest)
77315	teletherapy, isodose plan (whether hand or computer calculated); complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations)
77321	special teletherapy port plan, particles, hemibody, total body
77326	brachytherapy isodose calculation; simple (calculation made from single plane, one to four sources/ ribbon application, remote afterloading brachytherapy, 1 to 8 sources)
77327	brachytherapy isodose calculation; intermediate (multiplane dosage calculations, application involving five to ten sources/ribbons, remote afterloading brachytherapy, 9 to 12 sources)
77328	brachytherapy isodose calculation; complex (multiplane isodose plan, volume implant calculations, over ten sources/ribbons used, special spatial reconstruction, remote afterloading brachytherapy, over 12 sources)
77331	special dosimetry (eg, TLD, microdosimetry) (specify), only when prescribed by the treating physician
77332	treatment devices, design and construction; simple (simple block, simple bolus)
77333	treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)
77334	treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)
77336	continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy
77370	special medical radiation physics consultation

HCPCS	Explanation
77399	unlisted procedure, medical radiation physics, dosimetry and treatment devices and special services
77401	radiation treatment delivery, superficial and/or ortho voltage
77402	radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; up to 5 MeV
77403	radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 6-10 MeV
77406	radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 20 MeV or greater
77407	radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks; up to 5 MeV
77408	radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks; 6-10 MeV
77409	radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks; 11-19 MeV
77411	radiation treatment delivery, two separate treatment areas, three or more ports on a single treatment area, use of multiple blocks; 20 MeV or greater
77412	radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, special particle beam (eg, electron or neutrons); up to 5 MeV
77413	radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, special particle beam (eg, electron or neutrons); 6-10 MeV
77414	radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, special particle beam (eg, electron or neutrons); 11-19 MeV
77416	radiation treatment delivery, three or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, special particle beam (eg, electron or neutrons); 20 MeV or greater
77417	therapeutic radiology port film(s)
77419	weekly radiation therapy management; conformal
77420	weekly radiation therapy management; simple
77425	weekly radiation therapy management; intermediate
77430	weekly radiation therapy management; complex
77431	radiation therapy management with complete course of therapy consisting of on or two fractions only
77432	stereotactic radiation treatment management of cerebral lesion(s) (complete course of treatment consisting of one session)
77470	special treatment procedure (eg, total body irradiation, hemibody irradiation, per oral, vaginal cone irradiation)
77499	unlisted procedure, therapeutic radiology clinical treatment management
77600	hyperthermia, externally generated; superficial (ie, heating to a depth of 4 cm or less)

<b>HCPCS</b>	<b>Explanation</b>
77605	hyperthermia, externally generated; deep (ie, heating to depths greater than 4 cm)
77610	hyperthermia generated by interstitial probe(s); 5 or fewer interstitial applicators
77615	hyperthermia generated by interstitial probe(s); more than 5 interstitial applicators
77620	hyperthermia generated by intracavitary probe(s)
77750	infusion or instillation of radioelement solution
77761	intracavitary radioelement application; simple
77762	intracavitary radioelement application; intermediate
77763	intracavitary radioelement application; complex
77776	interstitial radioelement application; simple
77777	interstitial radioelement application; intermediate
77778	interstitial radioelement application; complex
77781	remote afterloading high intensity brachytherapy; 1-4 source positions or catheters
77782	remote afterloading high intensity brachytherapy; 5-8 source positions or catheters
77783	remote afterloading high intensity brachytherapy; 9-12 source positions or catheters
77784	remote afterloading high intensity brachytherapy; over 12 source positions or catheters
77789	surface application of radioelement
77790	supervision, handling, loading of radioelement
77799	unlisted procedure, clinical brachytherapy

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

<b>HCPCS</b>	<b>Explanation</b>
75600	aortography, thoracic, without serialography, radiological supervision and interpretation
75605	aortography, thoracic, by serialography, radiological supervision and interpretation
75625	aortography, abdominal, by serialography, radiological supervision and interpretation
75630	aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation
75650	angiography, cervicocerebral, catheter, including vessel origin, radiological supervision and interpretation
75658	angiography, brachial, retrograde, radiological supervision and interpretation
75660	angiography, external carotid, unilateral, selective, radiological supervision and interpretation
75662	angiography, external carotid, bilateral, selective, radiological supervision and interpretation
75665	angiography, carotid, cerebral, unilateral, radiological supervision and interpretation
75671	angiography, carotid, cerebral, bilateral, radiological supervision and interpretation
75676	angiography, carotid, cervical, unilateral, radiological supervision and interpretation
75680	angiography, carotid, cervical, bilateral, radiological supervision and interpretation
75685	angiography, vertebral, cervical, and/or intracranial, radiological supervision and interpretation
75705	angiography, spinal, selective, radiological supervision and interpretation
75710	angiography, extremity, unilateral, radiological supervision and interpretation
75716	angiography, extremity, bilateral, radiological supervision and interpretation
75722	angiography, renal, unilateral, selective (including flush aortogram), radiological supervision and interpretation
75724	angiography, renal, bilateral, selective (including flush aortogram), radiological supervision and interpretation
75726	angiography, visceral, selective or supraseductive, (with or without flush aortogram), radiological supervision and interpretation
75731	angiography, adrenal, unilateral, selective, radiological supervision and interpretation
75733	angiography, adrenal, bilateral, selective, radiological supervision and interpretation
75736	angiography, pelvic, selective or supraseductive, radiological supervision and interpretation

<b>HCPCS</b>	<b>Explanation</b>
75741	angiography, pulmonary, unilateral, selective, radiological supervision and interpretation
75743	angiography, pulmonary, bilateral, selective, radiological supervision and interpretation
75746	angiography, pulmonary, by nonselective catheter or venous injection, radiological supervision and interpretation
75756	angiography, internal mammary, radiological supervision and interpretation
75744	(complete procedure) has been deleted, see 36000-36015, 36400-36425 for intravenous procedure and 75743
75790	angiography, arteriovenous shunt (eg, dialysis patient), radiological supervision and interpretation
75801	lymphangiography, extremity only, unilateral, radiological supervision and interpretation
75803	lymphangiography, extremity only, bilateral, radiological supervision and interpretation
75805	lymphangiography, pelvic/abdominal, unilateral, radiological supervision and interpretation
75807	lymphangiography, pelvic/abdominal, bilateral, radiological supervision and interpretation
75809	shuntogram for investigation of previously placed indwelling nonvascular shunt (eg, LeVeen shunt, ventriculoperitoneal shunt), radiological supervision and interpretation
75810	splenoportography, radiological supervision and interpretation
75820	venography, extremity, unilateral, radiological supervision and interpretation
75822	venography, extremity, bilateral, radiological supervision and interpretation
75825	venography, caval, inferior, with serialography, radiological supervision and interpretation
75827	venography, caval, superior, with serialography, radiological supervision and interpretation
75831	venography, renal, unilateral, selective, radiological supervision and interpretation
75833	venography, renal, bilateral, selective, radiological supervision and interpretation
75840	venography, adrenal, unilateral, selective, radiological supervision and interpretation
75842	venography, adrenal, bilateral, selective, radiological supervision and interpretation
75860	venography, sinus or jugular, catheter, radiological supervision and interpretation
75870	venography, superior sagittal sinus, radiological supervision and interpretation
75872	venography, epidural, radiological supervision and interpretation
75880	venography, orbital, radiological supervision and interpretation

HCPCS	Explanation
75885	percutaneous transhepatic portography with hemodynamic evaluation, radiologic supervision and interpretation
75887	percutaneous transhepatic portography without hemodynamic evaluation, radiological supervision and interpretation
75889	hepatic venography, wedged or free, with hemodynamic evaluation, radiological supervision and interpretation
75891	hepatic venography, wedged or free, without hemodynamic evaluation, radiological supervision and interpretation
75893	venous sampling through catheter, with or without angiography (eg, for parathyroid hormone, renin), radiological supervision and interpretation
75894	transcatheter therapy, embolization, any method, radiological supervision and interpretation
75898	angiogram through existing catheter for follow-up study for transcatheter therapy, embolization or infusion
75900	exchange of a previously placed arterial catheter during thrombolytic therapy with contrast monitoring, radiological supervision and interpretation
75940	percutaneous placement of IVC filter, radiological supervision and interpretation
75960	transcatheter introduction of intravascular stent(s), (non-coronary vessel), percutaneous and/or open, radiological supervision and interpretation, each vessel
75961	transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), radiological supervision and interpretation
75962	transluminal balloon angioplasty, peripheral artery, radiological supervision and interpretation
75964	transluminal balloon angioplasty, each additional peripheral artery, radiological supervision and interpretation (list separately in addition to code for primary procedure)
75966	transluminal balloon angioplasty, renal or other visceral artery, radiological supervision and interpretation
75968	transluminal balloon angioplasty, each additional visceral artery, radiological supervision and interpretation (list separately in addition to code for primary procedure)
75970	transcatheter biopsy, radiological supervision and interpretation
75978	transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation
75980	percutaneous transhepatic biliary drainage with contrast monitoring, radiological supervision and interpretation
75982	percutaneous placement of drainage catheter for combined internal and external biliary drainage or of a drainage stent for internal biliary drainage in patients with an inoperable mechanical biliary obstruction, radiological supervision and interpretation

HCPCS	Explanation
75992	transluminal atherectomy, peripheral artery, radiological supervision and interpretation
75993	transluminal atherectomy, each additional peripheral artery, radiological supervision and interpretation (list separately in addition to code for primary procedure)
75994	transluminal atherectomy, renal, radiological supervision and interpretation
75995	transluminal atherectomy, visceral, radiological supervision and interpretation
75996	transluminal atherectomy, each additional visceral artery, radiological supervision and interpretation (list separately in addition to code for primary procedure)

The applicable HCPCS codes that a Medicare-participating hospital of CAH can report for **outpatient surgery** are all the codes from 11040 – 69979 **with some exceptions**. Codes that are within the list of exceptions **may not be billed by the hospital** as they fall within the range of minor procedures that the SNF may provide. These exceptions are:

HCPCS	Explanation
10040	acne surgery (eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)
10060	incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single
10120	incision and removal of foreign body, subcutaneous tissues; simple
11040	debridement; skin, partial thickness
11041	debridement; skin, full thickness
11042	debridement; skin, and subcutaneous tissue
11055	paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion
11056	paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); two to four lesions
11057	paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); more than four lesions
11200	removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions
11201	removal of skin tags, multiple fibrocutaneous tags, any area; each additional ten lesions (list separately in addition to code for primary procedure)
11300	shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less
11305	shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less
11400	excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms, or legs; lesion diameter 0.5 cm or less
11719	trimming of nondystrophic nails, any number
11720	debridement of nail(s) by any method(s); one to five
11721	debridement of nail(s) by any method(s); six or more
11900	injection, intralesional; up to and including seven lesions
11901	injection, intralesional; more than seven lesions
11920	tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less
11950	subcutaneous injection of "filling" material (eg, collagen); 1 cc or less
11951	subcutaneous injection of "filling" material (eg, collagen); 1.1 to 5.0 cc
11952	subcutaneous injection of "filling" material (eg, collagen); 5.1 to 10.0 cc
11954	subcutaneous injection of "filling" material (eg, collagen); over 10.0 cc
11975	insertion, implantable contraceptive capsules
11976	removal, implantable contraceptive capsules
11977	removal with reinsertion, implantable contraceptive capsules

<b>HCPCS</b>	<b>Explanation</b>
15780	dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	dermabrasion; segmental, face
15782	dermabrasion; regional, other than face
15783	dermabrasion; superficial, any site, (eg, tattoo removal)
15786	abrasion; single lesion (eg, keratosis, scar)
15787	abrasion; each additional four lesions or less (list separately in addition to code for primary procedure)
15788	chemical peel, facial; epidermal
15789	chemical peel, facial; dermal
15792	chemical peel, nonfacial; epidermal
15793	chemical peel, nonfacial; dermal
15810	salabrasion; 20 sq cm or less
15811	salabrasion; over 20 sq cm
16000	initial treatment, first degree burn, when no more than local treatment is required
16020	dressings and/or debridement, initial or subsequent; without anesthesia, office or hospital, small
17000	destruction by any method, including laser, with or without surgical curettement, all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions, including local anesthesia; first lesion
17003	destruction by any method, including laser, with or without surgical curettement, all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions, including local anesthesia; second through 14 lesions, each (list separately in addition to code for first lesion)
17004	destruction by any method, including laser, with or without surgical curettement, all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions, including local anesthesia, 15 or more lesions
17110	destruction by any method of flat warts, molluscum contagiosum, or milia; up to 14 lesions
17111	destruction by any method of flat warts, molluscum contagiosum, or milia; 15 or more lesions
17250	chemical cauterization of granulation tissue (proud flesh, sinus or fistula)
17340	cryotherapy (co2 slush, liquid n2) for acne
17360	chemical exfoliation for acne (eg, acne paste, acid)
17380	electrolysis epilation, each 1/2 hour
17999	unlisted procedure, skin, mucous membrane and subcutaneous tissue
20000	incision of soft tissue abscess (eg, secondary to osteomyelitis); superficial
20974	electrical stimulation to aid bone healing; noninvasive (nonoperative)
21084	impression and custom preparation; speech aid prosthesis

<b>HCPCS</b>	<b>Explanation</b>
21085	impression and custom preparation; oral surgical splint
21497	interdental wiring, for condition other than fracture
26010	drainage of finger abscess; simple
29058	application; plaster Velpeau
29065	application; shoulder to hand (long arm)
28075	application; elbow to finger (short arm)
29085	application; hand and lower forearm (gauntlet)
29105	application of long arm splint (shoulder to hand)
29125	application of short arm splint (forearm to hand); static
29126	application of short arm splint (forearm to hand); dynamic
29130	application of finger splint; static
29131	application of finger splint; dynamic
29200	strapping; thorax
29220	strapping; low back
29240	strapping; shoulder (eg, Velpeau)
29260	strapping; elbow or wrist
29280	strapping; hand or finger
29345	application of long leg cast (thigh to toes);
29355	application of long leg cast (thigh to toes); walker or ambulatory type
29358	application of long leg cast brace
29365	application of cylinder cast (thigh to ankle)
29405	application of short leg cast (below knee to toes);
29425	application of short leg cast (below knee to toes); walking or ambulatory type
29435	application of patellar tendon bearing (PTB) cast
29440	adding walker to previously applied cast
29445	application of rigid total contact leg cast
29450	application of clubfoot cast with molding or manipulation, long or short leg
29505	application of long leg splint (thigh to ankle or toes)
29515	application of short leg splint (calf to foot)
29540	strapping; ankle
29550	strapping; toes
29580	strapping; Unna boot
29590	Denis-Browne splint strapping
29700	removal or bivalving; gauntlet, boot or body cast
29705	removal or bivalving; full arm or full leg cast
29710	removal or bivalving; shoulder or hip spica, Minerva, or Risser jacket, etc.
29715	removal or bivalving; turnbuckle jacket
29720	repair of spica, body cast or jacket
29730	windowing of cast
29740	wedging of cast (except clubfoot casts)
29750	wedging of clubfoot cast
29799	unlisted procedure, casting or strapping
30300	removal foreign body, intranasal; office type procedure

HCPCS	Explanation
30901	control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method
31720	catheter aspiration (separate procedure); nasotracheal
31725	catheter aspiration (separate procedure); tracheobronchial with fiberscope, bedside
31730	transtracheal (percutaneous) introduction of needle wire dilator/ stent or indwelling tube for oxygen therapy
36000	introduction of needle or intracatheter, vein
36140	introduction of needle or intracatheter; extremity artery
36400	venipuncture, under age 3 years; femoral, jugular or sagittal sinus
36405	venipuncture, under age 3 years; scalp vein
36406	venipuncture, under age 3 years; other vein
36415	routine venipuncture or finger/heel/ear stick for collection of specimen(s)
36430	transfusion, blood or blood components
36468	single or multiple injections of sclerosing solutions, spider veins (telangiectasia); limb or trunk
36469	single or multiple injections of sclerosing solutions, spider veins (telangiectasia); face
36470	injection of sclerosing solution; single vein
36471	injection of sclerosing solution; multiple veins, same leg
36489	placement of central venous catheter (subclavian, jugular, or other vein) (eg for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy) percutaneous, over age 2
36600	arterial puncture, withdrawal of blood for diagnosis
36620	arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous
36680	placement of needle for intraosseous infusion
44500	introduction of long gastrointestinal tube (eg, Miller-Abbott) (separate procedure)
63691	Deleted. To report, see 95970, 95971.
64550	application of surface (transcutaneous) neurostimulator
65205	removal of foreign body, external eye; conjunctival superficial
69000	drainage external ear, abscess or hematoma; simple
69090	ear piercing
69200	removal foreign body from external auditory canal; without general anesthesia
69210	removal impacted cerumen (separate procedure), one or both ears
11740	evacuation of subungual hematoma
11043	***only when performed by a PT or OT*** debridement; skin, subcutaneous tissue, and muscle
11044	***only when performed by a PT or OT*** debridement; skin, subcutaneous tissue, muscle, and bone

Effective April 1, 2000, the excluded HCPCS codes for **chemotherapy items** are:

HCPCS	Explanation
J9000	Doxorubicin HCl, 10 mg
J9015	Aldesleukin, per single use vial
J9020	Asparaginase, 10,000 units
J9040	Bleomycin sulfate, 15 units
J9045	Carboplatin, 50 mg
J9050	Carmustine, 100 mg
J9060	Cisplatin, powder or solution, per 10 mg
J9062	Cisplatin, 50 mg
J9065	Injection, cladribine, per 1 mg
J9070	Cyclophosphamide, 100mg
J9080	Cyclophosphamide, 200 mg
J9090	Cyclophosphamide, 500 mg
J9091	Cyclophosphamide, 1 g
J9092	Cyclophosphamide, 2 g
J9093	Cyclophosphamide, lyophilized, 100 mg
J9094	Cyclophosphamide, lyophilized, 200 mg
J9095	Cyclophosphamide, lyophilized, 500 mg
J9096	Cyclophosphamide, lyophilized, 1 g
J9097	Cyclophosphamide, lyophilized, 2 g
J9100	Cytarabine, 100 mg
J9110	Cytarabine, 500 mg
J9120	Dactinomycin, 0.5 mg
J9130	Dacarbazine, 100 mg
J9140	Dacarbazine, 200 mg
J9150	Daunorubicin HCl, 10 mg
J9151	Daunorubicin citrate, liposomal formulation, 10 mg
J9170	Docetaxel, 20 mg
J9181	Etoposide, 10 mg
J9182	Etoposide, 100 mg
J9185	Fludarabine Phosphate 50 mg
J9200	Floxuride, 500 mg
J9201	Gemcitabine HCl, 200 mg
J9206	Irinotecan, 20 mg
J9208	Ifosfamide, per 1 gm
J9211	Idarubicin HCl, 5 mg
J9230	Mechlorethamine HCl, (nitrogen mustard), 10 mg
J9245	Injection, melphalan HCl, 50 mg
J9265	Paclitaxel, 30 mg
J9266	Pegaspargase, per single dose vial
J9268	Pentostatin, per 10 mg
J9270	Plicamycin, 2,500 mcg

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HCPCS	Explanation
J9280	Mitomycin, 5 mg
J9290	Mitomycin, 20 mg
J9291	Mitomycin, 40 mg
J9293	Injection, mitoxantrone HCl, per 5 mg
J9310	Rituximan, 100 mg
J9320	Streptozocin, 1 gm
J9340	Thiotepa, 15 mg
J9350	Topotecan, 4 mg
J9360	Vinblastine sulfate, 1 mg
J9370	Vincristine sulfate, 1 mg
J9375	Vincristine sulfate, 2 mg
J9380	Vincristine sulfate, 5 mg
J9390	Vincristine tartrate, per 10 mg
J9600	Porfimer sodium, 75 mg

Effective April 1, 2000, the excluded HCPCS codes for **chemotherapy administration** services are:

<b>HCPCS</b>	<b>Explanation</b>
36260	Insertion of implantable intra-arterial infusion pump (e.g., for chemotherapy of liver)
36261	Revision of implanted intra-arterial infusion pump
36262	Removal of implanted intra-arterial infusion pump
36489	Placement of central venous catheter (subclavian, jugular, or other vein) (e.g., for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); percutaneous, over age 2
36530	Insertion of implantable intravenous infusion pump
36531	Revision of implantable intravenous infusion pump
36532	Removal of implantable intravenous infusion pump
36533	Insertion of implantable venous access port, with or without subcutaneous reservoir
36534	Revision of implantable venous access port and/or subcutaneous reservoir
36535	Removal of implantable venous access port and/or subcutaneous reservoir
36640	Arterial catheterization for prolonged infusion therapy (chemotherapy), cutdown (see also 96420-96425)
36823	Insertion of arterial and venous cannula(s) for isolated extracorporeal circulation and regional chemotherapy perfusion to an extremity, with or without hyperthermia, with removal of cannula(s) and repair of arteriotomy and venotomy sites
96405	Chemotherapy administration, intralesional; up to and including 7 lesions
96406	Chemotherapy administration, intralesional; more than 7 lesions
96408	Chemotherapy administration, intravenous; push technique
96410	Chemotherapy administration, intravenous; infusion technique, up to one hour
96412	Chemotherapy administration, intravenous; infusion technique, one to 8 hours, each additional hour
96414	Chemotherapy administration, intravenous; infusion technique, initiation of prolonged infusion (more than 8 hours), required the use of a portable or implantable pump
96420	Chemotherapy administration, intra-arterial; push technique
96422	Chemotherapy administration, intra-arterial; infusion technique, up to one hour
96423	Chemotherapy administration, intra-arterial; infusion technique, one to 8 hours, each additional hour
96425	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump
96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis
96445	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis

<b>HCPCS</b>	<b>Explanation</b>
96450	Chemotherapy administration, into CNS (e.g., intrathecal), requiring and including lumbar puncture
96520	Refilling and maintenance of portable pump
96530	Refilling and maintenance of implantable pump or reservoir
96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents

Effective April 1, 2000, the excluded HCPCS codes for applicable **radioisotope services** are:

<b>HCPCS</b>	<b>Explanation</b>
79030	Radiopharmaceutical ablation of gland for thyroid carcinoma
79035	Radiopharmaceutical therapy for metastases of thyroid carcinoma
79100	Radiopharmaceutical therapy, polycythemia vera, chronic leukemia, each treatment
79200	Intracavitary radioactive colloid therapy
79300	Intersitial radioactive colloid therapy
79400	Radiopharmaceutical therapy, nonthyroid, nonhematologic
79420	Intravascular radiopharmaceutical therapy, particulate
79440	Intra-articular radiopharmaceutical therapy

Effective April 1, 2000, the excluded HCPCS codes for **customized prosthetic devices** are:

<b>HCPCS</b>	<b>Explanation</b>
L5050	Ankle, Symes, molded socket, SACH foot
L5060	Ankle, Symes, metal frame, molded leather socket, articulated ankle/foot
L5100	Below knee, molded socket, shin, SACH foot
L5105	Below knee, plastic socket, joints and thigh lacer, SACH foot
L5150	Knee disarticulation (or through knee), molded socket, external knee joints, shin, SACH foot
L5160	Knee disarticulation (or through knee), molded socket, bent knee configuration, external knee joints, shin SACH foot
L5200	Above knee, molded socket, single axis constant friction knee, shin, SACH foot
L5210	Above knee, short prosthesis, no knee joint (“stubbies”), with foot blocks, no ankle joints, each
L5220	Above knee, short prosthesis, no knee joint (“stubbies”), with articulated ankle/foot, dynamically aligned, each
L5230	Above knee, for proximal femoral focal deficiency, constant friction knee, shin, SACH foot
L5250	Hip disarticulation, Canadian type; molded socket, hip joint, single axis constant friction knee, shin, SACH foot
L5270	Hip disarticulation, tilt table type; molded socket, locking hip joint, single axis constant friction knee, shin, SACH foot
L5280	Hemipelvectomy, Canadian type; molded socket, hip joint, single axis constant friction knee, shin, SACH foot
L5300	Below knee, molded socket, SACH foot, endoskeletal system, including soft cover and finishing
L5310	Knee disarticulation (or through knee), molded socket, SACH foot endoskeletal system, including soft cover and finishing
L5320	Above knee, molded socket, open end, SACH foot, endoskeletal system, single axis knee, including soft cover and finishing
L5330	Hip disarticulation, Canadian type; molded socket, endo-skeletal system, hip joint, single axis knee, SACH foot, including soft cover and finishing
L5340	Hemipelvectomy, Canadian type; molded socket, endoskeletal system, hip joint, single axis knee, SACH foot, including soft cover and finishing
L5500	Initial, below knee “PTB” type socket, non-alignable system, pylon, no cover, SACH foot plaster socket, direct formed
L5505	Initial, above knee – knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot plaster socket, direct formed
L5510	Preparatory, below knee “PTB” type socket, non-alignable system, pylon, no cover, SACH foot plaster socket, direct formed
L5520	Preparatory, below knee “PTB” type socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, direct formed

<b>HCPCS</b>	<b>Explanation</b>
L5530	Preparatory, below knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, molded to model
L5535	Preparatory, below knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot, prefabricated, adjustable open end socket
L5540	Preparatory, below knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot, laminated socket, molded to model
L5560	Preparatory, above knee – knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, plaster socket, molded to model
L5570	Preparatory, above knee – knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, direct formed
L5580	Preparatory, above knee – knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, molded to model
L5585	Preparatory, above knee – knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, prefabricated adjustable open end socket
L5590	Preparatory, above knee – knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, laminated socket, molded to model
L5595	Preparatory, hip disarticulation – hemipelvectomy, pylon, no cover, SACH foot, thermoplastic or equal, molded to patient model
L5600	Preparatory, hip disarticulation – hemipelvectomy, pylon, no cover, SACH foot, laminated socket, molded to patient model
L5610	Addition to lower extremity, endoskeletal system, above knee, hydracandence system
L5611	Addition to lower extremity, endoskeletal system, above knee, - knee disarticulation, 4-bar linkage, with friction swing phase control
L5613	Addition to lower extremity, endoskeletal system, above knee, - knee disarticulation, 4-bar linkage, with hydraulic friction swing phase control
L5614	Addition to lower extremity, endoskeletal system, above knee, - knee disarticulation, 4-bar linkage, with pneumatic friction swing phase control
L5616	Addition to lower extremity, endoskeletal system, above knee, universal multiplex system, friction swing phase control
L5617	Addition to lower extremity, quick change self-aligning unit, above or below knee, each
L5618	Addition to lower extremity, test socket, Symes
L5620	Addition to lower extremity, test socket, below knee
L5622	Addition to lower extremity, test socket, knee disarticulation
L5624	Addition to lower extremity, test socket, above knee
L5626	Addition to lower extremity, test socket, hip disarticulation
L5628	Addition to lower extremity, test socket, hemipelvectomy
L5629	Addition to lower extremity, below knee, acrylic socket

<b>HCPCS</b>	<b>Explanation</b>
L5630	Addition to lower extremity, Symes type, expandable wall socket
L5631	Addition to lower extremity, above knee or knee disarticulation, acrylic socket
L5632	Addition to lower extremity, Symes type, "PTB" brim design socket
L5634	Addition to lower extremity, Symes type, posterior opening (Canadian) socket
L5636	Addition to lower extremity, Symes type, medial opening socket
L5637	Addition to lower extremity, below knee, total contact
L5638	Addition to lower extremity, below knee, leather socket
L5639	Addition to lower extremity, below knee, wood socket
L5640	Addition to lower extremity, knee disarticulation, leather socket
L5642	Addition to lower extremity, above knee, leather socket
L5643	Addition to lower extremity, hip disarticulation, flexible inner socket, external frame
L5644	Addition to lower extremity, above knee, wood socket
L5645	Addition to lower extremity, below knee, flexible inner socket, external frame
L5646	Addition to lower extremity, below knee, air cushion socket
L5647	Addition to lower extremity, below knee, suction socket
L5648	Addition to lower extremity, above knee, air cushion socket
L5649	Addition to lower extremity, ischial containment/narrow M-L socket
L5650	Addition to lower extremity, total contact, above knee or knee disarticulation socket
L5651	Addition to lower extremity, above knee, flexible inner socket, external frame
L5652	Addition to lower extremity, suction suspension, above knee or knee disarticulation socket
L5653	Addition to lower extremity, knee disarticulation, expandable wall socket
L5654	Addition to lower extremity, socket insert, Symes (Kemblo, Pelite, Aliplast, Plastazote, or equal)
L5655	Addition to lower extremity, socket insert, below knee (Kemblo, Pelite, Aliplast, Plastazote, or equal)
L5656	Addition to lower extremity, socket insert, knee disarticulation (Kemblo, Pelite, Aliplast, Plastazote, or equal)
L5658	Addition to lower extremity, socket insert, above knee (Kemblo, Pelite, Aliplast, Plastazote, or equal)
L5660	Addition to lower extremity, socket insert, Symes, silicone gel or equal
L5661	Addition to lower extremity, socket insert, multidurometer, Symes
L5662	Addition to lower extremity, socket insert, below knee, silicone gel or equal
L5663	Addition to lower extremity, socket insert, knee disarticulation, silicone gel or equal
L5664	Addition to lower extremity, socket insert, above knee, silicone gel or equal
L5665	Addition to lower extremity, socket insert, multidurometer, below knee
L5666	Addition to lower extremity, socket insert, cuff suspension
L5667	Addition to lower extremity, below knee/above knee, socket insert, suction suspension with locking mechanism
L5668	Addition to lower extremity, below knee, molded distal cushion
L5669	Addition to lower extremity, below knee/above knee, socket insert, suction

HCPCS	Explanation
	suspension without locking mechanism
L5670	Addition to lower extremity, below knee, molded supracondylar suspension ("PTS) or similar
L5672	Addition to lower extremity, below knee, removable medial brim suspension
L5674	Addition to lower extremity, below knee, latex sleeve suspension or equal, each
L5675	Addition to lower extremity, below knee, latex sleeve suspension or equal, heavy duty, each
L5676	Addition to lower extremity, below knee, knee joints, single axis, pair
L5677	Addition to lower extremity, below knee, knee joints, polycentric, pair
L5678	Addition to lower extremity, below knee, joint covers, pair
L5680	Addition to lower extremity, below knee, thigh lacer nonmolded
L5682	Addition to lower extremity, below knee, thigh lacer, gluteal/ischial, molded
L5684	Addition to lower extremity, below knee, fork strap
L5686	Addition to lower extremity, below knee, back check (extension control)
L5688	Addition to lower extremity, below knee, waist belt, webbing
L5690	Addition to lower extremity, below knee, waist belt, padded and lined
L5692	Addition to lower extremity, above knee, pelvic control belt, light
L5694	Addition to lower extremity, above knee, pelvic control belt, padded and lined
L5695	Addition to lower extremity, above knee, pelvic control, sleeve suspension, neoprene or equal, each
L5696	Addition to lower extremity, above knee or knee disarticulation, pelvic joint
L5697	Addition to lower extremity, above knee or knee disarticulation, pelvic band
L5698	Addition to lower extremity, above knee or knee disarticulation, Silesian bandage
L5699	All lower extremity prostheses, shoulder harness
L5700	Replacement, socket, below knee, molded to patient model
L5701	Replacement, socket, above knee/knee disarticulation, including attachment plate, molded to patient model
L5702	Replacement, socket, hip disarticulation, including hip joint, molded to patient model
L5704	Replacement, custom shaped protective cover, below knee
L5705	Replacement, custom shaped protective cover, above knee
L5706	Replacement, custom shaped protective cover, knee disarticulation
L5707	Replacement, custom shaped protective cover, hip disarticulation
L5710	Addition, exoskeletal knee-shin system, single axis, manual lock
L5711	Addition, exoskeletal knee-shin system, single axis, manual lock, ultra-light material
L5712	Addition, exoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)
L5714	Addition, exoskeletal knee-shin system, single axis, variable friction swing phase control
L5716	Addition, exoskeletal knee-shin system, polycentric, mechanical stance phase lock

<b>HCPCS</b>	<b>Explanation</b>
L5718	Addition, exoskeletal knee-shin system, polycentric, friction swing and stance phase control
L5722	Addition, exoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control
L5724	Addition, exoskeletal knee-shin system, single axis, fluid swing phase control
L5726	Addition, exoskeletal knee-shin system, single axis, external joints, fluid swing phase control
L5728	Addition, exoskeletal knee-shin system, single axis, fluid swing and stance phase control
L5780	Addition, exoskeletal knee-shin system, single axis, pneumatic/hydra pneumatic swing phase control
L5785	Addition, exoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)
L5790	Addition, exoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)
L5795	Addition, exoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)
L5810	Addition, endoskeletal knee-shin system, single axis, manual lock
L5811	Addition, endoskeletal knee-shin system, single axis, manual lock, ultra-light material
L5812	Addition, endoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)
L5814	Addition, endoskeletal knee-shin system, polycentric, hydraulic swing phase control, mechanical stance phase lock
L5816	Addition, endoskeletal knee-shin system, polycentric, mechanical stance phase lock
L5818	Addition, endoskeletal knee-shin system, polycentric, friction swing and stance phase control
L5822	Addition, endoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control
L5824	Addition, endoskeletal knee-shin system, single axis, fluid swing phase control
L5826	Addition, endoskeletal knee-shin system, single axis, hydraulic swing phase control, with miniature high activity frame
L5828	Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control
L5830	Addition, endoskeletal knee-shin system, single axis, pneumatic/swing phase control
L5840	Addition, endoskeletal knee-shin system, 4-bar linkage or multiaxial, pneumatic swing phase control
L5845	Addition, endoskeletal knee-shin system, stance flexion feature, adjustable
L5846	Addition, endoskeletal knee-shin system, microprocessor control feature, swing phase only
L5850	Addition, endoskeletal system, above knee or hip disarticulation, knee extension assist

<b>HCPCS</b>	<b>Explanation</b>
L5855	Addition, endoskeletal system, hip disarticulation, mechanical hip extension assist
L5910	Addition, endoskeletal system, below knee, alignable system
L5920	Addition, endoskeletal system, above knee or hip disarticulation, alignable system
L5925	Addition, endoskeletal system, above knee, knee disarticulation or hip disarticulation, manual lock
L5930	Addition, endoskeletal system, high activity knee control frame
L5940	Addition, endoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)
L5950	Addition, endoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)
L5960	Addition, endoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)
L5950	Addition, endoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)
L5960	Addition, endoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)
L5962	Addition, endoskeletal system, below knee, flexible protective outer surface covering system
L5964	Addition, endoskeletal system, above knee, flexible protective outer surface covering system
L5966	Addition, endoskeletal system, hip disarticulation, flexible protective outer surface covering system
L5968	All lower extremity prosthesis, ankle, multi-axial shock absorbing system
L5970	All lower extremity prostheses, foot, external keel, SACH foot
L5972	All lower extremity prostheses, flexible keel foot (Safe, Sten, Bock Dynamic or equal)
L5974	All lower extremity prostheses, foot single axis ankle/foot
L5975	All lower extremity prostheses, combination single axis ankle and flexible keel foot
L5976	All lower extremity prostheses, energy storing foot (Seattle Carbon Copy 11 or equal)
L5978	All lower extremity prostheses, foot, multi-axial ankle/foot
L5979	All lower extremity prostheses, multi-axial ankle/foot, dynamic response
L5980	All lower extremity prostheses, flex foot system
L5981	All lower extremity prostheses, flex-walk system or equal
L5982	All exoskeletal lower extremity prostheses, axial rotation unit
L5984	All endoskeletal lower extremity prostheses, axial rotation unit

<b>HCPCS</b>	<b>Explanation</b>
L5985	All endoskeletal lower extremity prostheses, dynamic prosthetic pylon
L5986	All lower extremity prostheses, multi-axial rotation unit ("MCP" or equal)
L5988	All lower extremity prostheses, combination vertical shock and multi-axial rotation/torsional force reducing pylon
L6050	Wrist disarticulation, molded socket, flexible elbow hinges, triceps pad
L6055	Wrist disarticulation, molded socket with expandable interface, flexible elbow hinges, triceps pad
L6100	Below elbow, molded socket, flexible elbow hinge, triceps pad
L6110	Below elbow, molded socket (Muenster or Northwestern suspension types)
L6120	Below elbow, molded double wall split socket, step-up hinges, half cuff
L6130	Below elbow, molded double wall split socket, stump activated locking hinge, half cuff
L6200	Elbow disarticulation, molded socket, outside locking hinge, forearm
L6205	Elbow disarticulation, molded socket with expandable interface, outside locking hinges, forearm
L6250	Above elbow, molded double wall socket, internal locking elbow, forearm
L6300	Shoulder disarticulation, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm
L6310	Shoulder disarticulation, passive restoration (complete prosthesis)
L6320	Shoulder disarticulation, passive restoration (shoulder cap only)
L6350	Interscapular thoracic, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm
L6360	Interscapular thoracic, passive restoration (complete prosthesis)
L6370	Interscapular thoracic, passive restoration (shoulder cap only)
L6400	Below elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping
L6450	Elbow disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping
L6500	Above elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping
L6550	Shoulder disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping
L6570	Interscapular thoracic, molded socket, endoskeletal system, including soft prosthetic tissue shaping
L6580	Preparatory, wrist disarticulation or below elbow, single wall plastic socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, IIUSMCII or equal pylon, no cover, direct formed

HCPCS	Explanation
L6582	Preparatory, wrist disarticulation or below elbow, single wall socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, "USMC" or equal pylon, no cover, direct formed
L6584	Preparatory, elbow disarticulation or above elbow, single wall plastic socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, "USMC" or equal pylon, no cover, molded to patient model
L6586	Preparatory, elbow disarticulation or above elbow, single wall socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, "USMC" or equal pylon, no cover, direct formed
L6588	Preparatory, shoulder disarticulation or intrascapular thoracic, single wall plastic socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, "USMC" or equal pylon, no cover, molded to patient model
L6590	Preparatory, shoulder disarticulation or intrascapular thoracic, single wall socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, "USMC" or equal pylon, no cover, direct formed
L6600	Upper extremity additions, polycentric hinge, pair
L6605	Upper extremity additions, single pivot hinge, pair
L6610	Upper extremity additions, flexible metal hinge, pair
L6615	Upper extremity addition, disconnect locking wrist unit
L6616	Upper extremity addition, additional disconnect insert for locking wrist unit, each
L6620	Upper extremity addition, flexion-friction wrist unit
L6623	Upper extremity addition, spring assisted rotational wrist unit with latch release
L6625	Upper extremity addition, rotation wrist unit with cable lock
L6628	Upper extremity addition, quick disconnect hook adapter, Otto Bock or equal
L6629	Upper extremity addition, quick disconnect lamination collar with coupling piece, Otto Bock or equal
L6630	Upper extremity addition, stainless steel, any wrist
L6632	Upper extremity addition, latex suspension sleeve, each
L6635	Upper extremity addition, lift assist for elbow
L6637	Upper extremity addition, nudge control elbow lock
L6640	Upper extremity addition, shoulder abduction joint, pair
L6641	Upper extremity addition, excursion amplifier, pulley type
L6642	Upper extremity addition, excursion amplifier, lever type
L6645	Upper extremity addition, shoulder universal joint, each
L6650	Upper extremity addition, standard control cable, extra

<b>HCPCS</b>	<b>Explanation</b>
L6660	Upper extremity addition, heavy duty control cable
L6665	Upper extremity addition, Teflon, or equal, cable lining
L6670	Upper extremity addition, hook to hand, cable adapter
L6672	Upper extremity addition, harness, chest or shoulder, saddle type
L6675	Upper extremity addition, harness, figure of eight type, for single control
L6676	Upper extremity addition, harness, figure of eight type, for dual control
L6680	Upper extremity addition, test socket, wrist disarticulation or below elbow
L6682	Upper extremity addition, test socket, elbow disarticulation above elbow
L6684	Upper extremity addition, test socket, shoulder disarticulation or interscapular thoracic
L6686	Upper extremity addition, suction socket
L6687	Upper extremity addition, frame type socket, below elbow or wrist
L6688	Upper extremity addition, frame type socket, above elbow or elbow disarticulation
L6689	Upper extremity addition, frame type socket, shoulder disarticulation
L6690	Upper extremity addition, frame type socket, interscapular-thoracic
L6691	Upper extremity addition, removable insert, each
L6692	Upper extremity addition, silicone gel insert or equal, each
L6693	Upper extremity addition, external locking elbow, forearm counterbalance
L6700	Terminal device, hook, Dorrance or equal, model #3
L6705	Terminal device, hook, Dorrance or equal, model #5
L6710	Terminal device, hook, Dorrance or equal, model #5X
L6715	Terminal device, hook, Dorrance or equal, model #5XA
L6720	Terminal device, hook, Dorrance or equal, model #6
L6725	Terminal device, hook, Dorrance or equal, model #7
L6730	Terminal device, hook, Dorrance or equal, model VLO
L6735	Terminal device, hook, Dorrance or equal, model #8
L6740	Terminal device, hook, Dorrance or equal, model #8X
L6745	Terminal device, hook, Dorrance or equal, model #88X
L6750	Terminal device, hook, Dorrance or equal, model #10P
L6755	Terminal device, hook, Dorrance or equal, model #I OX
L6765	Terminal device, hook, Dorrance or equal, model #12P
L6770	Terminal device, hook, Dorrance or equal, model #99X
L6775	Terminal device, hook, Doffance or equal, model #555

<b>HCPCS</b>	<b>Explanation</b>
L6780	Terminal device, hook, Doffance or equal, model #SS555
L6790	Terminal device, hook, Accu hook or equal
L6795	Terminal device, hook, 2 load or equal
L6800	Terminal device, hook, APRL VC or equal
L6805	Terminal device, modifier wrist flexion unit
L6806	Terminal device, hook, TRS Grip, Grip 111, VC, or equal
L6807	Terminal device, hook, Grip 1, Grip 11, VC, or equal
L6808	Terminal device, hook, TRS Adept, infant or child, VC, or equal
L6809	Terminal device, hook, TRS Super Sport, passive
L6810	Terminal device, pincher tool, Otto Bock or equal
L6825	Terminal device, hand, Dorrance, VO
L6830	Terminal device, hand, APRL, VC
L6835	Terminal device, hand, Sierra, VO
L6840	Terminal device, hand, Becker Imperial
L6845	Terminal device, hand, Becker Lock Grip
L6850	Terminal device, hand, Becker Plylite
L6855	Terminal device, hand, Robin-Aids, VO
L6860	Terminal device, hand, Robin-Aids, VO soft
L6865	Terminal device, hand, passive hand
L6867	Terminal device, hand, Detroit Infant Hand (mechanical)
L6868	Terminal device, hand, passive infant hand, Steeper, Hosmer or equal
L6870	Terminal device, hand, child mitt
L6872	Terminal device, hand, NYU child hand
L6873	Terminal device, hand, mechanical infant hand, Steeper or equal
L6875	Terminal device, hand, Bock, VC
L6880	Terminal device, hand, Bock, VO
L6920	Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device
L6930	Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device
L6935	Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device

HCPCS	Explanation
L6940	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device
L6945	Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
L6950	Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device
L6955	Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
L6960	Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device
L6965	Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
L6970	Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device
L6975	Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device
L7010	Electronic hand, Otto Bock, Steeper or equal, switch controlled
L7015	Electronic hand, System Teknik, Variety Village or equal, switch controlled
L7020	Electronic greifer, Otto Bock or equal, switch controlled
L7025	Electronic hand, Otto Bock or equal, myoelectronically controlled
L7030	Electronic hand, System Teknik, Variety Village or equal, myoelectronically controlled
L7035	Electronic greifer, Otto Bock or equal, myoelectronically controlled
L7040	Prehensile actuator, Hosmer or equal, switch controlled
L7045	Electronic hook, child, Michigan or equal, switch controlled
L7170	Electronic elbow, Hosmer or equal, switch controlled
L7180	Electronic elbow, Boston, Utah or equal, myoelectronically controlled

HCPCS	Explanation
L7185	Electronic elbow, adolescent, Variety Village or equal, switch controlled
L7186	Electronic elbow, child, Variety Village or equal, switch controlled
L7190	Electronic elbow, adolescent, Variety Village or equal, myoelectronically controlled
L7191	Electronic elbow, child, Variety Village or equal, myoelectronically controlled
L7260	Electronic waist rotator, Otto Bock or equal
L7266	Servo control, Steeper or equal
L7272	Analogue control, UNB or equal
L7274	Proportional control, 6-12 volt, Liberty, Utah or equal
L7362	Battery charger, six volt, Otto Bock or equal
L7364	Twelve volt battery, Utah or equal, each
L7366	Battery charger, twelve volt, Utah or equal