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Quarterly Update to 2018 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement

MLN Matters Number: MM10852	Related Change Request (CR) Number: 10852
Related CR Release Date: July 20, 2018	Effective Date: January 1, 2016
Related CR Transmittal Number: R4093CP	Implementation Date: October 1, 2018

PROVIDER TYPE AFFECTED

This MLN Matters® Article is intended for providers who submit claims to Medicare Administrative Contractors (MACs), including Durable Medical Equipment MACs (DME MACs) for services provided in a Skilled Nursing Facility (SNF) to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10852 provides updates to the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the Consolidated Billing (CB) provision of the SNF Prospective Payment System (PPS). Changes to Current Procedural Terminology (CPT)/HCPCS codes and Medicare Physician Fee Schedule designations are to revise Common Working File (CWF) edits to allow MACs to make appropriate payments in accordance with policy for SNF CB in the "Medicare Claims Processing Manual", Chapter 6, Section 20.6. Make sure your billing staffs are aware of these changes.

BACKGROUND

CR10852 alerts providers that the Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are excluded from the CB provision of the SNF PPS. Services excluded from SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay. Services not appearing on the exclusion lists submitted on claims to MACs, including DME MACs, will not be paid by Medicare to any providers other than a SNF.

For non-therapy services, SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay; however, SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay. In order to assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

The updated lists for institutional and professional billing are available at http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html. Certain codes are included as services that are not subject to SNF CB. You may submit these codes globally (no modifier), professional component only (modifier 26), or technical component only (modifier TC).

Certain codes are included as services that are not subject to SNF CB. These codes can be submitted globally (no modifier), professional component only (modifier 26), or technical component only (modifier TC). When the codes listed below are submitted globally or just for the technical component, the claims submitted to the MACs (Part B) are being rejected by the CWF. That is to say, they are not allowed to pay separately outside of the consolidated payment that is made to the SNF. When submitted with the 26 modifier for just the professional component, the claims have been allowed to pay. The codes are:

- Codes that should have been added effective January 1, 2016 - 77770, 77771, 77772
- Codes that should have been added effective January 1, 2017 - G0491, G0500, J9034, J9301, Q0083, Q0084, Q0085, 36598, 77385, 77386, 77770, 77771, 77772, 79005, 79101, 79445, 96446, 99151, 99152, 99155, 99156, and 99157
- Codes that should have been added effective January 1, 2018 - 00731, 00732, 00811, 00812, 00813, and 77772

The above errors are occurring because CMS did not add the codes to the appropriate coding lists with the 2016, 2017, and 2018 SNF CB Annual Updates. Therefore, for claims with dates of service on or after January 1, 2016, the MACs (Part B) will re-open and reprocess impacted claims, if you bring those claims to the attention of your MAC. MACs (Part B) will notify providers that if they have already received payment for these services from the SNF, they need to return that payment to the SNF in order to receive payment from Medicare. Providers may not be paid twice for the same service and such a request could be construed as a fraudulent claim.

The following HCPCS will be added to Major Category 1 (Exclusion of Services Beyond the Scope of a SNF) exclusions retroactive to July 1, 2018:

- Q5105 Injection, epoetin alfa, biosimilar, (Retacrit) (for esrd on dialysis), 100 units
- Q5106 Injection, epoetin alfa, biosimilar, (Retacrit) (for non-esrd use), 1000 units

For claims processed on or after October 1, 2018, HCPCS codes Q5105 and Q5106 will be added to Physician Services for SNF Consolidated Billing with an effective date of July 1, 2018.

Note: MACs will re-open and re-process the claims brought to their attention, for claims with dates of service on or after July 1, 2018, that have previously been denied/rejected prior to the implementation of CR 10852.

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ADDITIONAL INFORMATION

The official instruction, CR10852, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4093CP.pdf.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
July 20, 2018	Initial article released.

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