CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 4163	**Date: November 2, 2018**
	Change Request 11004

SUBJECT: Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions (SNF) (2018 Q4)

I. SUMMARY OF CHANGES: The purpose of this CR is to update the Medicare manuals to correct various minor technical errors and omissions. These changes are intended only to clarify the existing content and no policy, processing, or system changes are anticipated.

EFFECTIVE DATE: December 4, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: December 4, 2018

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/ 30.1.3/ Provider Treatment of Beneficiaries
R	6/ 10/ Skilled Nursing Facility (SNF) Prospective Payment System (PPS) and Consolidated Billing Overview
R	6/ 10.1/ Consolidated Billing Requirement for SNFs
R	6/ 10.4.1/ “Under Arrangements” Relationships
R	6/ 20.2.2/ Hospice Care for a Beneficiary’s Terminal Illness
R	6/ 20.4/ Screening and Preventive Services

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 4163	Date: November 2, 2018	Change Request: 11004

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I. GENERAL INFORMATION

A. Background: This CR updates the Medicare manuals with regard to SNF policy to clarify the existing content. These changes are being made to correct various omissions and minor technical errors. There are no policy changes.

Pub 100-04, Chapter 1, §30.1.3:

This section is revised by adding appropriate cross-references.

Pub 100-04, Chapter 6, §10:

This section is revised to clarify that the exclusion of certain customized devices from consolidated billing applies solely to designated *prosthetic* devices and not to orthotics (which, as a class, remain subject to consolidated billing), and by adding appropriate cross-references.

Pub 100-04, Chapter 6, §10.1:

This section is revised in order to abbreviate the term “consolidated billing” (CB) consistently throughout the section, and by adding an appropriate cross-reference.

Pub 100-04, Chapter 6, §10.4.1:

This section is revised to clarify the language on sample agreements between SNFs and their suppliers, and by adding an appropriate cross-reference.

Pub 100-04, Chapter 6, §20.2.2:

This section is revised to clarify the explanation of why hospice services are not subject to consolidated billing.

Pub 100-04, Chapter 6, §20.4:

This section is revised to clarify the explanation of why certain Part-D-only preventive vaccines are not subject to consolidated billing.

B. Policy: These changes are intended to clarify the existing content; there are no policy changes.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11004 - 04.1	Contractors and impacted providers shall be aware of the updates to Pub 100-04, Chapters 1 and 6.	X	X							SNF Pricer

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
11004 - 04.2	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X	X			

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Anthony Hodge, Anthony.Hodge@cms.hhs.gov , Bill Ullman, 410-786-5667 or william.ullman@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 1 - General Billing Requirements

30.1.3 - Provider Treatment of Beneficiaries
(Rev.4163, Issued: 11-02-18, Effective: 12-04-18, Implementation: 12-04-18)

In the agreement between CMS and a provider, the provider agrees to accept Medicare beneficiaries for care and treatment. The provider cannot impose any limitations with respect to care and treatment of Medicare beneficiaries that it does not also impose on all other persons seeking care and treatment. If the provider does not furnish treatment for certain illnesses and conditions to patients who are not Medicare beneficiaries, it need not furnish such treatment to Medicare beneficiaries in order to participate in the Medicare program. It may not, however, refuse to furnish treatment for certain illnesses or conditions to Medicare beneficiaries if it furnishes such treatment to others. Failure to abide by this rule is a cause for termination of the provider's agreement to participate in the Medicare program *(see the regulations at 42 CFR 489.53(a)(2), and also see Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, chapter 5, §10.2)*.

Medicare Claims Processing Manual

Chapter 6 - SNF Inpatient Part A Billing and SNF Consolidated Billing

10 - Skilled Nursing Facility (SNF) Prospective Payment System (PPS) and Consolidated Billing Overview

(Rev.4163, Issued: 11-02-18, Effective: 12-04-18, Implementation: 12-04-18)

All SNF Part A inpatient services are paid under a prospective payment system (PPS). Under SNF PPS, beneficiaries must meet the regular eligibility requirements for a SNF stay. That is, the beneficiary must have been an inpatient of a hospital for a medically necessary stay of at least three consecutive calendar days. In addition, the beneficiary must have been transferred to a participating SNF within 30 days after discharge from the hospital, unless the patient's condition makes it medically inappropriate to begin an active course of treatment in an SNF within 30 days after hospital discharge, and it is medically predictable at the time of the hospital discharge that the beneficiary will require covered care within a predetermined time period. (See the Medicare Benefit Policy Manual, Chapter 8, "Coverage of Extended Care Services Under Hospital Insurance," §20.2, for further information on the 30-day transfer requirement and exception.) To be covered, the extended care services must be needed for a condition which was treated during the patient's qualifying hospital stay, or for a condition which arose while in the SNF for treatment of a condition for which the beneficiary was previously treated in a hospital.

Also under SNF PPS all Medicare covered Part A services that are considered within the scope or capability of SNFs are considered paid in the PPS rate. In some cases this means that the SNF must obtain some services that it does not provide directly. Neither the SNF nor another provider or practitioner may bill the program for the services under Part B, except for services specifically excluded from PPS payment and associated consolidated billing requirements.

Any DME or oxygen furnished to inpatients in a covered Part A stay is included in the SNF PPS rate. The definition of DME in §1861(n) of the Social Security Act (the Act) provides that DME is covered by Part B only when intended for use in the home, which explicitly does not include a SNF. This definition applies to oxygen also. (See the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Service," §110.)

Most prosthetics and *all* orthotic devices are included in the Part A PPS rate. *An exception involves certain designated customized prosthetic devices that are specifically identified* as being outside the rate *(see the regulations at 42 CFR 411.15(p)(2)(xvi) and Major Category III.D of the SNF consolidated billing editing)*. Those *customized prosthetic devices* that are considered outside the PPS rate are billed by the qualified outside entity that furnished the service. That entity bills its normal MAC.

Services that are not considered to be furnished within SNF PPS are identified in sections §§20.1 - 20.4. These may be billed separately under Part B. Some services must be billed by the SNF. (This is referred to as "consolidated billing.") Some services must be billed by the rendering provider (SNF or otherwise). These are discussed further in §§20.1 - 20.4.

10.1 - Consolidated Billing Requirement for SNFs

(Rev.4163, Issued: 11-02-18, Effective: 12-04-18, Implementation: 12-04-18)

Section 4432 (b) of the Balanced Budget Act (BBA) requires consolidated billing *(CB)* for SNFs. Under the *CB* requirement, the SNF must submit ALL Medicare claims for ALL the services that its residents receive under Part A, **except** for certain excluded services described in §§20.1 - 20.3, **and** for all physical, occupational and speech-language pathology services received by residents under Part B (see §20.5). A

SNF resident is defined as a beneficiary who is admitted to a Medicare participating SNF or the participating, Medicare-certified, distinct part unit (DPU) of a larger institution. Under the regulations at 42 CFR 411.15(p)(3)(i)-(iv), if such a beneficiary leaves the facility (or the DPU), the beneficiary's status as a SNF "resident" for CB purposes (along with the SNF's responsibility to furnish or make arrangements for needed services) ends when any one of the following events occurs:

- The beneficiary is admitted as an inpatient to a Medicare-participating hospital or critical access hospital (CAH), or as a resident to another SNF;

- The beneficiary receives services from a Medicare-participating home health agency under a plan of care;

- The beneficiary receives one of the types of outpatient hospital services that CMS has designated as being exceptionally intensive (see §20.1.2); or

- The beneficiary is formally discharged (or otherwise departs) from the SNF or DPU, unless the beneficiary is readmitted (or returns) to that or another SNF before the following midnight. This provision is sometimes referred to as the "midnight rule" (see Pub. 100-02, Medicare Benefit Policy Manual, chapter 3, §20.1, which specifies that an inpatient day ". . . begins at midnight and ends 24 hours later"). A "discharge" from the Medicare-certified DPU includes situations in which the beneficiary is moved from the DPU to a Medicare non-certified area within the same institution.

When a beneficiary is absent from the SNF overnight (i.e., the absence from the SNF spans midnight), the beneficiary's status as a SNF "resident" for CB purposes would end upon the point of departure from the SNF (per the above-described "midnight rule"), and would not resume until the actual point of arrival back at the SNF the next day. Accordingly, that beneficiary would not be considered a SNF "resident" for CB purposes between those two points, so that any offsite services furnished during the interim (such as an overnight sleep study) would not be subject to CB.

It should be noted that the scenarios described in the first three clauses above would become relevant only if a beneficiary leaves the SNF but then arrives back in that or another SNF before the following midnight. This is because under the "midnight rule" discussed in the fourth clause, whenever a beneficiary leaves the SNF but does not arrive back in that or another SNF later on that same day, the beneficiary's "resident" status for CB purposes would end immediately upon departure--before any of the other events described in the first three clauses could even occur.

By contrast, when a beneficiary does return to that or another SNF by the end of the same day (a scenario that normally would serve to maintain the beneficiary's status as a "resident" of the originating SNF throughout the absence), the occurrence of one of the intervening events listed in the first three clauses above would nevertheless serve to end the beneficiary's "resident" status at that point. For example, when a beneficiary leaves the SNF to receive outpatient emergency services at the hospital, the emergency services would never be subject to CB—even in a situation where the beneficiary returns to the SNF later that same day—because the receipt of the emergency services themselves under the third clause above would have already served to suspend the beneficiary's SNF "resident" status with respect to those services under the regulations at 42 CFR 411.15(p)(3)(iii).

These requirements apply only to Medicare fee-for-service beneficiaries residing in a participating SNF or DPU.

Claims are submitted to the A/B MAC (A) on the ASC X12 837 institutional format or Form CMS-1450. All services billed by the SNF (including those furnished under arrangements with an outside supplier) for a resident of a SNF in a covered Part A stay are included in the SNF's Part A bill. If a resident is not in a covered Part A stay (Part A benefits exhausted, posthospital or level of care requirements not met), the SNF is required to bill for all physical therapy, occupational therapy, and/or speech-language pathology services

provided to a SNF resident under Part B. The *CB* provision requires that effective for services and items furnished on or after July 1, 1998, payment is made directly to the SNF.

Thus, SNFs are no longer able to "unbundle" services to an outside supplier that can then submit a separate bill directly to an A/B MAC (B) or DME MAC for residents in a Part A stay, or for SNF residents receiving physical therapy, occupational therapy, and/or speech-language pathology services paid under Part B. Instead, the SNF must furnish the services either directly or under an arrangement with an outside supplier or provider of services in which the SNF (rather than the supplier or provider of services) bills Medicare. Medicare does not pay amounts that are due a provider to any other person under assignment, or power of attorney, or any other direct payment arrangement. As a result, the outside supplier must look to the SNF (rather than the A/B MAC (A), or (B), or DME MAC or the beneficiary) for payment. The SNF may collect any applicable deductible or coinsurance from the beneficiary.

NOTE: The requirements for participation at 42 CFR 483.15(c)(1)(i)(A)-(F) specify the limited circumstances under which a resident can be involuntarily moved out of a Medicare-certified SNF or DPU. These circumstances can include situations in which the resident's health has improved to the point where he or she no longer needs SNF care. However, if a resident has exhausted Part A benefits but nevertheless continues to require SNF care, he or she cannot be moved out of the Medicare-certified SNF or DPU for reasons other than those specified in the regulations. For example, the resident cannot be moved to avoid the *CB* requirements, or to establish a new benefit period. The determination to move the beneficiary out of the SNF or DPU must not be made on the basis of the beneficiary having exhausted his or her benefits, but rather, on the beneficiary's lack of further need for SNF care. Once a resident of a Medicare-certified DPU ceases to require SNF care, he or she may then be moved from the DPU to the Medicare non-certified area of the institution. As discussed above, such a move would end the beneficiary's status as a SNF "resident" for *CB* purposes.

Enforcement of *CB* is done through editing in Medicare claims processing systems using lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the *CB* provision of SNF PPS. In order to assure proper payment in all settings, Medicare systems must edit for services, provided to SNF beneficiaries, both included and excluded from CB. Transmittals with instructions provide updates to previous lists of the exclusions, and some inclusions, to CB. Such transmittals can be found on the CMS Web site at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html or http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html. *Step-by-step instructions for accessing the exclusion list itself appear in the Medicare Benefit Policy Manual, Chapter 8, §10.2.*

The list of HCPCS codes enforcing CB may be updated each quarter. For the notice on CB for the quarter beginning January, separate instructions are published for A/B MACs (A) and A/B MACs (B)/DME MACs. Since this is usually the only quarter in which new permanent HCPCS codes are produced, this recurring update is referred to as an annual update. Other updates for the remaining quarters of the year will occur as needed prior to the next annual update. In lieu of another update, editing based on the prior list of codes remains in effect. Some non-January quarterly updates may apply to each of A/B MACs (A) and (HHH) and A/B MACs (B)/DME MACs, and the applicability of the instruction will be clear in each update. All future updates will be submitted via a Recurring Update Notification form.

- **Effective July 1, 1998**, *CB* became effective for those services and items that were not specifically excluded by law from the SNF prospective payment system (PPS) when they were furnished to residents of a SNF in a covered Part A stay and also includes physical therapy, occupational therapy, and/or speech-language pathology services in a noncovered stay. SNFs became subject to *CB* once they transitioned to PPS. Due to systems limitations, *CB* was not implemented at that time for residents not in a Part A covered stay (Part A benefits exhausted, post-hospital or level of care requirements not met). Section 313 of the Benefits Improvement and Protection Act (BIPA) of 2000 subsequently repealed this aspect of *CB* altogether, except for physical therapy, occupational therapy, and/or speech-language pathology services. In addition, for either type of resident, the following requirements were also delayed: (1) that the physicians forward the technical portions of their services

to the SNF; and (2) the requirement that the physician enter the facility provider number of the SNF on the claim.

- **Effective July 1, 1998,** under 42 CFR 411.15(p)(3)(iii) published on May 12, 1998, a number of other services are excluded from *CB*. The hospital outpatient department will bill these services directly to the A/B MAC (A) when furnished on an outpatient basis by a hospital or a critical access hospital (see §20.1.2). Physician's and other practitioner's professional services will be billed directly to the A/B MAC (B) (see §20.1.1). Hospice care (see §20.2.2) and the ambulance trip that initially conveys an individual to the SNF to be admitted as a resident, or that conveys an individual from the SNF when discharged and no longer considered a resident (see §20.3), are also excluded from *CB*.

- **Effective April 1, 2000**, §103 of the Balanced Budget Refinement Act (BBRA) excluded additional services and drugs from *CB* that therefore had to be billed directly to the A/B MAC (B) or DME MAC by the provider or supplier for payment (see §20.3). As opposed to whole categories of services being excluded, only certain specific services and drugs (identified by HCPCS code) were excluded in each category. These exclusions included ambulance services furnished in conjunction with renal dialysis services, certain specific chemotherapy drugs and their administration services, certain specific radioisotope services, and certain customized prosthetic devices.

- **Effective January 1, 2001**, §313 of the BIPA, restricted *CB* to the majority of services provided to beneficiaries in a Medicare Part A covered stay and only to therapy services provided to beneficiaries in a noncovered stay (see §20.5).

    - **Effective for claims with dates of service on or after April 1, 2001**, for those services and supplies that were not specifically excluded by law and are furnished to a SNF resident covered under the Part A benefit, physicians are required to forward the technical portions of any services to the SNF to be billed by the SNF to the A/B MAC (A) for payment (see §20.1.1).

10.4.1 - "Under Arrangements" Relationships

(Rev.4163, Issued: 11-02-18, Effective: 12-04-18, Implementation: 12-04-18)

Under an arrangement as defined in §1861(w) of the Act, Medicare's payment to the SNF represents payment in full for the arranged-for service, and the supplier must look to the SNF (rather than to A/B MAC (B)) for its payment. Further, in entering into such an arrangement, the SNF cannot function as a mere billing conduit, but must actually exercise professional responsibility and control over the arranged-for service (see the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, §10.3, *and the Medicare Benefit Policy Manual, Chapter 8, §70.4,* for additional information on services furnished under arrangements).

Medicare does not prescribe the actual terms of the SNF's relationship with its suppliers (such as the specific amount or timing of payment by the SNF), which are to be arrived at through direct negotiation between the parties to the agreement. However, in order for a valid "arrangement" to exist, the SNF must reach a mutual understanding with its supplier as to how the supplier is to be paid for its services. Documenting the terms of the arrangement confers the added benefit of providing both parties with a ready means of resolution in the event that a dispute arises over a particular service. This type of arrangement has proven to be effective in situations where suppliers regularly provide services to facility residents on an ongoing basis; e.g., laboratory and x-ray suppliers, DME supplies, etc. *Sample* model agreements involving arrangements between SNFs and their suppliers are available for review on CMS's "Best Practices Guidelines" website, at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/BestPractices.html.

If a SNF elects to utilize an outside supplier to furnish medically appropriate services that are subject to consolidated billing, but then refuses to reimburse that supplier for the services, then there is no valid arrangement as contemplated under §1862(a)(18) of the Act. Not only would this potentially result in

Medicare's noncoverage of the particular services at issue, but a SNF demonstrating a pattern of nonpayment would also risk being found in violation of the terms of its provider agreement. Under §1866(a)(1)(H)(ii) of the Act (and 42 CFR 489.20(s)), the SNF's provider agreement includes a specific commitment to comply with the requirements of the consolidated billing provision. Further, §1866(g) of the Act imposes a civil money penalty on any person who knowingly and willfully presents (or causes to be presented) a bill or request for payment inconsistent with an arrangement or in violation of the requirement for such an arrangement.

20.2.2 - Hospice Care for a Beneficiary's Terminal Illness

(Rev.4163, Issued: 11-02-18, Effective: 12-04-18, Implementation: 12-04-18)

Hospice care related to a beneficiary's terminal condition is excluded from SNF PPS and consolidated billing. This is because section 1862(a)(18) of the Social Security Act (the Act) specifies that SNF consolidated billing applies to "…covered skilled nursing facility services described in section 1888(e)(2)(A)(i)…" Section 1888(e)(2)(A)(i) of the Act, in turn, defines "covered skilled nursing facility services" specifically in terms of (I) Part A SNF services, along with (II) those non-excluded services that (if not for the enactment of SNF consolidated billing) would be types of services "…for which payment may be made **under Part B**…" (emphasis added). *Hospice services would not fall within the scope of clause (I) above because, unlike the **diagnostic** and **therapeutic** services covered under the Part A SNF benefit (see §1862(a)(1)(A) of the Act), hospice services are **palliative** (see §1862(a)(1)(C) of the Act). Hospice services also would not fall within the scope of clause (II) above, because this clause encompasses services that, if not for the enactment of consolidated billing, would be separately coverable **under Part B***, whereas the hospice benefit is a **Part A** benefit. Hospice services for terminal conditions are identified with the following types of bill: 81X or 82X. Services unrelated to the beneficiary's terminal condition are designated by the presence of condition code 07. Such unrelated services are included in SNF PPS and consolidated billing.

20.4 - Screening and Preventive Services

(Rev.4163, Issued: 11-02-18, Effective: 12-04-18, Implementation: 12-04-18)

The Part A SNF benefit is limited to services that are reasonable and necessary to "diagnose or treat" a condition that has already manifested itself. Accordingly, this benefit does not encompass screening services (which serve to check an at-risk individual for the possible presence of a specific latent condition, before it manifests any overt symptoms to diagnose or treat) or preventive services (which are aimed at warding off the occurrence of a particular condition altogether rather than diagnosing or treating it once it occurs). Coverage of screening and preventive services (e.g., screening mammographies, pneumococcal pneumonia vaccine, influenza vaccine, hepatitis B vaccine) is a separate Part B inpatient benefit when rendered to beneficiaries in a covered Part A stay and is paid outside of the Part A payment rate. For this reason, screening and preventive services must not be included on the global Part A bill. However, screening and preventive services remain subject to consolidated billing and, thus, must be billed separately by the SNF under Part B.

Accordingly, even though the SNF itself must bill for these services, it submits a separate Part B inpatient bill for them rather than including them on its global Part A bill. Screening and preventive services must be billed with a 22X type of bill. Swing Bed providers must use TOB 12x for eligible beneficiaries in a Part A SNF level of care. **NOTE:** For beneficiaries residing in the Medicare non-certified area of the facility, these services should be billed on a 23x type of bill. In transmittals for A/B MAC (A) billing providing the annual update list of HCPCS codes affected by SNF consolidated billing, such services are referred to as "Major Category IV". See §10.1 above for the link to where transmittals providing current lists of HCPCS codes used for Major Category IV can be found.

There are certain limited circumstances in which a vaccine would no longer be considered preventive in nature, and this can affect how the vaccine is covered. For example, while a booster shot of tetanus vaccine would be considered preventive if administered routinely in accordance with a recommended schedule, it would not be considered preventive when administered in response to an actual exposure to the disease

(such as an animal bite, or a scratch on a rusty nail). In the latter situation, such a vaccine furnished to an SNF's Part A resident would be considered therapeutic rather than preventive in nature, as its use is reasonable and necessary for treating an existing condition.

In terms of billing for an SNF's Part A resident, a vaccine that is administered for therapeutic rather than preventive purposes would be included on the SNF's global Part A bill for the resident's covered stay. Alternatively, if a vaccine is preventive in nature and is one of the three types of vaccines (i.e., pneumococcal pneumonia, hepatitis B, or influenza virus) for which a Part B benefit category exists (see §50.4.4.2 of the Medicare Benefit Policy Manual, Chapter 15), then the SNF would submit a separate Part B bill for the vaccine. (Under section 1888(e)(9) of the Social Security Act (the Act) and the implementing regulations at 42 CFR 413.1(g)(2)(ii), payment for an SNF's Part B services generally is made in accordance with the applicable fee schedule for the type of service being billed (see the Medicare Claims Processing Manual, Chapter 7, §10.5). However, when these three types of vaccines are furnished in the SNF setting, Part B makes payment in accordance with the applicable instructions contained in the Medicare Claims Processing Manual, Chapter 7, §80.1, and Chapter 18, §10.2.2.1.)

If the resident receives a type of vaccine that is preventive in nature but for which no Part B benefit category exists (e.g., diphtheria), then the vaccine would not be covered under either Parts A or B and, as a consequence, would become coverable under the Part D drug benefit. This is because priority of payment between the various parts of the Medicare law basically proceeds in alphabetical order: Part A is primary to Part B (see section 1833(d) of the Act), and both Parts A and B are primary to Part D (see section 1860D-2(e)(2)(B) of the Act).

Further, it is worth noting that unlike preventive services covered under Part B, those preventive vaccines covered under Part D are not subject to SNF CB, even when furnished to an SNF's Part A resident. This is because section 1862(a)(18) of the Act specifies that SNF CB applies to ". . . covered skilled nursing facility services described in section 1888(e)(2)(A)(i) . . . ." Section 1888(e)(2)(A)(i) of the Act, in turn, defines "covered skilled nursing facility services" specifically in terms of (I) Part A SNF services, along with (II) those non-excluded services that (if not for the enactment of SNF CB) would be types of services ". . . for which payment may be made **under Part B** . . ." (emphasis added). *Preventive and screening services as a class would not fall within the scope of clause (I) above because, as discussed previously, the **diagnostic** and **therapeutic** services covered under the Part A SNF benefit (see §1862(a)(1)(A) of the Act) do not encompass **preventive** services (see §1862(a)(1)(B) of the Act) or **screening** services (see §§1862(a)(1)(F), (G), (H), (L), (M), and (N) of the Act). Similarly, those Part D preventive drugs (such as preventive vaccines) for which **no** Part B benefit category exists would not fall within the scope of clause (II) above, because this clause encompasses services that, if not for the enactment of CB, would be separately coverable **under Part B**.*

Formerly, bone mass measurement (screening) was listed as a preventive service excluded from SNF consolidated billing. This was incorrect. Such services are diagnostic, not screening, procedures, and therefore are bundled into SNF PPS payment and subject to consolidated billing.