

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2573	Date: October 26, 2012
	Change Request 8044

SUBJECT: Manual Updates to Clarify SNF Claims Processing

I. SUMMARY OF CHANGES: The purpose of this CR is to update the Medicare manuals to clarify key components of SNF claims processing. These changes are intended only to clarify the existing policies and no system or processing changes are anticipated. The updated manuals and sections are as follows: Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, chapters 1 and 3; Pub. 100-02, Medicare Benefit Policy Manual, chapters 8 and 15; and Pub. 100-04, Medicare Claims Processing Manual, chapter 6.

EFFECTIVE DATE: April 1, 2013

IMPLEMENTATION DATE: April 1, 2013

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	Chapter 6 / 10.3 / Types of Services Subject to the Consolidated Billing Requirement for SNFs
R	Chapter 6 / 20 / Services Included in Part A PPS Payment Not Billable Separately by the SNF
R	Chapter 6 / 20.1.1 / Physician's Services and Other Professional Services Excluded From Part A PPS Payment and the Consolidated Billing Requirement
R	Chapter 6 / 20.1.2 / Other Excluded Services Beyond the Scope of a SNF Part A Benefit
R	Chapter 6 / 20.1.2.2 / Emergency Services
R	Chapter 6 / 20.2 / Services Excluded from Part A PPS Payment and the Consolidated Billing Requirement on the Basis of Beneficiary Characteristics and Election
R	Chapter 6 / 20.2.1 / Dialysis and Dialysis Related Services to a Beneficiary With ESRD
R	Chapter 6 / 20.2.2 / Hospice Care for a Beneficiary's Terminal Illness
R	Chapter 6 / 20.3 / Other Services Excluded from SNF PPS and Consolidated Billing
R	Chapter 6 / 20.3.1 / Ambulance Services
R	Chapter 6 / 20.4 / Screening and Preventive Services
R	Chapter 6 / 20.5 / Therapy Services
R	Chapter 6 / 40.3.5 / Determine Utilization on Day of Discharge, Death, or Day Beginning a Leave of Absence

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:

No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

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 obliged 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 Instructions

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2573	Date: October 26, 2012	Change Request: 8044
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SUBJECT: Manual Updates to Clarify SNF Claims Processing

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I. GENERAL INFORMATION

A. Background: The purpose of this CR is to update the Medicare manuals to clarify key components of SNF claims processing. These changes are intended only to clarify the existing policies and no system or processing changes are anticipated. The updated manuals and sections are as follows: Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, chapters 1 and 3; Pub. 100-02, Medicare Benefit Policy Manual, chapters 8 and 15; and Pub. 100-04, Medicare Claims Processing Manual, chapter 6.

B. Policy: This change request (CR) manualizes a number of policy clarifications pertaining to the skilled nursing facility (SNF) consolidated billing provision, including guidance issued previously in a series of Medicare Learning Network (MLN) Matters Special Edition articles on this subject.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility											
		A/B MAC		D M E	F I	C A R R I E R	R H I	Shared-System Maintainers				Oth er	
		P a r t A	P a r t B					F I S S	M C S	V M S	C W F		
8044.1	Contractors shall review and be aware of the manual revisions as they concern SNF claims processing.	X	X			X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		D M E	F I	C A R R I E R	R H I	Other
		P a r t A	P a r t B					
8044.2	MLN Article : A provider education article related to	X	X			X	X	

Number	Requirement	Responsibility					
		A/B MAC	D M E	F I	C A R R I E R	R H H I	Other
		P a r t A	P a r t B	M A C			
	this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.						

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Anthony Hodge, 410-786-6645 or 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) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:

No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

Section B: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do 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.

Medicare Claims Processing Manual

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

10.3 - Types of Services Subject to the Consolidated Billing Requirement for SNFs (Rev. 2573, Issued: 10-26-12, Effective: 04-01-13, Implementation: 04-01-13)

As previously discussed, the consolidated billing requirement applies to all services furnished to a SNF resident in a covered Part A stay (other than the excluded service categories described below) and for physical therapy, occupational therapy, and/or speech-language pathology services provided to residents and paid under Part B. Examples of services that are subject to consolidated billing include:

- Physical therapy, occupational therapy, and/or speech-language pathology services, regardless of whether they are furnished by (or under the supervision of) a physician or other health care professional (see §1888(e)(2)(A)(ii) of the Act). Physical therapy, occupational therapy, and/or speech-language pathology services (other than audiology services, which are considered diagnostic tests rather than therapy services) furnished to a SNF resident during a noncovered stay must still be billed by the SNF itself. *This is known as “Part B” consolidated billing (see §20.5 of this chapter).*
- Psychological *and other* services furnished by a clinical social worker; and
- Services furnished as an “incident to” the professional services of a physician or other excluded category of health care professional described in §20.1.1 below.

20 - Services Included in Part A PPS Payment Not Billable Separately by the SNF *(Rev. 2573, Issued: 10-26-12, Effective: 04-01-13, Implementation: 04-01-13)*

For cost reporting periods beginning on and after July 1, 1998, SNF services paid under Part A include posthospital SNF services for which benefits are provided under Part A, and all items and services which, prior to July 1, 1998, had been paid under Part B but furnished to SNF residents during a Part A covered stay regardless of source, except for the exclusions listed in the annual SNF consolidated billing update files. Annual update files, as well as subsequent quarterly updates to the annual update, for SNF consolidated billing can be found at <http://www.cms.hhs.gov/SNFConsolidatedBilling/>. This file lists services by HCPCS code, short descriptors, and the major category under which the HCPCS falls. HCPCS added or removed by subsequent quarterly update transmittals will be listed under the respective year's annual update at the above link. The respective year's annual update file will be updated to add or remove the HCPCS listed in the quarterly updates.

A general explanation of the five major categories can also be found at the above link.

NOTE: It is important for contractors/providers to understand the major categories for SNF CB. Some major categories exclude services by revenue code (see section 20.1.2.2 for emergency room exclusion) as well as bill types (see section 20.2.1.2 on coding for renal dialysis facilities and 20.2.2 for hospice facilities).

Services paid under Part A cannot be billed under Part B. Any service paid under Part A that is billed separately will not be paid separately, or payment will be recovered if already paid at the time of the SNF billing. The following subsections list the types of services that can be billed under Part B for SNF residents for whom Part A payment is made.

20.1.1 - Physician's Services and Other Professional Services Excluded From Part A PPS Payment and the Consolidated Billing Requirement *(Rev. 2573, Issued: 10-26-12, Effective: 04-01-13, Implementation: 04-01-13)*

Except for the therapy services, *physician's professional services* and services of certain nonphysician providers listed below are excluded from Part A PPS-payment and the requirement for consolidated billing, and must be billed separately by the practitioner to the *Part B MAC*. See below for Rural Health Clinic (RHC)/Federally Qualified Health Center (FQHC) instructions.

For this purpose "physician service" means the professional *services of the physician as defined under the Medicare physician Fee Schedule*. *For services that contain both a technical component and a professional component, the technical component, if any, must be billed by the SNF for its Part A inpatients. The Part B MAC will pay only the professional component to the physician. For example, the technical component of a diagnostic radiology test (representing the performance of the procedure itself) is subject to SNF CB, whereas the professional component (representing the physician's interpretation of the test results) is excluded and, thus, remains separately billable under Part B.*

- Physician's services other than physical, occupational, and speech-language pathology services furnished to SNF residents;
- 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; and
- Certified registered nurse anesthetists.

*SNF CB excludes the categories of practitioner services described above, and this exclusion applies specifically to those professional services that ordinarily require performance by the practitioner personally (see the regulations at 42 CFR 411.15(p)(2)(i) and 415.102(a)(3)). This means, for example, that an otherwise bundled task (such as a routine blood draw) cannot be converted into an excluded physician service merely by having a physician perform it personally, as such a task does not **ordinarily require** performance by the physician. This exclusion also does not encompass services that are performed by someone else as an incident to the practitioner's professional service. Such "incident to" services remain subject to SNF CB and, accordingly, must be billed to Medicare by the SNF itself (see §10.3 of this chapter).*

Providers with the following specialty codes assigned by CMS upon enrollment with Medicare are considered physicians for this purpose. Some limitations are imposed by §§1861(q) and (r) of the Act. These providers may bill their carrier directly.

Physician Specialty Codes

- | | |
|---|---|
| 01 General Practice | 02 General Surgery |
| 03 Allergy/Immunology | 04 Otolaryngology |
| 05 Anesthesiology | 06 Cardiology |
| 07 Dermatology | 08 Family Practice |
| 10 Gastroenterology | 11 Internal Medicine |
| 12 Osteopathic Manipulative Therapy | 13 Neurology |
| 14 Neurosurgery | 16 Obstetrics Gynecology |
| 18 Ophthalmology | 19 Oral Surgery (Dentists only) |
| 20 Orthopedic Surgery | 22 Pathology |
| 24 Plastic and Reconstructive Surgery | 25 Physical Medicine and Rehabilitation |
| 26 Psychiatry | 28 Colorectal Surgery (formerly Proctology) |
| 29 Pulmonary Disease | 30 Diagnostic Radiology |
| 33 Thoracic Surgery | 34 Urology |
| 35 Chiropractic | 36 Nuclear Medicine |
| 37 Pediatric Medicine | 38 Geriatric Medicine |
| 39 Nephrology | 40 Hand Surgery |
| 41 Optometry | 44 Infectious Disease |
| 46 Endocrinology | 48 Podiatry |
| 66 Rheumatology | 69 Independent Labs |
| 70 Multi specialty Clinic or Group Practice | 76 Peripheral Vascular Disease |
| 77 Vascular Surgery | 78 Cardiac Surgery |
| 79 Addiction Medicine | 81 Critical Care (Intensivists) |
| 82 Hematology | 83 Hematology/Oncology |
| 84 Preventive Medicine | 85 Maxillofacial Surgery |
| 86 Neuropsychiatry | 90 Medical Oncology |
| 91 Surgical Oncology | 92 Radiation Oncology |
| 93 Emergency Medicine | 94 Interventional Radiology |
| 98 Gynecological/Oncology | 99 Unknown Physician Specialty |

Nonphysician Provider Specialty Codes

- | | |
|----------------------------|---|
| 42 Certified Nurse Midwife | 43 Certified Registered Nurse Anesthetist, Anesthesia Assistants (effective 1/1/89) |
| 50 Nurse Practitioner | 62 Clinical Psychologist (billing independently) |
| 68 Clinical Psychologist | 89 Certified Clinical Nurse Specialist |
| 97 Physician Assistant | |

NOTE: Some HCPCS codes are defined as all professional components in the fee schedule. Fee schedule definitions apply for this purpose.

Effective July 1, 2001, the Benefits Improvement and Protection Act (BIPA) established payment method II, in which CAHs can bill and be paid for physician services billed to their intermediary. CAHs must bill the professional fees using revenue codes 96x, 97x, or 98x on an 85x type of bill (TOB). Like professional services billed to the carrier, the specific line items containing these revenue codes for professional services are excluded from the requirement for consolidated billing.

RHC/FQHC Instructions:

Effective January 1, 2005, section 410 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) amended the SNF consolidated billing law to specify that when a SNF's Part A resident receives the services of a physician (or another type of practitioner that the law identifies as being excluded from SNF consolidated billing) from a RHC or a Federally Qualified Health Center FQHC, those services are not subject to CB merely by virtue of being furnished under the auspices of the RHC or FQHC.

Accordingly, under section 410 of the MMA of 2003, services otherwise included within the scope of RHC and FQHC services that are also described in clause (ii) of section 1888(e)(2)(A) are excluded from consolidated billing, effective with services furnished on or after January 1, 2005. Only this subset of RHC/FQHC services may be covered and paid separately when furnished to SNF residents during a covered Part A stay. Use TOBs 71x and 73x, respectively, to bill for these RHC/FQHC services. *See Pub. 100-02, Medicare Benefit Policy Manual, chapter 13, section 30.4.B for additional information on RHC/FQHC services furnished to residents of SNFs.*

20.1.2 - Other Excluded Services Beyond the Scope of a SNF Part A Benefit

(Rev. 2573, Issued: 10-26-12, Effective: 04-01-13, Implementation: 04-01-13)

SNF-516.3

The following services are not included in Part A PPS payment when furnished in a Medicare participating hospital or CAH and may be paid to the provider rendering them.

This exception does not apply if the service is furnished in an ambulatory surgical center (ASC) or other independent (non-hospital) facility, *because it specifically addresses those services that are so far beyond the normal scope of SNF care as to require the intensity of the hospital setting in order to be furnished safely and effectively.* In transmittals for FI billing providing the annual update list of HCPCS codes affected by SNF consolidated billing, such services are referred to as "Major Category I" of SNF consolidated billing editing. Note that of the types of services listed, only ambulatory surgeries are listed as inclusions, rather than exclusions, to consolidated billing.

- Certain cardiac catheterizations;
- Certain computerized axial tomography (CT) scans;
- Certain magnetic resonance imaging (MRIs);
- Certain ambulatory surgeries involving the use of a hospital operating room *or comparable hospital facilities (i.e., the use of a gastrointestinal (GI) suite or endoscopy suite for the insertion of a percutaneous esophageal gastrostomy (PEG) tube)*; For Part A inpatients, the professional portion of these services is billed by the rendering practitioner to the carrier. Any hospital outpatient charges are billed to the FI.
- Certain radiation therapies;
- Certain angiographies, and lymphatic and venous procedures;
- Emergency services;
- Ambulance services when related to an excluded service within this list; and

- Ambulance transportation related to dialysis services.

These relatively costly services are beyond the general scope of care in SNFs, *and their receipt has the effect of temporarily suspending a beneficiary's status as an SNF "resident" for CB purposes with respect to such services.* Even though it may be medically appropriate for a beneficiary to be cared for in a SNF while receiving radiation therapy, the SNF is not responsible for paying for excluded radiation therapy itself when the beneficiary receives it as a hospital outpatient. Similarly, angiography codes and codes for some lymphatic and venous procedures are considered beyond the general scope of services delivered by SNFs. The hospital or CAH must bill the FI for the services. Excluded services provided to Medicare beneficiaries in swing beds subject to SNF PPS are to be billed on TOB 13x by the swing bed hospital.

Services directly related to these services, defined as services billed for the same place of service and with the same line item date of service as the services listed below, are also excluded from SNF CB, with exceptions as listed below.

- Note that anesthesia, drugs incident to radiology and supplies (revenue codes 037x, 0255, 027x and 062x) will be bypassed by enforcement edits when billed with CT Scans, Cardiac Catheterizations, MRIs, Radiation Therapies, or Angiographies or surgeries.

In general, bypasses also allow CT Scans, Cardiac Catheterization, MRI, Radiation Therapy, Angiography, and Outpatient Surgery HCPCS codes 0001T – 0021T, 0024T – 0026T, or 10021 - 69990 (except HCPCS codes listed in the table below) to process and pay. This includes all other revenue code lines on the incoming claim that have the same line item date of service (LIDOS).

20.1.2.2 - Emergency Services

(Rev. 2573, Issued: 10-26-12, Effective: 04-01-13, Implementation: 04-01-13)

Emergency room services performed in hospitals, including CAHs, are excluded from SNF CB for beneficiaries that are in skilled Part A SNF stays. Hospitals report emergency room (ER) services under the 045X (Emergency Room -"x" represents a varying third digit) revenue code with a line item date of service (LIDOS) indicating the date the patient entered the ER. Services related to the ER encounter are also excluded from the SNF CB provision. *"Emergency" services are defined in the regulations at 42 CFR 424.101 as ". . . services that are necessary to prevent death or serious impairment of health and, because of the danger to life or health, require use of the most accessible hospital available and equipped to furnish those services." In this context, "false alarm" situations may occasionally arise, in which the initial assessment of a beneficiary's condition as life-threatening subsequently proves to be unfounded (for example, where a patient's chest pain and shortness of breath initially appear to be symptoms of a heart attack, but upon subsequent examination turn out to be merely a bad case of indigestion). Such situations still qualify for the emergency services exclusion from SNF CB as long as the initial symptoms provided a reasonable basis for assuming the onset of a medical emergency, even though this assumption ultimately was not borne out by subsequent events.*

Where services related to the ER encounter span more than one service date, hospitals must identify those services by appending a modifier ET (Emergency Services) to those line items. The reporting of the ET modifier will alert CWF that these are related ER services performed on subsequent dates so the SNF CB edits in CWF will be bypassed.

20.2 - Services Excluded from Part A PPS Payment and the Consolidated Billing Requirement on the Basis of Beneficiary Characteristics and Election

(Rev. 2573, Issued: 10-26-12, Effective: 04-01-13, Implementation: 04-01-13)

These services must be provided to specific beneficiaries, either: (A) End Stage Renal Disease (ESRD) beneficiaries, or (B) beneficiaries who have elected hospice, by specific licensed Medicare providers, and are excluded from SNF PPS and consolidated billing. SNFs will not be paid for Category II.A. services (dialysis, etc.) when the SNF is the place of service. To receive Medicare payment, these services must be provided in a renal dialysis facility. Hospices must also be the only type of provider billing hospice services.

In transmittals for FI billing that provide the annual update list of HCPCS codes affected by SNF consolidated billing, such services are referred to as “Major Category II” of SNF consolidated billing editing. See §10.1 above for the link to where transmittals providing current lists of HCPCS codes used for edits for these types of services, known as “Major Category II” in SNF **CB** editing for FIs.

20.2.1 – Dialysis and Dialysis Related Services to a Beneficiary With ESRD

(Rev. 2573, Issued: 10-26-12, Effective: 04-01-13, Implementation: 04-01-13)

Beneficiaries with ESRD may receive dialysis and dialysis related services from a hospital-based or free-standing RDF, or may receive home dialysis supplies and equipment from a supplier. The following services are excluded from SNF **CB**:

- Certain dialysis services and supplies, including any related necessary ambulance services;
- Home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies (other than those furnished or arranged for by the SNF itself) are not included in the SNF Part A PPS rate. These services may be billed separately to the FI by the ESRD facility as appropriate; dialysis supplies and equipment may be billed to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) by the supplier; and
- Erythropoiesis Stimulating Agents (ESAs) for certain dialysis patients, subject to methods and standards for its safe and effective use (see 42 CFR 405.2163(g) and (h)) may be billed by the RDF to the FI, or by the retail pharmacy to the DME MAC.

*By contrast, services that fall outside the scope of the Part B dialysis benefit do not qualify for the dialysis exclusion from SNF CB. For example, this exclusion does not encompass “acute” dialysis, which involves patients who do not have ESRD but require dialysis temporarily while their kidneys have shut down following a severe medical trauma (such as a drug overdose or a traffic accident). In contrast to maintenance dialysis for ESRD patients (who, in the absence of a kidney transplant, would remain on periodic dialysis indefinitely), there is an expectation with acute dialysis that the patient’s own kidneys will eventually recover and resume their normal function. Because acute dialysis does not fall within the scope of the Part B dialysis benefit, it is not excluded from SNF CB and, consequently, is included within the SNF’s global per diem payment for the resident’s covered Part A stay. Similarly, the SNF CB exclusion described above for ESAs does not encompass situations involving their use for a **non-dialysis** purpose (such as ameliorating the side effects of chemotherapy treatments).*

20.2.2 – Hospice Care for a Beneficiary’s Terminal Illness

(Rev. 2573, Issued: 10-26-12, Effective: 04-01-13, Implementation: 04-01-13)

SNF-515.1

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), 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.

20.3 – Other Services Excluded from SNF PPS and Consolidated Billing

(Rev. 2573, Issued: 10-26-12, Effective: 04-01-13, Implementation: 04-01-13)

SNF-515.1

The following services may be billed separately under Part B by the rendering provider, supplier, or practitioner (other than the SNF that receives the Part A PPS payment) and paid to the entity that furnished the service. These services may be provided by any Medicare provider licensed to provide them, other than the SNF that receives the Part A PPS payment, and are excluded from Part A PPS payment and the requirement for consolidated billing, and are referred to as “Major Category III” for consolidated billing edits applied to claims submitted to FIs.

- A *medically necessary* ambulance trip (other than a transfer to another SNF) that transports a beneficiary to the SNF for the initial admission or from the SNF following a final discharge, *or that occurs pursuant to the offsite provision of Part B dialysis services (see section 20.3.1 of this chapter for additional situations involving ambulance transportation)*;
- Certain chemotherapy *drugs*. *The chemotherapy exclusion applies solely to the particular chemotherapy codes designated under Major Category III.A of the SNF website’s FI/A/B MAC Annual Update. These same codes also appear on the list of exclusions in File 1 of the SNF website’s Carrier/A/B MAC Annual Update (though not displayed as a separate subcategory). The excluded chemotherapy codes serve to identify those high-intensity chemotherapy drugs that are not typically administered in a SNF, are exceptionally expensive, or require special staff expertise to administer. By contrast, chemotherapy drugs that are relatively inexpensive and are administered routinely in SNFs do not qualify for this exclusion and, thus, remain subject to SNF CB. Further, this exclusion would not encompass any **related** items that, while commonly furnished **in conjunction with** chemotherapy, are not themselves inherently chemotherapeutic in nature (that is, they specifically address the **side effects** of the chemotherapy rather than actively destroying cancer cells). Examples of such chemotherapy-related drugs would include anti-emetics (anti-nausea drugs), as well as drugs that function as an adjunct to an anti-emetic, such as an anti-anxiety drug that helps to relieve anticipatory nausea. Even when furnished in conjunction with a chemotherapy drug that is itself excluded (and, thus, separately payable under Part B), these related drugs would remain subject to SNF CB. Similarly, if a drug designated by one of the excluded chemotherapy codes is prescribed for an off-label use that is not actually associated with chemotherapy, it would no longer be considered an excluded “chemotherapy” drug in such an instance, because it is not being used for a chemotherapeutic purpose.*
- *Certain* chemotherapy administration services. The chemotherapy administration codes are included in SNF PPS payment for beneficiaries in a Part A stay when performed alone or with other surgery, but are excluded if they occur with the same line item date of service as an excluded chemotherapy agent. A chemotherapy agent must also be billed when billing these services, and physician orders must exist to support the provision of chemotherapy;
- Certain radioisotope services;
- Certain customized prosthetic devices;
- For services furnished during 1998 only, the transportation costs of electrocardiogram equipment for electrocardiogram test services; and

- **All services** provided to risk-based MCO beneficiaries. These beneficiaries may be identified with a label attached to their Medicare card and/or a separate health insurance card from an MCO indicating all services must be obtained or arranged through the MCO.

The HCPCS code ranges for chemotherapy, chemotherapy administration, radioisotopes, and customized prosthetic devices are set in statute. The statute also gives the Secretary authority to make modifications in the particular codes that are designated for exclusion within each of these service categories. See §10.1 above for the link to where transmittals providing current lists of HCPCS codes used for Major Category III SNF consolidated billing editing for FIs can be found.

20.3.1 - Ambulance Services

(Rev. 2573, Issued: 10-26-12, Effective: 04-01-13, Implementation: 04-01-13)

The following ambulance transportation and related ambulance services for residents in a Part A stay are not included in the Part A PPS payment. Except for specific exclusions, consolidated billing includes those medically necessary ambulance trips that are furnished during the course of a covered Part A stay. Carriers and intermediaries are responsible for assuring that payment is made only for ambulance services that meet established coverage criteria.

In most cases, ambulance trips are excluded from consolidated billing when resident status has ended. The ambulance company then must bill the carrier or intermediary (as appropriate) directly for payment. Listed below are a number of specific circumstances under which a beneficiary may receive ambulance services that are covered by Medicare, but excluded from consolidated billing.

The following ambulance services may be billed as Part B services by the supplier in the following situations only.

- The ambulance trip is to the SNF for admission (the second character (destination) of any ambulance HCPCS modifier is N (SNF) other than modifier QN, and the date of service is the same as the SNF 21X admission date.);
- The ambulance trip is from the SNF after discharge, to the beneficiary's home (the first character (origin) of any HCPCS ambulance modifier is N (SNF), the second character (destination) of the HCPCS ambulance modifier is R (Residence), and date of ambulance service is the same date as the SNF through date). Note: this includes beneficiaries discharged home to receive services from a Medicare-participating home health agency under a plan of care;
- The ambulance trip is to a hospital based or nonhospital based ESRD facility (the first character (origin) of the HCPCS ambulance modifier is N (SNF), *and* the second character (destination) HCPCS ambulance modifier code is G (Hospital-based dialysis facility) or J (Non-hospital based dialysis facility)) for the purpose of receiving dialysis and related services excluded from consolidated billing.
- The ambulance trip is from the SNF to a Medicare-participating hospital or a CAH for an inpatient admission (the first character (origin) of the HCPCS ambulance modifier is N (SNF), *and* the second character (destination) of the HCPCS modifier is H).
- The ambulance trip *follows* a formal discharge or other departure from the SNF to any destination other than another SNF, and the beneficiary does not return to that or any other SNF by midnight of that same day; and
- *An ambulance trip* that conveys a beneficiary to a hospital or CAH and back to the SNF, for the specific purpose of receiving emergency or other excluded services (see section 20.1.2 above for list

of other excluded services). *As discussed in section 20.1.2, the receipt of these exceptionally intensive outpatient hospital services has the effect of temporarily suspending the beneficiary's status as an SNF "resident" for CB purposes with respect to those services; moreover, once suspended in this manner, the beneficiary's "resident" status would not resume until he or she actually arrives back at the SNF. Accordingly, the **entire** related ambulance roundtrip--both the outbound (SNF-to-hospital) portion and the return (hospital-to-SNF) portion--would be excluded from SNF CB and billed separately under Part B.*

The following ambulance services are included in SNF CB and may **not** be billed as Part B services to the intermediary or carrier when the beneficiary is in a Part A stay:

- Under the regulations at 42 CFR 411.15(p)(3)(iv), the day of departure from SNF 1 is a covered Part A day (to which consolidated billing would apply) **only** if the beneficiary's *admission* to SNF 2 **occurs** by midnight of the day of departure (the first and second character of the ambulance modifier is N). Patient Status is 03. *An ambulance trip that is medically necessary to effect this type of SNF-to-SNF transfer would be bundled back to SNF 1, as in this specific situation the beneficiary would continue to be considered a "resident" of SNF 1 for CB purposes up until the actual point of admission to SNF 2.*
- Ambulance transports to or from a diagnostic or therapeutic site other than a hospital or renal dialysis facility (e.g., an independent diagnostic testing facility (IDTF), cancer treatment center, radiation therapy center, wound care center, etc.). The ambulance transport is included in the SNF PPS rate if the first or second character (origin or destination) of any HCPCS code ambulance modifier is "D" (diagnostic or therapeutic site other than "P" or "H"), and the other modifier (origin or destination) is "N" (SNF). The first SNF is responsible for billing the services to the FI.
- *An SNF resident's ambulance roundtrip to a physician's office (first or second character (origin or destination) of any HCPCS code ambulance modifier is "P" (physician's office), and the other modifier (origin or destination) is "N" (SNF)) is subject to SNF CB and would remain the responsibility of the SNF, because even though the physician's services are themselves excluded from SNF CB, this exclusion does not affect the beneficiary's overall status as an SNF "resident" for CB purposes. Further, while a physician's office is not normally a covered destination under the **separate Part B** ambulance benefit, the SNF benefit's Part A coverage of ambulance transportation under the regulations at 42 CFR 409.27(c) incorporates **only** the Part B ambulance benefit's general medical necessity requirement at 42 CFR 410.40(d)(1), and not any of the latter benefit's more detailed coverage restrictions regarding destinations.*

See chapter 15 for *additional information on Part B coverage of Ambulance Services.*

*In contrast to the ambulance coverage described above, Medicare simply does not provide any coverage at all under Part A **or** Part B for any **non-ambulance** forms of transportation, such as ambulette, wheelchair van, or litter van. Further, as noted previously, in order for the Part A SNF benefit to cover transportation via ambulance, the regulations at 42 CFR 409.27(c) specify that the ambulance transportation must be **medically necessary**--that is, the patient's condition is such that transportation by any means other than ambulance would be medically contraindicated.*

*This means that in a situation where it is medically feasible to transport an SNF resident by some means other than an ambulance--for example, via wheelchair van--the wheelchair van would not be covered (because Medicare does not cover any non-ambulance forms of transportation), and an ambulance **also** would not be covered (because the use of an ambulance in such a situation would not be medically necessary). With respect to noncovered services for which a resident may be financially liable, the SNF is required under the regulations at 42 CFR 483.10(b)(6) to ". . . inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate."*

20.4 - Screening and Preventive Services

(Rev. 2573, Issued: 10-26-12, Effective: 04-01-13, Implementation: 04-01-13)

SNF-515.7

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 a member of an at-risk population 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 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 FI 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), payment for an SNF’s Part B services is made in accordance with the applicable fee schedule for the type of service being billed.)

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).*

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.

20.5 – Therapy Services

(Rev. 2573, Issued: 10-26-12, Effective: 04-01-13, Implementation: 04-01-13)

Therapy services are edited as inclusions, rather than exclusions, to consolidated billing. Physical therapy, speech-language pathology services, and occupational therapy are *bundled into the SNF’s global per diem payment for a resident’s covered Part A stay. They are also* subject to the SNF “Part B” consolidated billing requirement (*for services furnished to SNF residents during **noncovered** stays*) and must be billed by the SNF alone for its Part B residents on a 22x type of bill.

*As noted in section 10.3 of this chapter, therapy services furnished to SNF residents remain subject to consolidated billing even when performed by a type of practitioner, such as a physician, whose services would otherwise be excluded (see section 1888(e)(2)(A)(ii) of the Social Security Act and the regulations at 42 CFR 411.15(p)(1)(i)). Further, while most services either clearly fall within the category of therapy or clearly fall outside of it, there are a few services (such as certain debridement codes) which, based on the specific type of practitioner involved, are sometimes considered “therapy” services and other times not. However, because the consolidated billing provision focuses on the nature of the therapy service itself (rather than the type of practitioner who happens to be performing it), these “sometimes therapy” codes are **always** considered therapy services in the specific context of SNF consolidated billing. This means that a practitioner who furnishes such a service to an SNF resident must always look to the SNF itself (rather than to Part B) for payment.*

SNF residents that fall below a Medicare skilled level of care may be moved out of the SNF or certified distinct part unit (DPU) to the Medicare non-certified area of the facility. In doing so, the beneficiary is no longer subject to the SNF consolidated billing rule and therapy services may be billed directly to Medicare by the provider rendering the service or if billed by the SNF should be submitted on a 23x type of bill. If the entire facility qualifies as a Medicare-certified SNF, all Part B therapies must continue to be billed by the SNF on a 22x type of bill. The CWF SNF CB therapy edit will be bypassed for 22x bill types that contain therapy services when those line item dates of service fall within a non-covered period reported on an inpatient 21x bill type. For additional instructions, see Chapter 7, SNF Part B Billing, *section 10.1*. In transmittals for FI billing providing the annual update list of HCPCS codes affected by SNF consolidated billing, such services are referred to as “Major Category V” of SNF consolidated billing. See *section 10.1* above for the link to where transmittals providing current lists of HCPCS codes used for Major Category V can be found.

40.3.5 - Determine Utilization on Day of Discharge, Death, or Day Beginning a Leave of Absence

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SNF-517.6.B, A3-3103.4

Generally, the day of discharge, death, or a day on which a patient begins a leave of absence, is not counted as a utilization day. (See the Medicare Benefit Policy Manual, Chapter 3, “Duration of Covered Inpatient Services.”) This is true even where one of these events occurs on a patient’s first day of entitlement or the first day of a provider’s participation in the Medicare program. In addition, a benefit period may begin with a stay in a hospital or SNF, on that day.

The exception to the general rule of not charging a utilization day for the day of discharge, death, or day beginning a leave of absence is where the patient is admitted with the expectation that he will remain overnight but is discharged, dies, or is transferred to a nonparticipating provider or a nonparticipating distinct part of the same provider before midnight of the same day. In these instances, such a day counts as a utilization day. This exception includes the situation where the beneficiary was admitted (with the expectation that he would remain overnight) on either the first day of his entitlement or the provider’s first day of participation, and on the same day he was discharged, died, or transferred to a nonparticipating provider.

Payment is not made under PPS unless a covered day can be billed. Also, *for a noncovered day such as the day of discharge (for which no payment is possible under PPS), separate* billing is not allowed for ancillary services. Ancillary charges for *such* days have *already* been included in the PPS rates for *those* days that *can* be billed. *This is because, in accordance with the longstanding instructions in Pub. 15-1, Provider Reimbursement Manual, Part I, chapter 22, section 2205.1, ancillary charges for services furnished on the day of (but before the actual moment of) discharge are included on the SNF’s cost report and reflected in final cost settlement (see also §40.6.3 of this chapter). Accordingly, such charges have been built into the PPS base. As a result, even though the day of discharge itself is not a Medicare-covered day for the SNF, the PPS per diem for all of the covered days leading up to the day of discharge is somewhat higher than it otherwise would have been, reflecting the historical cost of these day-of-discharge services.*

When a patient is discharged on the first day of a provider’s participation or the first day of the patient’s entitlement, complete the bill as follows:

- Admission date is the actual date of admission;
- From date of service is the date the patient became entitled or date the SNF began participation; and
- The number of noncovered days = 1.