CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2921	**Date: April 4, 2014**
	Change Request 8669

SUBJECT: Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions

I. SUMMARY OF CHANGES: The purpose of this CR is to update the Medicare manuals to correct various minor technical errors and omissions including (but not limited to) changes relating to three previous Change Requests: 6030, 7701, and 8044. These changes are intended only to clarify the existing content and no policy, processing, or system changes are anticipated.

EFFECTIVE DATE: May 5, 2014
IMPLEMENTATION DATE: May 5, 2014

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 / 30.1.1 / Provider Charges to Beneficiaries
R	6 / 20.1.1 / Physician's Services and Other Professional Services Excluded From Part A PPS Payment and the Consolidated Billing Requirement
R	6 / 20.1.2 / Other Excluded Services Beyond the Scope of a SNF Part A Benefit
R	6 / 20.3 / Other Services Excluded from SNF PPS and Consolidated Billing
R	6 / 20.3.1 / Ambulance Services
R	6 / 20.4 / Screening and Preventive Services
R	6 / 30.7 / Annual Updates to the SNF Pricer

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 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 Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2921	Date: April 4, 2014	Change Request: 8669

SUBJECT: Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions

EFFECTIVE DATE: May 5, 2014

IMPLEMENTATION DATE: May 5, 2014

I. GENERAL INFORMATION

A. Background: The purpose of this CR is to update the Medicare manuals to correct various minor technical errors and omissions including (but not limited to) changes relating to three previous Change Requests: 6030, 7701, and 8044. These changes are intended only to clarify the existing content and no policy, processing, or system changes are anticipated.

B. Policy: These changes are intended only to clarify the existing content and no policy, processing, or system changes are anticipated.

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	
8669.1	Contractors shall be aware of the updates to Pub. 100-04 Chapters 1 and 6.	X	X							Hospital, Providers, SNF

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

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

"Should" denotes 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, 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.

30.1.1 - Provider Charges to Beneficiaries

(Rev.2921, Issued: 04-04-14, Effective: 05-05-14, Implementation: 05-05-14)

In the agreement/attestation statement signed by a provider, it agrees not to charge Medicare beneficiaries (or any other person acting on a beneficiary's behalf) for any service for which Medicare beneficiaries are entitled to have payment made on their behalf by the Medicare program. This includes items or services for which the beneficiary would have been entitled to have payment made had the provider filed a request for payment (see §50).

The provider may bill the beneficiary for the following items:

- Part A deductible;
- Part B deductible;
- First 3 pints of blood, which is called the blood deductible (if there is a charge for blood or the blood is not replaced);
- Part B coinsurance;
- Part A coinsurance; or
- Services that are not Medicare covered services. See Chapter 30 for related requirements.

SNFs may not require, request, or accept a deposit or other payment from a Medicare beneficiary as a condition for admission, continued care, or other provision of services, except as follows:

- A SNF may request and accept payment for a Part A deductible and coinsurance amount on or after the day to which it applies.
- A SNF may request and accept payment for a Part B deductible and coinsurance amount at the time of or after the provision of the service to which it applies.
- A SNF may not request or accept advance payment of Medicare deductible and coinsurance amounts.
- A SNF may require, request, or accept a deposit or other payment for services if it is clear that the services are not covered by Medicare and proper notice is provided. See Chapter 30 for instructions about ABNs and demand bills.
- SNFs, but not hospitals, may bill the beneficiary for holding a bed during a leave of absence if the requirements in §30.1.1.*1 are met.*

20.1.1 - Physician's Services and Other Professional Services Excluded From Part A PPS Payment and the Consolidated Billing Requirement

(Rev.2921, Issued: 04-04-14, Effective: 05-05-14, Implementation: 05-05-14)

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

Physician Specialty Codes

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 for additional information on *Part B coverage of* RHC/FQHC services.

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

(Rev.2921, Issued: 04-04-14, Effective: 05-05-14, Implementation: 05-05-14)

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; *and*
- Ambulance services when related to an excluded service within this list *(see §20.3 of this chapter for 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).

20.3 – Other Services Excluded from SNF PPS and Consolidated Billing

(Rev.2921, Issued: 04-04-14, Effective: 05-05-14, Implementation: 05-05-14)

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 *(that is, anti-cancer)* 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 a use that is not actually associated with *fighting cancer*, it would no longer be considered an excluded "chemotherapy" drug in such an instance, because it is not being used for a chemotherapeutic purpose *within the meaning of this exclusion*.

- 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.2921, Issued: 04-04-14, Effective: 05-05-14, Implementation: 05-05-14)

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. *However, it should be noted that in addition to the "medical necessity" criterion in the regulations at 42 CFR 409.27(c) pertaining specifically to ambulance transports under the SNF benefit (i.e., the patient's medical condition is such that transportation by any means other than ambulance would be contraindicated), coverage in this context also involves the underlying requirement of being reasonable and necessary for diagnosing or treating the patient's condition. For example, a SNF-to-SNF transfer would be considered reasonable and necessary in a situation where needed care is unavailable at the originating SNF, thus necessitating a transfer to the receiving SNF in order to obtain that care. By contrast, a SNF-to-SNF transfer that is prompted by non-medical considerations (such as a patient's personal preference to be placed in the receiving SNF) is not considered reasonable and necessary for diagnosing or treating the patient's condition and, thus, would not be bundled back to the originating SNF.*

- 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.2921, Issued: 04-04-14, Effective: 05-05-14, Implementation: 05-05-14)

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) *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).

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.

30.7 – Annual Updates to the SNF Pricer

(Rev.2921, Issued: 04-04-14, Effective: 05-05-14, Implementation: 05-05-14)

Rate and weight information used by the SNF Pricer is updated periodically, usually annually. Updates occur each October, to reflect the fact that SNF PPS rates are effective for a Federal fiscal year. Updates may also occur at other points in the year when required by legislation. The following update items, when changed, are published in the "**Federal Register**:"

- Four components of the unadjusted Federal rates for both Rural and Urban areas. Components include the nursing case-mix, non-case mix, therapy case-mix, and therapy non-case-mix amounts.
- A table of nursing and therapy indices to be used for each RUG;
- The *factors to be applied in making the area* wage *adjustment*;
- Changes, if any, to the labor and non-labor percentages.

Whenever these update items change, Medicare also publishes a Recurring Update Notification to inform providers and contractors about the changes. These Recurring Update Notifications also describe how the changes will be implemented through the SNF Pricer.