| CMS Manual System | Department of Health & Human Services (DHHS) |
| --- | --- |
| Pub 100-04 Medicare Claims Processing | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 4001** | **Date: March 16, 2018** |
| | **Change Request 10512** |

**Transmittal 4001, dated March 16, 2018, has no corrections but as part of a companion package is being re-issued to correct a typo in all the revision lines to correctly spell the word "Implementation" in Pub. 100-01, Transmittal 114, and in addition, to correct a spacing issue in Pub. 100-02, Transmittal 242, to create a spacing line between the heading for section 70.4 and the paragraph that follows. Transmittal number, date issued and all other information remains the same.**

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

**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: June 19, 2018**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: June 19, 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/ 30.1.1.1/ Charges to Hold a Bed During SNF Absence |
| R | 6/ 10.1/ Consolidated Billing Requirement for SNFs |
| R | 6/ 10.4/ Furnishing Services that are Subject to SNF Consolidated Billing Under an "Arrangement" With an Outside Entity |
| R | 6/ 20.1.2/ Other Excluded Services Beyond the Scope of a SNF Part A Benefit |
| R | 6/ 20.2.1/ Dialysis and Dialysis Related Services to a Beneficiary With ESRD |
| R | 6/ 20.3/ Other Services Excluded from SNF PPS and Consolidated Billing |
| R | 6/ 20.3.1/ Ambulance Services |
| R | 6/ 40.3.3/ Same Day Transfer |
| R | 6/ 40.3.4/ Situations that Require a Discharge or Leave of Absence |
| R | 6/ 40.3.5/ Determine Utilization on Day of Discharge, Death, or Day Beginning a Leave of Absence |
| R | 6/ 40.3.5.2/ Leave of Absence |
| R | 20/ 10.2/ Coverage Table for DME Claims |
| R | 30/ 130.3/ Application of Limitation on Liability to SNF and Hospital Claims for Services Furnished in Noncertified or Inappropriately Certified Beds |
| R | 30/ 130.4/ Determining Liability for Services Furnished in a Noncertified SNF or Hospital Bed |

**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: 4001 | Date: March 16, 2018 | Change Request: 10512 |
|---|---|---|---|

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

**EFFECTIVE DATE: June 19, 2018**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: June 19, 2018**

**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. No policy, processing, or system changes are anticipated.

**Pub 100-04, Chapter 1, §30.1.1.1:**

This section is revised by updating the existing citation to the regulations at 42 CFR 483.10(b)(5)-(6), in order to reflect their revision and redesignation at 42 CFR 483.10(g)(17)-(18) in the long-term care facility requirements reform final rule (81 FR 68825, 68854, October 4, 2016).

**Pub 100-04, Chapter 6, §10.1:**

This section is revised to expand and clarify the discussion of a beneficiary's status as a SNF "resident" for consolidated billing purposes to conform more closely with the corresponding regulations at 42 CFR 411.15(p)(3), as well as by adding some appropriate cross-references, and by updating the existing citation to the regulations at 42 CFR 483.12(a)(2)(i)-(vi), in order to reflect their redesignation at 42 CFR 483.15(c)(1)(i)(A)-(F) in the long-term care facility requirements reform final rule (81 FR 68826, October 4, 2016).

**Pub 100-04, Chapter 6, §10.4:**

This section is revised by updating the existing citation to the regulations at 42 CFR 483.75(h), in order to reflect their redesignation at 42 CFR 483.70(g) in the long-term care facility requirements reform final rule (81 FR 68830, October 4, 2016).

**Pub 100-04, Chapter 6, §20.1.2:**

This section is revised to restore a minor edit that was agreed to during the internal review of CR 9748 but was then inadvertently omitted from the published version.

**Pub 100-04, Chapter 6, §20.2.1:**

The final paragraph of this section is revised to reflect the statutory addition of acute dialysis to the scope of the Part B dialysis benefit and, by extension, to the scope of the dialysis exclusion from SNF consolidated billing as well.

**Pub 100-04, Chapter 6, §20.3:**

This section is revised to clarify the language in a parenthetical phrase.

**Pub 100-04, Chapter 6, §20.3.1:**

This section is revised to clarify that the exclusion of dialysis-related ambulance transports from SNF consolidated billing applies to the entire ambulance roundtrip from the SNF, and to clarify the discussion of a beneficiary's status as a SNF "resident" for consolidated billing purposes. In addition, the existing citation to the regulations at 42 CFR 483.10(b)(6) is updated in order to reflect their revision and redesignation at 42 CFR 483.10(g)(18) in the long-term care facility requirements reform final rule (81 FR 68825, 68854, October 4, 2016).

**Pub 100-04, Chapter 6, §40.3.3**:

This section is revised to clarify the language on counting inpatient days.

**Pub 100-04, Chapter 6, §40.3.4**:

This section is revised to clarify the language on counting inpatient days and the discussion of a beneficiary's status as a SNF "resident" for consolidated billing purposes.

**Pub 100-04, Chapter 6, §40.3.5**:

This section is revised to clarify the language on counting inpatient days and the language that describes the nonparticipating portion of the same institution that also includes a participating distinct part.

**Pub 100-04, Chapter 6, §40.3.5.2**:

This section is revised to clarify the language that describes the nonparticipating portion of the same institution that also includes a participating distinct part.

**Pub 100-04, Chapter 20, §10.2**:

In column A ("Conditions"), a cross-reference in item 2 is corrected, and in column B ("Review Action"), the next-to-last paragraph in item 2 is revised to clarify the language describing the nonparticipating portion of the same institution that also includes a participating distinct part.

**Pub 100-04, Chapter 30, §130.3**:

Paragraphs A and B of this section are revised to clarify the language describing the nonparticipating portion of the same institution that also includes a participating distinct part.

**Pub 100-04, Chapter 30, §130.4**:

Paragraph A of this section is revised to clarify the language describing the nonparticipating portion of the same institution that also includes a participating distinct part.

**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 | D M E | Shared-System Maintainers | Other |

| | | A | B | HHH | MAC | FISS | MCS | VMS | CWF | |
|---|---|---|---|---|---|---|---|---|---|---|
| 10512 - 04.1 | Contractors and impacted providers shall be aware of the updates to Pub 100-04, Chapters 1, 6, 20, and 30. | X | X | | | | | | | Hospital, Providers, SNF Pricer |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | |
|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | CEDI |
| | | A | B | HHH | | |
| 10512 - 04.2 | MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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 5 business days after receipt of the notification from CMS announcing the availability of the 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. | 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

### 30.1.1.1 - Charges to Hold a Bed During SNF Absence

*(Rev.4001, Issued: 03-16-18, Effective: 06- 19- 18, Implementation: 06-19-18)*

Charges to the beneficiary for admission or readmission are not allowable. However, when temporarily leaving a SNF, a resident can choose to make bed-hold payments to the SNF.

Bed-hold payments are readily distinguishable from payments made prior to initial admission, in that the absent individual has already been admitted to the facility and has established residence in a particular living space within it. Similarly, bed-hold payments are distinguishable from payments for readmission, in that the latter compensate the facility merely for agreeing in advance to allow a departing resident to reenter the facility upon return, while bed-hold payments represent remuneration for the privilege of actually maintaining the resident's personal effects in the particular living space that the resident has temporarily vacated.

One indicator that post-admission payments do, in fact, represent permissible bed-hold charges related to maintaining personal effects in a particular living space (rather than a prohibited charge for the act of readmission itself) would be that the charges are calculated on the basis of a per diem bed-hold payment rate multiplied by however many days the resident is absent, as opposed to assessing the resident a fixed sum at the time of departure from the facility.

Under §1819(c)(1)(B)(iii) of the Act and 42 CFR *483.10(g)(17)-(18)*, the facility must inform residents in advance of their option to make bed-hold payments, as well as the amount of the facility's charge. For these optional payments, the facility should make clear that the resident must affirmatively elect to make them prior to being billed. A facility cannot simply deem a resident to have opted to make such payments and then automatically bill for them upon the resident's departure from the facility.

# Medicare Claims Processing Manual
## Chapter 6 - SNF Inpatient Part A Billing and SNF Consolidated Billing

### 10.1 - Consolidated Billing Requirement for SNFs
***(Rev.4001, Issued: 03-16-18, Effective: 06- 19- 18, Implementation: 06-19-18)***

Section 4432 (b) of the Balanced Budget Act (BBA) requires consolidated billing for SNFs. Under the consolidated billing 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 consolidated billing *(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 SNF 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 consolidated billing 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 consolidated billing 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 consolidated billing purposes.

Enforcement of SNF consolidated billing is done through editing in Medicare claims processing systems using lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing 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 SNF CB. Transmittals with instructions provide updates to previous lists of the exclusions, and some inclusions, to SNF 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.

The list of HCPCS codes enforcing SNF CB may be updated each quarter. For the notice on SNF 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**, consolidated billing 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 consolidated billing once they transitioned to PPS. Due to systems limitations, consolidated billing 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 consolidated billing 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 consolidated billing. 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 SNF PPS consolidated billing.

- **Effective April 1, 2000**, §103 of the Balanced Budget Refinement Act (BBRA) excluded additional services and drugs from consolidated billing 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 SNF consolidated billing 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 - Furnishing Services that are Subject to SNF Consolidated Billing Under an "Arrangement" With an Outside Entity

***(Rev.4001, Issued: 03-16-18, Effective: 06- 19- 18, Implementation: 06-19-18)***

As discussed in §10.1 and §10.3, the SNF consolidated billing provisions (at §1862(a)(18), §1866(a)(1)(H)(ii), and §1888(e)(2)(A) of the Act) place with the SNF itself the Medicare billing responsibility for most of its residents' services. "Part A" consolidated billing requires that a SNF must include on its Part A bill almost all of the services that a resident receives during the course of a Medicare-covered stay, other than those services that are specifically excluded from the SNF's global PPS per diem payment for the covered stay. (These "excluded" services, such as the services of physicians and certain other practitioners, remain separately billable to the A/B MAC (B) directly by the outside entity that actually

furnishes them.) In addition, "Part B" consolidated billing makes the SNF itself responsible for submitting the Part B bills for any physical therapy, occupational therapy, and/or speech-language pathology services that a resident receives during a noncovered stay (see §20.5).

Further, for any Part A or Part B service that is subject to SNF consolidated billing, the SNF must either furnish the service directly with its own resources, or obtain the service from an outside entity (such as a supplier) under an "arrangement," as described in §1861(w) of the Act and in §80.5. Under such an arrangement, the SNF must reimburse the outside entity for those Medicare-covered services that are subject to consolidated billing; i.e., services that are reimbursable only to the SNF as part of its global PPS per diem or those Part B services that must be billed by the SNF.

Since the inception of the SNF PPS, several problematic situations have been identified where the SNF resident receives services that are subject to consolidated billing from an outside entity, such as a supplier. (In this context, the term "supplier" can also include those practitioners who, in addition to performing their separately billable professional services, essentially act as a supplier by also furnishing other services that are subject to the consolidated billing requirement.) As discussed in greater detail below, such situations most commonly arise in one of the following two scenarios: 1) A SNF does not accurately identify services as being subject to consolidated billing when ordering such services from a supplier or practitioner; or 2) A supplier fails to ascertain a beneficiary's status as a SNF resident when the beneficiary (or another individual acting on the beneficiary's behalf) seeks to obtain such services directly from the supplier without the SNF's knowledge.

The absence of a valid arrangement in the situations described above creates confusion and friction between SNFs and their suppliers. Suppliers need to understand which services are subject to consolidated billing to avoid situations where they might improperly attempt to bill the A/B MAC (B) (or other payers such as Medicaid and beneficiaries) directly for the services. In addition, when ordering or furnishing services "under arrangements," both parties need to reach a common understanding on the terms of payment; e.g., how to submit an invoice, how payment rates will be determined, and the turn-around time between billing and payment. Without this understanding, it may become difficult to maintain the strong relationships between SNFs and their suppliers that are necessary to ensure proper coordination of care to the Medicare beneficiaries. Whenever possible, SNFs should document arrangements with suppliers in writing, particularly with suppliers furnishing services on an ongoing basis, such as laboratories, x-ray suppliers, and pharmacies. This also enables the SNF to obtain the supplier's assurance that the arranged-for services will meet accepted standards of quality (under the regulations at *42 CFR 483.70(g)(2)*, SNFs must ensure that services obtained under an arrangement with an outside source meet professional standards and principles that apply to professionals providing such services).

However, it is important to note that the absence of a valid arrangement does NOT invalidate the SNF's responsibility to reimburse suppliers for services included in the SNF "bundle" of services represented by the SNF PPS global per diem rate. As the SNF has already been paid for the services, the SNF must be considered the responsible party when medically necessary supplier services are furnished to beneficiaries in Medicare Part A stays. This obligation applies even in cases where the SNF did not specifically order the service; e.g., during a scheduled physician's visit, the physician performs additional diagnostic tests that had not been ordered by the SNF; a family member arranges a physician visit without the knowledge of SNF staff and the physician bills the SNF for "incident to" services.

Finally, while establishing a valid arrangement prior to ordering services from a supplier minimizes the likelihood of a payment dispute between the parties, it is not unreasonable to expect occasional disagreements between the parties that may result in non-payment of a supplier claim. However, it is important to note that there are potentially adverse consequences to SNFs when patterns of such denials are identified. Specifically, all participating SNFs agree to comply with program regulations when entering into a Medicare provider agreement which, as explained below, requires a SNF to have a valid arrangement in place whenever a resident receives services that are subject to consolidated billing from any entity other than the SNF itself. Moreover, in receiving a bundled per diem payment under the SNF PPS that includes such services, the SNF is accepting Medicare payment, and financial responsibility, for the service.

Accordingly, these instructions reiterate and clarify the applicable consolidated billing requirements that pertain to SNFs and to the outside suppliers that serve SNF residents.

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

***(Rev.4001, Issued: 03-16-18, Effective: 06- 19- 18, Implementation: 06-19-18)***

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 Part A and B institutional 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 A/B MAC (B). Any hospital outpatient charges are billed to the A/B MAC (A).
- 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 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 a 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 A/B MAC (A) 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. This language *addresses* excluding as "directly related" those items and services that are so closely associated with the excluded procedure that it would actually be impossible to perform the excluded procedure itself without them, such as the anesthesia for an excluded ambulatory surgical

procedure under §20.1.2.1, or an otherwise bundled diagnostic test when needed to identify the cause of (and appropriate course of treatment for) a medical emergency under §20.1.2.2.

- Note that anesthesia, drugs incident to radiology and supplies 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 those HCPCS codes listed in Major Category I. F.) 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).

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

***(Rev.4001, Issued: 03-16-18, Effective: 06-19-18, Implementation: 06-19-18)***

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 A/B MAC (A) 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 494.80(a)(2) and (a)(4), 494.90(a)(4), and 494.100) may be billed by the RDF to the A/B MAC (A), 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. *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). The Part B dialysis benefit generally* does not *cover dialysis for those beneficiaries who do not have ESRD. However, an exception involves* "acute" dialysis *(HCPCS code G0491)*, *for* patients who do not have ESRD but require dialysis temporarily following *an acute kidney injury (AKI) from* 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. *For services furnished on or after January 1, 2017, section 808(a) of Public Law 114-27 added acute dialysis to* the scope of the Part B dialysis benefit, *thereby effectively adding such services to the scope of the dialysis exclusion* from SNF CB *as well.*

## 20.3 - Other Services Excluded from SNF PPS and Consolidated Billing

***(Rev.4001, Issued: 03-16-18, Effective: 06-19-18, Implementation: 06-19-18)***

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 A/B MACs (A).

- 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 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 A/B MAC (A) Annual Update. These same codes also appear on the list of exclusions in File 1 of the SNF website's A/B MAC (B) 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 *fighting the* cancer *itself*). 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 A/B MACs (A) can be found.

## 20.3.1 - Ambulance Services

***(Rev.4001, Issued: 03-16-18, Effective: 06-19-18, Implementation: 06-19-18)***

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. A/B

MACs (A), (B), (HHH), and DME MACs 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 A/B MAC (A), (B), or (HHH), or DME MAC (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 *or from* a hospital based or nonhospital based ESRD facility (the first *or second* character (origin *or destination*) of the HCPCS ambulance modifier is N (SNF), and the *other* character *of the* HCPCS ambulance modifier 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 *before the following* midnight; 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 A/B MAC (A), (B), or (HHH) 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 *before the following* midnight (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 A/B MAC (A).

- 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(g)(18)* 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*/Medicaid* or by the facility's per diem rate."

## 40.3.3 - Same Day Transfer

***(Rev.4001, Issued: 03-16-18, Effective: 06-19-18, Implementation: 06-19-18)***

The day of admission counts as a utilization day, except in the situation where the patient was admitted with the expectation that he remain overnight but was transferred to another participating provider before *the following* midnight. In this instance, the first provider completes the bill as follows:

- Indicate "0" in Covered Days;
- Insert condition code "40" to indicate the patient was transferred from one participating provider to another before *the* midnight *immediately following* the admission *to the first provider*; and,
- Admission date, statement "from" and "through" dates are the same.

No payment is made to the originating participating provider. Instead, the participating provider to which the patient was transferred counts the admission day as a utilization day that includes the day of admission and may bill the HIPPS default code.

If a patient is transferred from a Medicare participating facility to a nonparticipating facility the day of admission counts as a utilization day and the Medicare-participating facility may bill the HIPPS default code.

These general rules apply to transfers between SNFs and between a hospital and an SNF. However, under these same circumstances, if the two providers represent an institution composed of a participating hospital and a distinct part participating SNF, the first provider cannot bill for accommodations, but may bill for ancillary charges.

## 40.3.4 - Situations that Require a Discharge or Leave of Absence

***(Rev.4001, Issued: 03-16-18, Effective: 06-19-18, Implementation: 06-19-18)***

Medicare systems are set up so that the SNF need not submit a discharge bill when the situation is that the beneficiary (who leaves the SNF and then returns *before the following* midnight) receives outpatient services from a Medicare participating hospital, CAH, or other appropriate provider during his/her absence. Edits allow hospitals and CAHs to bill for these services for a beneficiary in a Part A PPS stay. Receipt of outpatient services from another provider does not normally result in a SNF discharge.

Two situations force a discharge from a SNF: 1) the beneficiary's admission as an inpatient to a Medicare participating hospital or CAH, or 2) the beneficiary's transfer to another SNF for inpatient services. A beneficiary cannot be an inpatient in more than one facility at a time. Consequently, the SNF **must** submit a discharge bill if either of these events occur.

If the patient is readmitted to the SNF, the SNF should submit a new bill (TOB 211 or 212) with a new admission date. See §40.3.2, Patient Readmitted Within 30 days After Discharge, for further instructions.

Bills for excluded services (identified in §20 of this chapter) rendered by participating hospitals, CAHs, or other appropriate providers may be paid to the rendering provider in addition to the Part A PPS payment made to the SNF. Other outpatient services furnished to a resident in a Part A PPS stay by another provider/supplier must be billed by the SNF. Home health or outpatient services provided during a leave of absence do not affect the leave and no discharge bill is required.

Home health services are not payable unless the patient is confined to his home, and under Medicare regulations, a SNF cannot qualify as a home. Where the beneficiary receives services from a home health agency, the home health agency is responsible for billing.

If the beneficiary is formally discharged or otherwise departs for reasons other than described above but then, is readmitted or returns *before the following* midnight, he is not considered discharged. The SNF is responsible for billing for services during the period of absence, unless such services are otherwise excluded from Part A PPS payment or are excluded from Medicare coverage *(see §10.1)*.

**NOTE:** This instruction only applies to Medicare fee-for-service beneficiaries in a participating SNF.

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

*(Rev.4001, Issued: 03-16-18, Effective: 06-19-18, Implementation: 06-19-18)*

**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*nother,* nonparticipating-provider *(*or *to* a nonparticipating *portion* of the same provider*)* before *the following* midnight. 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). 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.

## 40.3.5.2 - Leave of Absence

*(Rev.4001, Issued: 03-16-18, Effective: 06-19-18, Implementation: 06-19-18)*

A leave of absence for the purposes of this instruction is a situation where the patient is absent, but not discharged, for reasons other than admission to a hospital, other SNF, or *nonparticipating portion* of the same *institution*. If the absence exceeds 30 consecutive days, the 3-day prior stay and 30-day transfer requirements, as appropriate, must again be met to establish re-entitlement to SNF benefits.

Leave of absence (LOA) days are shown on the bill with revenue code 018X and LOA days as units. However, charges for LOA days are shown as zero on the bill, and the SNF cannot bill the beneficiary for them except as specified in Chapter 1 of this manual at §30.1.1.1. Occurrence span code 74 is used to report the LOA from and through dates. Providers should review the RAI manual to clarify situations where an LOA is not appropriate, for example observation stays in a hospital lasting greater than 24 hours.

# Medicare Claims Processing Manual
## Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

### 10.2 - Coverage Table for DME Claims
*(Rev.4001, Issued: 03-16-18, Effective: 06-19-18, Implementation: 06-19-18)*
**B3-2105**

Reimbursement may be made for expenses incurred by a patient for the rental or purchase of durable medical equipment (DME) for use in his/her home provided that all the conditions in column A below have been met. Column B indicates the action A/B MACs (A), (B), and (HHH), and DME MACs will take to establish that the conditions have been met.

| A - Conditions | B - Review Action |
|---|---|
| l. Payment may be made for the following: | 1. Payment may be made for following: |
| (a) Items of DME that are medically necessary | (a) The HCPCS file shows coverage status of items. If item is not listed in the HCPCS file, the MAC will develop LMRP to determine whether the item is covered. |
| (b) Separate charges for repair, maintenance and delivery | (b) Repairs - only if DME is being purchased or is already owned by patient and repair is necessary to make the equipment serviceable. Medicare pays the least expensive alternative. (See special exception in Chapter 15 of the Medicare Benefit Policy Manual for repair of dialysis delivery system.)<br>NOTE: See Chapter 15 of the Medicare Benefit Policy Manual for handling claims suggesting deliberate or malicious damage or destruction.<br>Maintenance - only if the equipment is being purchased, or is already owned by the patient, and if the maintenance is extensive amounting to repairs, i.e., requiring the services of skilled technicians. (MACs deny claims for routine maintenance and periodic servicing, e.g., testing, cleaning, checking, oiling, etc.) (See special exception in Chapter 15 of the Medicare Benefit Policy Manual for maintenance of dialysis delivery system.)<br>Delivery - of rented or purchased equipment is covered, but the related payment is included in the fee schedule for the item. Additional payment may be made at the discretion of the MAC in special circumstances (see Chapter 15 of the Medicare Benefit Policy Manual) |
| (c) Separate charges for disposable supplies, e.g., oxygen, if essential to the | (c) Claim must indicate that:<br>• The patient has the DME for which the |

| A - Conditions | B - Review Action |
|---|---|
| effective use of medically necessary durable medical equipment. Separate charges for replacement of essential accessories such as hoses, tubes, mouthpieces, etc., only if the beneficiary owns or is purchasing durable medical equipment (BPM, Chapter 15, §110). (Medications used in connection with durable medical equipment are covered under certain conditions - see Chapter 15 of the Medicare Benefit Policy Manual) | supply is intended;<br>• The DME continues to be medically necessary; and<br>• The items are readily identifiable as the type customarily used with such equipment.<br>**NOTE:** If the quantity of accessories and/or supplies included in a claim seems excessive or if claims for such items are received from the same claimant with undue frequency, see Chapter 5 of the Medicare Program Integrity Manual. |
| 2. DME must be for use in patient's residence other than a health care institution. (BPM*, Chapter 15,* §*110.1.D* & PIM, Chapter 5, §1) | 2. Payment cannot be made for equipment for use in an institution classified as:<br>a. A participating hospital,<br>b. An emergency hospital,<br>c. Meets §1861(e)(1) of the Act,<br>d. A participating SNF or<br>e. Meets §1819(a)(1) of the Act.<br>*If an* institution *that includes* a *Medicare-participating* distinct part *SNF also has a nonparticipating portion* that does not meet 1819(a)(1), the patient may be considered in his/her residence if he/she was physically located in such *nonparticipating portion* during the use period.<br>DMEPOS (DME, P&O, and supplies) items provided to hospice patients are generally included in the payment for hospice services. Items of DMEPOS are covered by Medicare and paid in addition to the hospice payment only when those items or supplies are provided to the patient for treatment of a condition or illness not related to the patient's terminal illness. |
| 3. Physician's prescription required. | A supplier must maintain and, upon request, make available to the MAC, the detailed written order (or, when required, the Certificate of Medical Necessity (CMN)) from the treating physician. See the Medicare Program Integrity Manual, Chapter 5. |

# Medicare Claims Processing Manual
## Chapter 30 - Financial Liability Protections

### 130.3 - Application of Limitation on Liability to SNF and Hospital Claims for Services Furnished in Noncertified or Inappropriately Certified Beds

***(Rev.4001, Issued: 03-16-18, Effective: 06-19-18, Implementation: 06-19-18)***

**A. General**

Payment for SNF and hospital claims may not be denied solely on the basis of a beneficiary's placement in a non-certified *portion* of *the same institution that also includes* a participating SNF or hospital. When requested by the beneficiary or his/her authorized representative, a provider must submit a claim to the A/B MAC (A) for services rendered in a non-certified bed. When the A/B MAC (A) reviews a claim for services rendered in a non-certified bed, it first determines whether the beneficiary consented to the placement. (See subsection C.) If the A/B MAC (A) finds that the beneficiary consented, it denies the claim. If it finds that the beneficiary did not consent, it determines whether there are any other reasons for denying the claim. (See subsection D.) If there is another reason for denying the claim, the A/B MAC (A) denies it. However, if none of the reasons for denial exist, beneficiary liability must be waived as provided under §1879(e) of the Act and a further determination must be made as to whether the provider, rather than the Medicare program, must accept liability for the services in question. (See "Coverage of Extended Care Services Under Hospital Insurance" in the Medicare Benefit Policy Manual, Chapter 8.)

**B. Provider Notice Requirements**

When a SNF or hospital places a patient in a noncertified or inappropriately certified portion of *the institution* because it believes the patient does not require a covered level of care, or for any other reason, it must notify the patient (or authorized representative) in writing that services in a noncertified or inappropriately certified bed are not covered. The provider uses the appropriate notice specified in §70 for SNFs or swing beds, §80 for inpatient hospitals, to advise the beneficiary of its decision to place him/her in a noncertified bed, using language such as:

> We are placing you in a part of *the institution* that is not appropriately certified by Medicare because (you do not require a level of care that will qualify as skilled nursing care/or covered hospital services under Medicare)/(or state any other reasons for the noncertified bed placement). Nonqualifying services furnished a patient in a noncertified or inappropriately certified bed are not payable by Medicare. However, you may request us to file a claim for Medicare benefits. Based on this claim, Medicare will make a formal determination and advise whether any benefits are payable to you.

(For related general billing requirements, see Chapter 1, §60 of this manual, or other chapters specific to the benefit being billed: Chapter 3 for inpatient hospitals and swing beds, Chapter 6 for swing bed PPS and inpatient SNFs, and Chapter 7 for outpatient SNFs.)

**C. Determining Beneficiary Consent**

The CMS presumes that the beneficiary did not consent to being placed in a noncertified bed. In order to rebut the presumption of lack of consent, the provider must indicate on the bill the date it provided the beneficiary with an ABN notifying the beneficiary that the accommodations would no longer be covered; and requested the beneficiary's signed acknowledgement (on the ABN) of having received such a statement. Moreover, in any case in which a Medicare beneficiary gives his/her consent to placement in a noncertified bed, the provider must, if requested by the A/B MAC (A) (contemplated only at an appeal level of claim processing), submit a copy of the ABN signed by the beneficiary to the A/B MAC (A), for a determination

of the ABN's validity. The ABN must be signed by the beneficiary (provided he/she is competent to give such consent) or by the beneficiary's authorized representative. If the beneficiary or his/her authorized representative refuses to sign the form, the provider may annotate the file to indicate it presented the ABN to the beneficiary (or his/her authorized representative), but the beneficiary refused to sign. As long as the provider's ABN notifies the beneficiary of the likely Medicare noncoverage, the beneficiary's refusal to sign the ABN does not render it invalid. (See §40.3.4.6.) If any of the above requirements is not met, the A/B MAC (A) automatically determines the ABN is defective.

When the A/B MAC (A) receives a claim with an indication that the provider has provided the beneficiary or his/her authorized representative, with an ABN, the A/B MAC (A) denies the claim and notifies the beneficiary that §1879 limitation on liability cannot be applied because of the beneficiary's valid consent to be cared for in a noncertified or inappropriately certified bed. If the A/B MAC (A) determines that the ABN is not valid, the A/B MAC (A) processes the claim in accordance with §130.4.

If the beneficiary appeals the initial denial, the A/B MAC (A) obtains the ABN from the provider and determines whether it is valid. If the A/B MAC (A) determines that the ABN is invalid, it notifies the provider and the beneficiary that payment **may** be made to the extent that all other requirements are met.

**D. Determining Whether Other Requirements for Payment are Met**

Denials still are appropriate for any of the following reasons. The A/B MAC (A) must undertake the development needed to permit a determination as to whether:

- The patient did not receive or require otherwise covered hospital services or a covered level of SNF care;

- The benefits are exhausted;

- The physician's certification requirement is not met;

- There was no qualifying 3-day hospital stay (applicable to SNFs only); or

- Transfer from the hospital to the SNF was not made on a timely basis. (However, if transfer to an institution which contains a participating SNF is made on a timely basis, a claim cannot be denied solely on the grounds that the transfer requirement is not met because the bed in which the beneficiary is placed is not a certified SNF bed.)

The A/B MAC (A) denies cases falling within these categories under existing procedures. Also, if the beneficiary receives care in a totally nonparticipating institution, denial on the grounds that the beneficiary was not in a participating SNF or hospital is still appropriate.

## 130.4 - Determining Liability for Services Furnished in a Noncertified SNF or Hospital Bed

***(Rev.4001, Issued: 03-16-18, Effective: 06-19-18, Implementation: 06-19-18)***

The A/B MAC (A) presumes that the provider properly notified the beneficiary of noncoverage, and that the beneficiary assented, if the claim includes the proper indicators of liability notification.

The following development occurs only if the beneficiary appeals the A/B MAC (A)'s decision that the beneficiary may not have liability waived because the provider gave him/her timely notice that Medicare would not cover the accommodation; and that he/she consented to being placed in a noncertified bed.

**A. Beneficiary Liability**

If the A/B MAC (A) determines that the beneficiary did not consent to placement in *a* noncertified *portion of the same institution that also includes* the participating facility (see §130.3.C), and that no other basis for denial of the claim exists (see §130.3.D), it finds the beneficiary not liable under §1879 of the Act.

**B. Provider Liability**

If the beneficiary is found not liable under §1879, liability may rest with the provider, or with the program. Liability rests with the Medicare program, unless any of the following conditions exist, in which case the provider is liable for the services.

The provider did not give timely written notice to the beneficiary of the implications of receiving care in a noncertified or inappropriately certified bed as discussed in §130.3.B;

The provider failed to provide the beneficiary with an appropriate ABN and/or did not attempt to obtain a valid consent statement from the beneficiary. (See §130.3.C.); or

The A/B MAC (A) determined from medical records in its claims files that it is clear that the beneficiary required and received services equivalent to a covered level of SNF care, or that constituted covered hospital services, and the provider had no reasonable basis for placing the beneficiary in a noncertified bed. Following are examples of situations in which it would be found that the provider did in fact have a reasonable basis to place a beneficiary in a noncertified bed:

**EXAMPLES:**

- The A/B MAC (A), a QIO, or Utilization Review Committee had advised the provider that the beneficiary did not require a covered level of SNF care or covered hospital services preadmission/admission;

- The beneficiary's attending physician specifically advised the provider (verified by documentation in the medical record) that the beneficiary no longer required a covered level of care or services; note that if covered care had previously existed, effective July 1, 2005, notification under the expedited determination process would be required (see §20);

- A beneficiary not requiring covered services had a change in his/her condition that later required a covered level of care or services and the provider had no certified bed available (of course, the SNF transfer requirement must be met, see the Medicare Benefit Policy Manual, Chapter 8.); or

- The A/B MAC (A) has other sufficient evidence to determine that the provider acted in good faith but inadvertently placed the beneficiary in a noncertified bed.