CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3379	**Date: October 16, 2015**
	Change Request 9336

SUBJECT: Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions (2015)

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: November 16, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: November 16, 2015

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	Chapter 6 / 20.1.2 / Other Excluded Services Beyond the Scope of a SNF Part A Benefit
R	Chapter 6 / 20.1.2.1 / Outpatient Surgery and Related Procedures – INCLUSION
R	Chapter 6 / 20.2.1 / Dialysis and Dialysis Related Services to a Beneficiary With ESRD
R	Chapter 6 / 20.4 / Screening and Preventive Services
R	Chapter 6 / 30.4.3 / Decision Logic Used by the Pricer on Claims

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

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I. GENERAL INFORMATION

A. Background: 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.

Pub. 100-04, Chapter 6:

§§20.1.2 and 20.1.2.1 are each revised by removing a parenthetical reference to revenue codes (originally added in CR 3070) that has become obsolete. §20.2.1 is revised by updating the regulations citation that appears in the third bullet point, and also by reformatting the material in the fourth bullet point as a separate paragraph (as had been originally intended when that material was manualized in CR 8044). In §20.4, the description of screening services in the first paragraph (as added by CR 8044) is revised for greater clarity, and the final three words of the quoted material appearing at the end of the sixth paragraph (also added by CR 8044) are revised by restoring the emphasized font, which subsequently was inadvertently removed in the course of manualizing CR 8669. In §30.4.3, item 6a is clarified by eliminating extraneous and redundant language.

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	
9336 - 04.1	Contractors shall be aware of the updates to Pub. 100-04 Chapter 6: §§20.1.2 and 20.1.2.1 are each revised by removing a parenthetical reference to revenue codes (originally added in CR 3070) that has become obsolete. §20.2.1 is revised by updating the regulations citation that appears in the third bullet point, and also by reformatting the material in the fourth bullet point as a separate paragraph (as had been originally intended when that material was manualized in CR 8044). In §20.4, the description of	X	X							Hospital, Providers, SN

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	screening services in the first paragraph (as added by CR 8044) is revised for greater clarity, and the final three words of the quoted material appearing at the end of the sixth paragraph (also added by CR 8044) are revised by restoring the emphasized font, which subsequently was inadvertently removed in the course of manualizing CR 8669. In §30.4.3, item 6a is clarified by eliminating extraneous and redundant language.									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9336 - 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				

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:

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

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

(Rev. 3379, Issued: 10-16-15, Effective: 11-16-15, Implementation: 11-16-15)

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 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 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).

20.1.2.1 Outpatient Surgery and Related Procedures – INCLUSION

(Rev. 3379, Issued: 10-16-15, Effective: 11-16-15, Implementation: 11-16-15)

Inclusions, rather than exclusions, are given in this one case, because of the great number of surgical procedures that are excluded and can only be safely performed in a hospital operating room setting. It is easier to automate edits around the much shorter list of inclusions under this category, representing minor procedures that can be performed in the SNF itself. Additionally, this was the approach originally taken in the regulation to present this information.

- Note that anesthesia, drugs, supplies and lab services will be bypassed by enforcement edits when billed with outpatient surgeries excluded from SNF CB. The bypass is implemented for these services when the line item date of service matches the line item date of service for the excluded surgery. For revenue codes not requiring a line item date of service (i.e., pharmacy and supplies), the bypass will be implemented when no line item date of service is present.

See §10.1 above for the link to where transmittals providing current lists of HCPCS codes used for Major Category I SNF consolidated billing editing can be found.

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

(Rev. 3379, Issued: 10-16-15, Effective: 11-16-15, Implementation: 11-16-15)

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

- Certain dialysis services and supplies, including any related necessary ambulance services;

- Home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies (other than those furnished or arranged for by the SNF itself) are not included in the SNF Part A PPS rate. These services may be billed separately to the FI by the ESRD facility as appropriate; dialysis supplies and equipment may be billed to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) by the supplier; and

- Erythropoiesis Stimulating Agents (ESAs) for certain dialysis patients, subject to methods and standards for its safe and effective use (see 42 CFR *494.80(a)(2) and (a)(4), 494.90(a)(4), and 494.100*) may be billed by the RDF to the FI, or by the retail pharmacy to the DME MAC.

By contrast, services that fall outside the scope of the Part B dialysis benefit do not qualify for the dialysis exclusion from SNF CB. For example, this exclusion does not encompass “acute” dialysis, which involves

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

20.4 - Screening and Preventive Services

(Rev. 3379, Issued: 10-16-15, Effective: 11-16-15, Implementation: 11-16-15)

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

Accordingly, even though the SNF itself must bill for these services, it submits a separate Part B inpatient bill for them rather than including them on its global Part A bill. Screening and preventive services must be billed with a 22X type of bill. Swing Bed providers must use TOB 12x for eligible beneficiaries in a Part A SNF level of care. **NOTE:** For beneficiaries residing in the Medicare non-certified area of the facility, these services should be billed on a 23x type of bill. In transmittals for 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.

30.4.3 - Decision Logic Used by the Pricer on Claims

(Rev. 3379, Issued: 10-16-15, Effective: 11-16-15, Implementation: 11-16-15)

The SNF Pricer shall calculate the rate for each line item with revenue code 0022 on a SNF claim. The SNF Pricer shall determine the rate using the following information:

- "HIPPS-CODE" on line item 0022;
-"CBSA"
- Per diem amounts defined within the Pricers as types of rate based on the statement covers "THRU-DATE":
Inpatient rate = Nursing case mix component
General service rate = Non-case-mix component
Therapy rate = Therapy non-case mix component
Rehabilitation rate = Therapy case-mix component
- Labor and non labor percentages based on the statement covers "THRU-DATE";
- Wage index, "SNF-FED BLEND" year, and "SNF-FACILITY RATE" based on the statement covers "THRU_DATE"
- Rate adjustments applicable to the specific RUG code;
- Nursing index based on the RUG code;
- Therapy index based on the rehabilitation RUG code;

On input records with TOB 21x (that is, all provider submitted claims and provider or FI initiated adjustments), Pricer will perform the following calculations in numbered order for each RUG code:

(1) Multiply the applicable urban or rural inpatient rate depending on CBSA by the nursing index;

(2) Multiply the applicable urban or rural rehab rate by the therapy index, add to (1);

(3) For the top 23 RUG categories, add the general service rate to the sum of (1) and (2) for the (non-wage-adjusted) total PPS rate and proceed to step (4); **OR** for the lower 43 RUG categories, add the

general service rate to the therapy rate to the sum of (1) and (2) for the (non-wage- adjusted) total PPS rate and proceed to step (4);

(4) Multiply the sum of (3) by the labor percentage then multiply the product by the applicable wage index and round;

(5) Multiply the sum of (3) by the non- labor percentage and round;

(6) Add the product of (5) to the non-labor product in (4) for the (wage-adjusted) total PPS rate.

Conditional Steps completed if applicable after (6):

(6a) If diagnosis code 042 is present, multiply (6) by 2.28.