Medicare Claims Processing Manual

Chapter 7 - SNF Part B Billing (Including Inpatient Part B and Outpatient Fee Schedule)

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(Rev. 10880, 08-06-21)

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10 - Billing for Medical and Other Health Services

(Rev. 10880, Issued: 08-06-21, Effective: 11-08-21, Implementation: 11-08-21)

See Business Requirements at ***https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R20CP.pdf.***

There are three situations in which a SNF may submit a claim for Part B services. These are identified in subsections A through C below.

No bill is required when:

- The patient is not enrolled under Part B;
- Payment was made or will be made by the Public Health Service, VA, or other governmental entity;
- Workers' compensation has paid or will pay the bill; or
- Payment was made by liability, no-fault insurance, group health plan, or a large group health plan.

A - Beneficiaries in a Part B Inpatient Stay (Part B Residents)

A Part B inpatient stay includes services furnished to inpatients whose benefit days are exhausted, or who are not entitled to have payment made for services under Part A. A more detailed description of services covered for beneficiaries in a Part B stay is *found* at §10.1 – Billing for Inpatient Services Paid Under Part B.

B - Outpatient Services

Covered Part B services rendered to beneficiaries who are not inpatients of a SNF are considered SNF outpatient services. They include the services listed in §10.1 below as well as additional services described in the Medicare Benefit Policy Manual, Chapter 8, "Coverage of Extended Care (SNF) Services Under Hospital Insurance," §§80 and Medicare Benefit Policy Manual, Chapter 6, "Hospital Services Covered Under Part B." Detailed instructions for billing are located in §10.2 – Billing for Outpatient SNF Services.

C - Beneficiaries in a Part A Covered Stay

SNFs are required to consolidate billing to their intermediary for their covered Medicare inpatient services. However, certain services rendered to SNF inpatients are excluded from the SNF Prospective Payment System (PPS) reimbursement and are also excluded from consolidated billing by the SNF. Those services must be billed to Part B by the rendering provider and not by the SNF (except screening and preventive services as described in the next paragraph.) A list of services excluded from consolidated billing is

found in the Medicare Claims Processing Manual, Chapter 6, "SNF Inpatient Part A Billing," §§20 – 20.4.

Screening and preventive services are not included in the SNF PPS amount but may be paid separately under Part B for Part A patients who also have Part B coverage. Screening and preventive services are covered only under Part B. Only the SNF may bill for screening and preventive services under Part B for its covered Part A inpatients. Bill type 22X is used *in billing screening and preventive services* for beneficiaries in a covered Part A stay and for beneficiaries that are Part B residents. TOB 23x is used for SNF outpatients or for beneficiaries not in the SNF or DPU. The SNF must provide the service or obtain it under arrangements.

Coverage, billing and payment guidelines are found in the Medicare Claims Processing Manual, Chapter 18, "Preventive and Screening Services;" Chapter 17, "Drugs and Biologicals;" and the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §50.4.4.2.

There are certain medical and other health services for which payment may not be made to a SNF. Most of these are professional services performed by physicians and other practitioners. These services are always billed to the Medicare Part B *MAC*. Others are services that have been determined to require a hospital setting to assure beneficiary safety. *Part A MAC* shared systems receive an annual file listing these non-payable HCPCS in November, and, if necessary, a quarterly update via a one-time-only notification.

Physicians, non-physician practitioners, and suppliers billing the *Part B MAC*, and providers billing the *Part A MAC* should consult the CMS Web site at http://www.cms.hhs.gov/SNFConsolidatedBilling/ for lists of separately billable services.

10.1 - Billing for Inpatient SNF Services Paid Under Part B
(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

When the beneficiary in a Medicare-certified SNF is not entitled to Part A benefits, limited benefits are provided under Part B. Reasons for not being entitled to have payment made under Part A are that:

- The beneficiary does not have Medicare Part A Health Insurance;
- The beneficiary is not in a Medicare-certified bed;
- The inpatient stay is not at a covered level of care and no Part A program payment is possible; or
- The inpatient stay is not covered because the beneficiary did not have a 3-day qualifying stay.

When no Part A program payment is possible, some or all services may be medically necessary and can be covered as ancillary services under Part B. The following services may be billed by the SNF or the rendering provider or supplier under an arrangement with the SNF:

- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests;
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;
- Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations;
- Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices;
- Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition;
- Outpatient physical therapy, outpatient speech-language pathology services, and outpatient occupational therapy (see Pub. 100-02 Medicare Benefit Policy Manual, chapter 15, "Covered Medical and Other Health Services," §220 and 230.
- Screening mammography services;
- Screening pap smears;
- Influenza, pneumococcal pneumonia, and hepatitis B vaccines;
- Colorectal screening;
- Bone mass measurements;

- Diabetes self-management;
- Prostate screening;
- Ambulance services;
- Hemophilia clotting factors for hemophilia patients competent to use these factors without supervision);
- Immunosuppressive drugs;
- Oral anti-cancer drugs;
- Oral drug prescribed for use as an acute anti-emetic used as part of an anti-cancer chemotherapeutic regimen; and
- Epoetin Alfa (EPO).

See chapter 6 of Pub. 100-02, Medicare Benefit Policy Manual for a discussion of the circumstances under which the above services may be covered as Part B Inpatient services.

Coverage rules for these services are described in Pub. 100-02, Medicare Benefit Policy Manual, Chapters 10, 14, or 15. Specific billing instructions are found in the Medicare Claims Processing Manual, Chapters 13, 15, 16, 18, 20, or 23.

Outpatient physical therapy, outpatient speech-language pathology services, and outpatient occupational therapy (see Chapter 10, §§60) are billable services for SNF inpatients not in a Part A stay. However, they must be billed by the SNF even when another entity renders the services under an arrangement with the SNF.

The determination of whether to use TOB 22x or 23x is a function of the type of facility in which the beneficiary resides. If the facility is not Medicare-certified, it is not a SNF, although it may have a Medicare-certified distinct part unit (DPU). If the beneficiary is in a SNF or SNF DPU, Part B services must be billed on TOB 22x.

All services rendered to SNF patients residing in the non-Medicare-certified portion of an institution that is not primarily engaged in the provision of skilled services must be billed on TOB 23x. Beneficiaries residing in such portions of the facility are considered outpatients of the SNF for Medicare purposes.

If the entire facility qualifies as a Medic are-certified SNF, all Part B services rendered to residents are billed on TOB 22x.

10.1.1 - Editing of Skilled Nursing Facilities Part B Inpatient Services

(Rev. 3481, Issued: 03-18-16. Effective: 06-20-16, Implementation: 06-20-16)

Medicare pays under Part B for physicians' services and for non-physician medical and other health services listed below when furnished by a participating hospital to an inpatient of the SNF when patients are not eligible or entitled to Part A benefits or the patient has exhausted their Part A benefits.

The SSM shall edit to prevent payment on Type of Bill 22x for claims containing the revenue codes listed in the table below.

010x	011x	012x	013x	014x	015x	016x	017x
018x	019x	020x	021x	022x	023x	024x	0250
0251	0252	0253	0256	0257	0258	0259	0261
0269	0270	0273	0277	0279	029x	0339	036x
0370	0374	041x	045x	0472	0479	049x	050x
051x	052x	053x	0541	0542	0543	0544	0546
0547	0548	0549	055x	057x	058x	059x	060x
0630	0631	0632	0633	0637	064x	065x	066x
067x	068x	072x	0762	078x	079x	093x	0940
0941	0943	0944	0945	0946	0947	0949	095x
0960	0961	0962	0969	097x	098x	099x	100x
210x	310x						

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 96
RARC: M28
MSN: 21.21

10.2 – Billing for Outpatient SNF Services

(Rev. 229, Issued 07-20-04 Effective/Implementation 08-19-04)
SNF-529

Coverage is available for all of the services described in §10.1. However, beneficiaries not in the Medicare-certified Distinct Part Unit (DPU) are not required to have therapy services (physical therapy, occupational therapy, and speech language pathology) billed by the SNF. Therapy services need only be bundled to the SNF for those SNF residents in a Medicare-certified DPU. For additional information see Chapter 6, SNF Inpatient Part A Billing, §20.5 Therapy Services.

10.3 - Determining How Much to Charge Before Billing Is Submitted

(Rev. 1, 10-01-03)
SNF-529.1

The SNF may be able to determine from the SNF's records, from a transferring hospital, or from the patient the extent to which the Part B cash deductible is met. The SNF may charge the patient for the unmet deductible and coinsurance. The SNF should submit a bill even if no payment can be made because the unmet Part B cash deductible exceeds

the covered charges. In addition, a bill is required when the SNF becomes aware that no bill has been submitted for covered services even though the time limitation for filing has expired.

10.4 - Charges for Services Provided in Different Accounting Years

(Rev. 1, 10-01-03)
SNF-529.2

The SNF must not put charges for services provided in different accounting years on the same bill. At the end of the SNF's accounting year, the SNF should submit a bill that contains the charges for all services furnished to the patient since the last bill through the end of the year. The SNF should include bills in which the deductible covers all charges. All services furnished in the succeeding accounting year should be placed on a separate bill. Complete all items on the subsequent bill.

10.5 - General Payment Rules and Application of Part B Deductible and Coinsurance

(Rev. 685, Issued: 09-23-05, Effective: 12-27-05, Implementation: 12-27-05)
SNF-529.3

Section 1888(e)(9) of the Social Security Act (the Act) requires that the payment amount for Part B SNF services shall be the amount prescribed in the otherwise applicable fee schedule. Thus, where a fee schedule exists for the type of service, the fee amount will be paid. Where a fee does not exist on the Medicare Physician Fee Schedule (MPFS) the particular service is priced based on cost. This is also true for all “carrier-priced” codes on the MPFS, but not for services paid on the Clinical Diagnostic Laboratory Fee Schedule. All lab services missing fees are to be gap-filled. Some specific services continue to be paid on a cost basis and are specifically stated in the sections below where cost applies.

Where payment is made under a fee schedule, the beneficiary's deductible and coinsurance are based on the approved amount. Where payment is made on a cost basis, deductible and coinsurance are based on charges for the service.

20 - Use of Healthcare Common Procedure Coding System (HCPCS)

(Rev. 1, 10-01-03)
SNF-530, SNF-530.3

HCPCS is required for reporting all SNF services paid under Part B, whether paid by Medicare fee schedules or by some other mechanism. A description of HCPCS codes is found in the Medicare Claims Processing Manual, Chapter 23.

The SNF should use the CPT-4 portion of HCPCS and/or Level II as directed by the manual sections applicable to the Part B service that is being billed. Currently, HCPCS codes are not applicable on SNF Part A inpatient claims.

For Part B claims, there are separate codes for the technical component, professional component, and/or complete procedure. Generally, SNFs bill for the technical component only, using the code that describes the procedure provided.

There may be specific rules for use of HCPCS codes for specific types of services (e.g., SNF's must bill global services for therapies). These will be described in the manual sections for the applicable service.

Revenue codes, HCPCS codes, line item dates of service, and units are required. Charges must be reported by HCPCS code. If the same revenue code applies to two or more HCPCS codes, the SNF should repeat the revenue code and show the line item date of service, units and charge for each HCPCS code on a separate line.

30 - Billing Formats

(Rev. 3053, Issued: 08-28-14, Effective: ICD-10: Upon Implementation of ICD-10 ASC-X12: 01-01-12, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: 09-30-14)

The SNF must use the current ASC X12 837 institutional claim format or if permissible Form CMS-1450 to bill for covered Part B services. Instructions for those formats are located in the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the CMS-1450 Data Set."

30.1 - Frequency of Billing for Skilled Nursing Facilities (SNFs)

(Rev. 1, 10-01-03)
SNF-561

SNFs must bill repetitive Part B services on a single individual monthly bill (or at the conclusion of treatment). This avoids Medicare processing costs in holding such bills for monthly review and reduces bill processing costs for relatively small claims. See the Medicare Claims Processing Manual, Chapter 1, "General Billing Requirements," §50.2.2, for additional instructions when billing repetitive services and billing repetitive services during an inpatient stay.

Other one-time Part B services must be billed upon completion of the services.

30.2 - Guidelines for Submitting Corrected Bills

(Rev. 1, 10-01-03)
SNF-562, SNF-562.A

When a SNF or intermediary discovers an error on an original bill, there are three methods for correcting the bill depending on the type of error. The SNF or intermediary may submit a late charge bill, an adjustment request, or maintain a log of charges. Each of the methods and appropriate use are explained in the Medicare Claims Processing Manual, Chapter 1, "General Billing Requirements," §130.

40 - Billing Part B Rehabilitation Services
(Rev. 1, 10-01-03)
SNF-515.6

Part B rehabilitation services other than audiology services must be billed by the SNF for Part A inpatients, for Part B residents (those not in a covered Part A stay) and for outpatients. Effective January 1, 1999, the MPFS is the payment basis for these services.

The Medicare Claims Processing Manual, Chapter 5, "Part B Outpatient Rehabilitation and CORF Services," contains instructions for billing, payment, and applicable HCPCS codes.

40.1 - Audiologic Tests
(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

Audiologic tests will generally be billed to the carrier by the provider of service. For tests that include both a professional component and technical component, the SNF may elect to bill the technical component to the intermediary, but is not required to bill the service. See Pub 100-02 chapter 15, section 80.3 for further information on audiology.

Payment to SNFs for audiologic tests are bundled into the PPS payment amount for beneficiaries in a covered SNF Part A stay, whether provided directly by the SNF or under arrangements by an independent provider based on a contract with the SNF. Independent audiologists may bill the carrier directly for services rendered to beneficiaries **not** in a SNF Part A covered stay. For beneficiaries not in a covered Part A SNF stay, who are sometimes referred to as beneficiaries in a Part B SNF stay, audiologic tests are payable under Part B when billed by the SNF as type of bill 22X, or when billed directly to the carrier by the provider of the service. Payment is based on the Medicare Physician Fee Schedule (MPFS), whether by the carrier or the intermediary.

Since audiologic tests are **not** bundled with speech -language pathology services, payment is made to the provider of service or to the SNF where the services are provided under arrangements with the SNF for SNF outpatients.

50 - Billing Part B Radiology Services and Other Diagnostic Procedures
(Rev. 1, 10-01-03)

Acceptable HCPCS codes for radiology and other diagnostic services are taken primarily from the CPT-4 portion of HCPCS. Payment is the lower of billed charges or the fee schedule amount. In either case, any applicable deductible and coinsurance amounts are subtracted from the payment amount prior to payment. Coinsurance is calculated on the Medicare payment amount after the subtraction of any applicable deductible amount.

Additional instructions for coverage, billing, payment, and specific instructions for the services listed below are found in the Medicare Claims Processing Manual, Chapter 13, "Radiology Services":

- Contrast material other than low osmolar contrast material (LOCM) for radiology;
- LOCM;
- Radiopharmaceuticals;
- IV Persantine;
- Transportation of equipment;
- Position Emission Tomography (PET); and
- Adenosine.

50.1 - Bone Mass Measurements

(Rev. 1, 10-01-03)
SNF-535.5

Sections 1861(s)(15) and §1861(rr)(1) of the Act (as added by §4106 of the Balanced Budget Act (BBA) of 1997) standardized Medicare coverage of medically necessary bone mass measurements by providing for uniform coverage under Medicare Part B. This standardized coverage is effective for claims with dates of service furnished on or after July 1, 1998. The Medicare Claims Processing Manual, Chapter 13, "Radiology Services," contains coverage, billing, and payment requirements for bone mass measurements.

60 - Billing for Durable Medial Equipment (DME), Orthotic/Prosthetic Devices, and Supplies (including Surgical Dressings)

(Rev. 3053, Issued: 08-28-14, Effective: ICD-10: Upon Implementation of ICD-10 ASC-X12: 01-01-12, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: 09-30-14)

A SNF may not bill for DME furnished to its Part A inpatients as necessary DME must be supplied to the beneficiary as part of SNF services. A SNF may not bill for DME furnished to its Part B inpatients or outpatients. However, a SNF may qualify as a supplier and enroll with the National Supplier Clearinghouse. In such cases, the SNF is given a separate supplier number to bill outpatient DME to the DME MAC. The DME MAC will furnish billing guidelines and payment will be made directly to the SNF as a supplier.

The SNF or other entity that furnishes prosthetic and/or orthotic devices to SNF residents for whom Part A benefits are not payable (no Part A entitlement or benefits exhausted) and for SNF outpatients may bill for such items. The SNF bills the A/B MAC (A). Suppliers bill the A/C MAC (B) or DME MAC. See Chapter 20 for DMEPOS billing requirements, including definition of "supplier."

Prosthetic and orthotic devices are:

- Prosthetic devices (other than dental) that replace all or part of an internal body organ (including connective tissue) or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repair of such devices (see the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Service," §120); and

- Leg, arm, and neck braces, trusses, and artificial legs, arms, and eyes, including adjustments, repairs, and replacement required because of breakage, wear, loss, or a change in the patient's physical condition (see the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Service," §130).

SNFs bill supplies to its A/B MAC (A) for outpatients.

60.1 - Billing

(Rev. 3053, Issued: 08-28-14, Effective: ICD-10: Upon Implementation of ICD-10 ASC-X12: 01-01-12, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: 09-30-14)

The SNF must bill the A/B MAC (A) for prosthetic/orthotic devices, supplies and surgical dressings using the ASC X12 837 institutional claim format or if permissible Form CMS-1450. Requirements for billing can be found in the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the CMS 1450 Data Set."

The SNF must bill prosthetic and orthotic devices under revenue code 274, along with the appropriate HCPCS code. When billing for maintenance and servicing of these items, revenue code 274 along with the appropriate HCPCS code must be used.

The SNF should report "Units of Service" on Form CMS-1450 the number of items billed to the SNF's A/B MAC (A) for orthotics and prosthetics.

Supplies may be billed for SNF outpatients under revenue code 270. Payment is made based on a fee schedule.

The SNF should bill the A/B MAC (A) for surgical dressings under revenue code 623. HCPCS codes for reporting surgical dressing are normally found in the Level II HCPCS codes in the A6000 series. The A/B MAC (A) makes payment based on the surgical dressing fee schedule.

SNFs use 22X type of bill for orthotic and prosthetic devices and surgical dressings when billing for its Part B inpatients. Orthotic and prosthetic devices, surgical dressings, and supplies for outpatients are billed with 23X type of bill.

(See the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Service," §100 for coverage data.)

60.2 - Determining Payment and Patient Liability

(Rev. 1, 10-01-03)
SNF-534.D, SNF-534.E

There may be prosthetic and orthotic devices, for which the SNF would bill that are not included in the fee schedule. When fee schedule amounts are not available for a particular item, the intermediary will pay based on cost.

To determine the SNF's Part B payment, the SNF subtracts any unmet Part B deductible from the lower of the actual charge or the fee schedule amount for the item or service and multiply the remainder by 80 percent. This is the final payment. The patient's liability is the remaining 20 percent plus any deductible remaining to be met.

60.3 - Billing for Enteral and Parenteral Nutritional Therapy as a Prosthetic Device

(Rev. 1, 10-01-03)
(Rev. 3053, Issued: 08-28-14, Effective: ICD-10: Upon Implementation of ICD-10 ASC-X12: 01-01-12, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: 09-30-14)

Parenteral nutritional (PEN) therapies including the necessary equipment, medical supplies and nutrients provided to an inpatient (where Part A payment cannot be made), or to individuals who are not inpatients are covered as a prosthesis under the Part B prosthetic device benefit as long as the requirements in the Coverage Manual are met, and the required documentation is submitted.

The SNF or the supplier must bill the DME MAC. The SNF or supplier should refer to the most recent HCPCS directory or billing instructions distributed by the DME MAC for current HCPCS coding information. If the SNF bills the DME MAC., it must obtain a supplier number from the National Supplier Clearinghouse and must use the ASC X12 837 professional claim format, or if permissible Form CMS-1500.

Billing Instructions are in the Medicare Claims Processing Manual, Chapter 26, "Completing and Processing the Form CMS-1500 Data Set."

DME MAC jurisdictions are based on the residence of the beneficiary. The DME MAC for each State is shown on the CMS Web site at http://www.cms.hhs.gov/medicare/medicare-contracting/medicare-administrative-contractors/medicareadministrativecontractors.html .

70 - Drugs

(Rev. 1, 10-01-03)
SNF-536, SNF 536.1

Drugs and biologicals furnished to outpatients for therapeutic purposes that are self-administered are not covered by Medicare unless those drugs and biologicals must be put

directly into an item of durable medical equipment or a prosthetic device. Exceptions to this rule are:

- Self administered drugs administered in an emergency situation;
- Self-administered oral versions of covered injectable cancer drugs prescribed as an anti-cancer chemotherapeutic;
- Self-administered anti-emetic drugs;
- Oral anti-emetic drugs as full therapeutic replacements for intravenous dosage forms as part of a chemotherapeutic regimen provided that the drug(s) be administered or prescribed by a physician for use immediately before, at, or within 48 hours after the time of administration of the chemotherapeutic agent; and
- Immunosuppressive drugs furnished to transplant patients.

See the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §§50 for coverage of drugs.

See the Medicare Claim Processing Manual, Chapter 17, "Drugs," §§80 for billing and payment instructions.

Where covered under Part B, self administered drugs for SNF inpatients not entitled to Part A benefits should be billed using type of bill 22X, and for SNF outpatients, using type of bill 23X.

70.1 - Immunosuppressive Drugs Furnished to Transplant Patients
(Rev. 1, 10-01-03)

Part B of Medicare covers FDA-approved immunosuppressive drugs. Payment is made for those immunosuppressive drugs that have been specifically labeled as such and approved for marketing by the FDA, as well as those prescription drugs, such as prednisone, that are used in conjunction with immunosuppressive drugs as part of a therapeutic regimen reflected in FDA-approved labeling for immunosuppressive drugs. Therefore, antibiotics, hypertensives, and other drugs that are not directly related to rejection are not covered.

Deductible and coinsurance apply. SNFs bill using TOB 22X for Part B residents and TOB 23x for outpatients.

See the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §§50 for coverage of drugs.

See the Medicare Claim Processing Manual, Chapter 17, "Drugs," §§80 for billing and payment instructions.

80 - Screening and Preventive Services
(Rev. 1, 10-01-03)

Screening and preventive services are only covered as a Medicare Part B benefit. When furnished to a beneficiary in a SNF Part A covered stay, the SNF must bill its intermediary using 22X type of bill. These services are billed on TOB 23x for SNF outpatients and beneficiaries outside the Medicare-certified SNF or DPU.

See §10.C for billing preventive services for covered SNF Part A inpatients.

A SNF may bill screening and preventive services for its Part B residents using 22X type of bill or the supplier may bill its carrier. Screening and preventive services rendered to SNF outpatients may be billed with 23X type of bill or the supplier may bill its carrier.

HCPCS codes are required. See the Medicare Claims Processing Manual, Chapter 18, "Preventive and Screening Services" for coverage, billing, appropriate HCPCS codes, and payment requirements.

Payment is made under the Medicare Physician's Fee Schedule (MPFS) or clinical diagnostic lab fee schedule depending on the service.

80.1 - Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines
(Rev. 1, 10-01-03)
SNF-536.2

Part B of Medicare pays 100 percent for pneumococcal pneumonia vaccines (PPV) and influenza virus vaccines and their administration. Payment is made on a cost basis. Deductible and coinsurance do not apply. Part B of Medicare also covers the hepatitis B vaccine and its administration. Deductible and coinsurance apply.

Medicare Claims Processing Manual, Chapter 18, "Preventive and Screening Services," contains instructions for simplified billing of Influenza virus vaccine and Pneumococcal Pneumonia vaccine by mass immunizers.

80.2 - Mammography Screening
(Rev. 3053, Issued: 08-28-14, Effective: ICD-10: Upon Implementation of ICD-10 ASC-X12: 01-01-12, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: 09-30-14)

Section 4163 of the Omnibus Budget Reconciliation Act of 1990 added §1834(c) of the Act to provide for Part B coverage of mammography screening for certain women entitled to Medicare for screenings performed on or after January 1, 1991. The term

"screening mammography" means a radiologic procedure provided to an asymptomatic woman for the purpose of early detection of breast cancer and includes a physician's interpretation of the results of the procedure. Unlike diagnostic mammographies, there do not need to be signs, symptoms, or history of breast disease in order for the exam to be covered.

The technical component portion of the screening mammography should be billed on the ASC X12 837 institutional claim format or if permissible Form CMS-1450 under bill type 22X for SNF Part A and Part B inpatients or 23X for SNF outpatients. Claims for mammography screening should include only the charges for the screening mammography.

80.2.1 - Diagnostic and Screening Mammograms Performed With New Technologies

(Rev. 1, 10-01-03)

Section 104 of the Benefits Improvement and Protection Act 2000, (BIPA) entitled "Modernization of Screening Mammography Benefit," provides for new payment methodologies for both diagnostic and screening mammograms that utilize advanced new technologies for the period April 1, 2001, through December 31, 2001. See the Medicare Claims Processing Manual, Chapter 18, "Preventive and Screening Services," for the payment method for this period, applicable HCPCS codes, and other billing and processing instructions.

Effective January 1, 2002, payment is based on the mammography benefit pricing file furnished by CMS.

80.3 - Screening Pap Smears

(Rev. 1, 10-01-03)
SNF-541.2

Sections 1861(s)(14) and 1861(nn) of the Act, (as enacted by §6115 of the Omnibus Budget Reconciliation Act of 1989) provides for coverage of screening pap smears for services provided on or after July 1, 1990. Screening pap smears are laboratory tests consisting of a routine exfoliative cytology test (Papanicolaou test) provided for the purpose of early detection of cervical cancer. It includes a collection of the sample of cells and a physician's interpretation of the test.

Payment is made under the clinical diagnostic laboratory fee schedule.

80.4 - Screening Pelvic Examinations

(Rev. 1, 10-01-03)

Section 4102 of the BBA of 1997 (P.L. 105-33) amended §1861(nn) of the Act (42 USC 1395X(nn)) to include coverage of screening pelvic examinations for all female beneficiaries for services provided January 1, 1998, and later. Effective July 1, 2001, the

Consolidated Appropriations Act of 2001 (P.L. 106-554) modifies §1861(nn) to provide Medicare coverage for biennial screening pelvic examinations.

Payment is made under the Medicare Physician's Fee Schedule (MPFS).

80.5 - Prostate Cancer Screening
(Rev. 1, 10-01-03)

Sections 1861(s)(2)(P) and 1861(oo) of the Act (as added by §4103 of the Balanced Budget Act of 1997), provide for coverage of certain prostate cancer screening tests subject to certain coverage, frequency, and payment limitations. Effective for services furnished on or after January 1, 2000, Medicare covers prostate cancer screening tests/procedures for the early detection of prostate cancer. Coverage of prostate cancer screening tests includes the following procedures furnished to an individual for the early detection of prostate cancer:

- Screening digital rectal examination; and
- Screening prostate specific antigen (PSA) blood test

Each test may be paid at a frequency of once every 12 months for men who have attained age 50 (i.e., starting at least one day after they have attained age 50), if at least 11 months have passed following the month in which the last Medicare-covered screening digital rectal examination was performed (for digital rectal exams) or PSA test was performed (for PSA tests).

Payment is made under the clinical diagnostic laboratory fee schedule.

80.6 - Colorectal Cancer Screening
(Rev. 1, 10-01-03)

See the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §80.5, for coverage of colorectal rectal screening services.

Effective for services furnished on or after January 1, 1998, payment may be made for colorectal cancer screening for the early detection of cancer. For screening colonoscopy services (one of the types of services included in this benefit) prior to July 2001, coverage was limited to high-risk individuals. For services July 1, 2001, and later, screening colonoscopies are covered for individuals not at high risk. Screening colonoscopies are not payable to the SNF. Screening colonoscopies are only covered when rendered in a hospital or CAH.

For all other colorectal screening services payment is made under the MPFS or the clinical diagnostic laboratory fee schedule based on the service rendered.

80.7 - Glaucoma Screening
(Rev. 1, 10-01-03)

The Benefits Improvement and Protection Act of 2000, §102, provides annual coverage for glaucoma screening for Medicare beneficiaries with diabetes mellitus, or a family history of glaucoma, or African-Americans age 50 and over. Conditions of coverage for glaucoma screening are located in the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services."

Payment is made under the Medicare Physician's Fee Schedule (MPFS).

90 - Billing for Laboratory Tests Under Part B - General
(Rev. 1, 10-01-03)

Section 1833(h)(5) of the Act (as enacted by The Deficit Reduction Act of 1984, Public Law 98-369) requires the establishment of a fee schedule for clinical diagnostic laboratory tests paid under Part B.

Section 1833g(5)(A)iii of Title XVIII provides that "in the case of a clinical diagnostic laboratory test provided under an arrangement (as defined in §1861(w)(1)) made by a hospital, critical access hospital or skilled nursing facility, payment shall be made to the hospital or skilled nursing facility."

SNFs **must** make arrangements under Part A and **may** make arrangements under Part B under which the SNF bills the intermediary and receives payment. Under this process, the SNF pays the lab for services whatever amount the SNF and the lab agree on, and the beneficiary may not be charged by the lab.

Where the SNF and a lab have entered into such an arrangement, the arrangement may include Part A only or may include Part A and Part B. Such an arrangement is voluntary on the part of both the lab and the SNF for Part B services.

In the absence of such an arrangement under Part B, the lab may bill the program for lab services furnished to residents for whom Part A cannot be paid, and for SNF outpatients, and the SNF may not bill the program for these services. Hospital labs and labs in other SNFs would bill the intermediary. Independent labs would bill the carrier.

Laboratory tests performed for the SNF's Medicare inpatients covered under Part A are included in the PPS SNF payment.

If the FI receives fee amounts for HCPCS included on both the clinical diagnostic laboratory fee schedule and the SNF extract of the MPFS, the SNF receives the amount on the laboratory fee schedule.

Payment is made for specimen collection fees and travel allowance as discussed in Medicare Claims Processing Manual, Chapter 16, "Laboratory Services from Independent Labs, Physicians, and Providers."

Bill type 22X for lab services to Part B residents and 23X for nonresidents should be used.

Neither deductible nor coinsurance applies to lab fee schedule payments.

See the Medicare Claims Processing Manual, Chapter 16, "Laboratory Services from Independent Labs, Physicians, and Providers," for additional coverage, billing, and payment requirements.

90.1 - Glucose Monitoring
(Rev. 1, 10-01-03)

Medicare Part B may pay for a glucose monitoring device and related disposable supplies under its durable medical equipment benefit if the equipment is used in the home or in an institution that is used as a home. A hospital or SNF is not considered a home under this benefit (§1861(h) of the Act, 42 CFR 410.38).

Routine glucose monitoring of diabetics is never covered in a SNF, whether the beneficiary is in a covered Part A stay or not. Glucose monitoring may only be covered when it meets all the conditions of a covered laboratory service, including use by the physician in modifying the patient's treatment.

100 - Epoetin (EPO)
(Rev. 1, 10-01-03)
SNF-543

EPO is a biologically engineered protein which stimulates the bone marrow to make new red blood cells. Patients with anemia associated with chronic renal failure include all ESRD patients regardless of whether they are on dialysis.

EPO is covered for the treatment of anemia for patients with chronic renal failure who are receiving dialysis when it is administered in a renal dialysis facility (RDF).

EPO is not included in SNF PPS and may be billed separately when given in conjunction with dialysis by the Renal Dialysis Facility. It must be billed by the RDF.

EPO is not a SNF outpatient benefit.

110 - Carrier Claims Processing for Consolidated Billing for Physician and Non-Physician Practitioner Services Rendered to Beneficiaries in a Non-Covered SNF Stay
(Rev. 846, Issued: 02-10-06; Effective: 12-15-05; Implementation: 03-13-06)

For Medicare beneficiaries in a non-covered stay, only therapy services are subject to consolidated billing. All other covered SNF services must be separately billed to the carrier for payment consideration. Refer to section 110 in Chapter 6, SNF Inpatient Part

A Billing for additional information on carrier claims processing. A list of therapy codes that are subject to consolidated billing for beneficiaries in a non-covered SNF stay can be found on the CMS Web site at http://www.cms.hhs.gov/SNFConsolidatedBilling/.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R10880CP	08/06/2021	Internet Only Manual Updates to Pub. 100-01, 100-02, and 100-04 to Implement Consolidated Appropriations Act Changes and Correct Errors and Omissions (SNF)	11/08/2021	12009
R3481CP	03/18/2016	Updates to Pub. 100-04, Chapters 3, 6, 7 and 15 to Correct Remittance Advice Messages	06/20/2016	9562
R3053CP	08/28/2014	Update to Pub. 100-04, Chapters 7 and 8 to Provide Language-Only Changes for Updating ICD-10 and ASC X12	09/30/2014	8579
R2905CP	03/14/2014	Update to Pub. 100-04, Chapters 7 and 8 to Provide Language-Only Changes for Updating ICD-10 and ASC X12 – Rescinded and replaced by Transmittal 3053	10/01/2014	8579
R1472CP	03/06/2008	Update of Institutional Claims References	04/07/2008	5893
R1421CP	01/25/2008	Update of Institutional Claims References - Rescinded and Replaced by Transmittal 1472	04/07/2008	5893
R980CP	06/14/2006	Changes Conforming to CR 3648 Instructions for Therapy Services - Replaces Rev. 941	10/02/2006	4014
R941CP	05/05/2006	Changes Conforming to CR 3648 Instructions for Therapy Services	10/02/2006	4014
R846CP	02/10/2006	New Skilled Nursing Facility Consolidated Billing Web site Address	03/13/2006	4297
R685CP	09/23/2005	Discontinuation of the Skilled Nursing Facility (SNF) HCPCS Help File and Notification to Fiscal Intermediaries (FIs) and Providers of the Redesigned SNF Consolidated Billing (CB)	12/27/2005	4044

		Annual Update File Posted on CMS Web Site		
R351CP	10/29/2004	Editing of Hospitals and Skilled Nursing Facilities Part B Inpatient Services (Full Replacement of Change Request 3366)	01/03/2005	3531
R301CP	09/17/2004	Editing Of Hospital And Skilled Nursing Facility Part B Inpatient Services	01/03/2005	3366
R251CP	07/23/2004	Editing Of Hospital And Skilled Nursing Facility Part B Inpatient Services	01/03/2005	3366
R229CP	07/20/2004	Additional Clarification of Bill Types 22x and 23x Submitted by Skilled Nursing Facilities (SNFs) With Instructions for Involuntarily Moving a Beneficiary Out of the SNF and Ending a Benefit Period	08/19/2004	3323
R076CP	02/06/2004	SNF Inpatient Part A Billing	N/A	3133
R020CP	10/31/2003	Add a paragraph regarding the SNF NO PAY FILE	11/05/2003	2968
R001CP	10/01/2003	Initial Publication of Manual	NA	NA

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