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INSIDE THIS ISSUE

How CMS-3347-P changes will affect SNFs

CMS announced proposed changes to the Medicare long-term care requirements that would reform "unnecessary, obsolete, or excessively burdensome" requirements for SNFs on July 17. The proposed rule, "Medicare & Medicaid Programs; Requirements for Long-Term Care Facilities: Regulatory Provisions to Promote Efficiency and Transparency" (CMS-3347-P), fueled by the Trump administration, aims to reduce red tape surrounding SNF compliance and regulations.

Most notably, the proposed changes would delay some Phase 3 Requirements of Participation rules, making the deadline for implementation one year after the rule is finalized. Specifically, the designation and training of the infection preventionist (483.80), QAPI (483.74), and the compliance and ethics program (483.85) would be delayed.

This lightening of regulations is being held in high regard by SNFs because, among other things, it will reduce the paperwork currently required. "It appears today that CMS is much more willing to take a balanced approach to resident care, rather than focusing on regulatory paperwork," says **Reg Hislop III, PhD,** managing partner at H2 Healthcare, LLC, and author of Reg's Blog.

Key takeaways of CMS-3347-P:

- Should the proposal be finalized, SNFs will be required to inform residents of their **primary physician's name and contact information** only upon admission to the facility or if there is a change of physician.
- **Records of grievances** are currently required to be kept for a minimum of three years. CMS-3347-P will cut this in half by reducing the record-keeping period to 18 months.
- If passed, the proposal will shorten the time frame that **nursing staffing data** will need to be kept from 18 months to 15 months, or per state laws, whichever is longer. This regulation will also differentiate between general feedback and grievances. According to the final rule, SNFs will be able to distinguish for themselves whether or not a resident's comment rises to the level of an official grievance.
- In the event of resident **transfer or discharge**, CMS-3347-P will require that residents receive a written report explaining why they are being moved, in terms they can easily understand. Under the new rule, facilities would only need to notify the state ombudsman of "facility-initiated involuntary transfers and discharges" unless an emergency arises and the resident is expected to return to the facility after the event. The current rules require that the state ombudsman

be notified of all transfers, but "not having to report to the ombudsman every single resident that is discharged will significantly reduce the burden for [SNFs]," says **Maureen McCarthy, RN, BS RAC-MT, QCP-MT, DNS-MT, RAC-MTA,** president and CEO at Celtic Consulting.

- Currently**, PRN orders of psychotropic medications** cannot be extended past 14 days without a physician or qualified practitioner evaluating the resident first. CMS-3347-P will allow an extension of prescriptions beyond the two-week mark without an examination of the resident, provided the physician has clear documentation as to why he or she is extending it. Although this will lighten the workload for physicians, there is a potential for abuse and overprescribing of psychotropic drugs, says McCarthy.
- **Directors of food and nutrition services** at facilities will no longer be required to take additional food and safety courses, provided that they have either been in the director role for a minimum of two years and regularly consult with a dietitian or they have completed a minimum course in food and safety. This rule is proposed for SNFs to curb the costs of training existing staff and the potential need to hire new staff.
- If passed, SNFs will no longer be required to have an **infection preventionist** (IP) at the facility part-time. The minimum requirement will be that the IP attend the facility only frequently enough to meet Injury Prevention and Control Program objectives. McCarthy stresses the cost-saving effect of this rule, saying that SNFs would no longer need an IP on their staff, but could instead contract one on a consulting basis. Since the IP rule was originally created, SNFs have established policies to enhance care of residents and lower the risk of infections, so an IP on-site at all times isn't necessarily crucial anymore, says **Stefanie Corbett, DHA,** regulatory specialist for long-term care at HCPro. To ease the burden of contracting an IP, CMS began offering free online training courses in infection prevention to SNF staff in March.
- CMS-3347-P will remove the requirement for facilities to have an **ethics compliance officer**. Currently, ethics and compliance programs are required to be reviewed annually, but the new proposal will only require a biennial review.
- The new proposal will allow older existing facilities to use the 2001 **Fire Safety Equivalency System** (FSES) requirements, rather than the more recent 2012 FSES requirements. This requirement is proposed to dissuade current SNFs from moving facilities or building new facilities to comply with current fire codes.
- New facilities will still be subject to the rule of **two residents per room**, with an attached bathroom. It's proposed that older facilities not be subject to this requirement, allowing them to have up to four residents occupy a room with an attached bathroom.
- The proposal will increase the time frame for facilities to **report abuse of residents**. CMS doesn't specify what this new timeline will be, but it will give flexibility to SNFs when reporting abuse.
- Under the proposed rule, facilities must attempt to use alternatives before using **bed rails**. The risks and benefits of bed rails will need to be explained to the resident, and consent of the resident must be given before use.

If finalized, CMS projects an estimated $616 million in savings annually. While CMS touts these savings, McCarthy doesn't expect SNFs to save any money right away. Since Phase 3 is scheduled to be implemented in just a few months, she expects that many SNFs will have already allocated expenses in anticipation of the original 2019 implementation deadline. McCarthy suspects SNFs will save time, rather than out-of-pocket expenses, in the first few years after implementation.

While McCarthy believes that this rule will pass before the deadline, she asserts the importance of being in compliance with current regulations in the event the rule doesn't pass—SNFs should have a contingency plan in place.

Background

President Trump issued Executive Order 13777, "Reducing Regulation and Controlling Regulatory Costs," in January 2017, which states that for every new regulation dated 2017 and beyond, two existing regulations need to be repealed.

The aim of this executive order is primarily focused on curbing government spending, and CMS is not immune. CMS issued a final rule on October 4, 2016, "Medicare

Despite proposed delay, SNFs should move forward with compliance and ethics program plans

In July, CMS released a proposed rule that, if finalized, would delay the implementation of some Phase 3 requirements. This includes *Conditions of Participation* §483.85, which requires SNFs to put into place a compliance and ethics program.

If CMS finalizes the rule, the implementation deadline would move from November 28, 2019 to one year after the release of the final rule.

"Despite the proposed delay, providers should definitely continue creating, maintaining, and implementing their compliance and ethics programs," says **Jerri Lynn Ward, JD,** co-founder of Garlo Ward, P.C.

Compliance and ethics programs are integral to every SNF's risk management program, so continue preparing as if there is no delay. "Right now, the rule is proposed, but if it becomes a final rule and CMS pushes the deadline out a year, it will just give you more time to implement the compliance and ethics program Requirement of Participation (RoP)," says **Todd Selby,** healthcare attorney with Hall, Render, Killian, Heath & Lyman, P.C.

Additionally, SNFs want to have a compliance program in place that meets the Office of Inspector General's guidance for compliance and ethics.

"If you are ever subject to a payback or you have a significant compliance issue in your facility, having a compliance program can help alleviate any proposed recoveries. For example, let's say CMS says you owe a $2 million overpayment for a billing issue. Having a compliance program can help reduce the consequences and possibly help reduce the overpayment," Selby says.

As providers continue to implement or administer compliance and ethics programs, they should be aware of the revisions made in the proposed rule to the RoPs.

CMS eliminated some requirements that it says are unnecessary or burdensome, says Selby.

The proposed rule, "Medicare & Medicaid Programs; Requirements for Long-Term Care Facilities: Regulatory Provisions to Promote Efficiency and Transparency (CMS-3347-P)," includes the following proposed changes related to compliance and ethics programs:

Organizations with five or more facilities no longer need a compliance officer and designated liaison for each facility. CMS determined that the previous requirement was overly burdensome, says Ward.

"Operating organizations with five or more facilities can effectively develop, implement, and oversee a compliance and ethics program from the corporate level that is tailored to the complexity of the organization and its facilities," Ward says.

The explanation in the rule proposes that "each facility assign a specific individual within the high-level personnel of the operating organization with the overall responsibility to oversee compliance."

Elimination of the annual review requirement. Similarly, CMS saw the annual review requirement as an unnecessary burden and proposes that SNFs periodically review their compliance program and hold a formal review every other year, Selby explains.

Although not required, SNFs may consider reviewing their program more frequently if compliance and ethics violations occur.

"My opinion is that facilities should review programs between required reviews and that such reviews might be triggered by occurrences in the facility. I believe these programs should work in tandem with Quality Assurance Committees," says Ward.

Removal of the requirement for a designated compliance and ethics contact to which individuals can report violations. Even though that position is no longer required, reporting of violations is still required under federal and state law. Thus, facilities must have a process for that, including for anonymous reporting. CMS is leaving the details of that process to individual facilities.

The bottom line is that these updates, while important, are not significant changes to the compliance and ethics RoPs. As such, SNFs should continue moving forward with implementing and maintaining their ethics and compliance programs.

and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities" (81 *FR* 68688), that revised requirements SNFs must meet to participate in Medicare. The 2017 executive order prompted CMS to reevaluate their three-phase plan and look for ways to redact costly regulations set forth in Phase 1.

Phase 3 of the 2016 final rule

CMS implemented the "Final Rule: Medicare and Medicaid Programs: Reform of Requirements for Long-Term Care Facilities" in 2016. The rule was broken down into three phases, the first of which was implemented in November 2016, followed by Phase 2 in November 2017.

Phase 3 was to be implemented in November 2019, but CMS-3347-P proposes changes to the rule that would push back the deadline to November 2020. While it's probable some form of the rule could pass, SNFs still need to be prepared to comply with the final rule by the November 2019 deadline.

Although a majority of these provisions are intended to cut costs and paperwork for SNFs, CMS claims that resident health and safety will not be compromised.

When asked if he thinks the rule will pass as is, Hislop replied, "Because the rule is fairly innocuous, it doesn't change regulatory or compliance aspects. People will continue to advocate for regulatory relief. Historically, these kinds of proposed rules tend to come through intact."

CMS will be accepting comments on the proposal until September 16. ■

PDPM Preparedness

Enhance your pre-admission process prior to PDPM with these 7 tips

The pre-admission process will take on an entirely new level of importance once Patient-Driven Payment Model (PDPM) goes into effect on Oct. 1, 2019.

In PDPM, payment hinges on proper admission practices. The clinical data gathered before admission informs the case-mix group the patient could fall into, says Reta Underwood, RAC-CT, C-NM, QCP, Medicare specialist and president of Consultants for Long Term Care.

As such, many facilities admissions processes are not set up to collect the amount of data required by PDPM. Without that clinical data, providers may miss valuable revenue opportunities, says Eleisha Wilkes, RN, RAC-CT, clinical consultant with Proactive Medical Review.

With PDPM implementation right around the corner, many facilities may adapt their admissions process to meet PDPM's new requirements. Consider implementing the following best practices for a solid PDPM-ready preadmission process.

Why pre-admission matters in PDPM

Before exploring PDPM pre-admission tips, it's helpful to review why front-end data collection can be critical to financial success in PDPM.

PDPM bases reimbursement on the patient's acuity. The primary payment drivers include:

- Acute care admitting diagnoses
- Functional status
- Comorbidities

Reporting the most accurate primary diagnosis and comorbidities will significantly impact the patient's case mix groups and set the payment rate, Wilkes says.

The clinical team will need patient information as early as possible because in PDPM, the initial 5-day assessment sets the per diem rate for the entire Part A covered stay.

"Everything must be gathered and documented by the completion of that 5-day PPS assessment, which must be completed no later than day 8 of the Part A stay," Wilkes says. "With this tight timeframe, anything you can gather pre-admission is going to be extremely helpful."

The new payment model eliminates the 14, 30, 60- and 90-day assessments, so the initial assessment is the facility's one shot at attaining the most accurate payment rate.

PDPM allows providers to complete an interim payment assessment (IPA) to capture a change in the

patient's clinical status and thus update the payment. However, an IPA does not impact the variable per diem schedule established by the 5-day assessment.

In most cases, providers should not rely on the IPA to make up for lost reimbursement dollars due to missing key clinical diagnoses and comorbidities in the initial assessment. They need to ensure they're appropriately reporting the primary diagnosis and comorbidities in the 5-day assessment, Wilkes says.

As such, waiting weeks to receive patient records from the hospital or a physician's office is no longer an option for SNF providers. You must gather it during pre-admission; otherwise providers will often not have the clinical data to support accurate payment.

Utilize the pre-admission team to identify important conditions

Train the pre-admissions team to screen for important conditions that will significantly impact the PDPM payment rate. By highlighting specific conditions for the clinical team and MDS coordinator, they may include them in their evaluations and documentation from the start, Wilkes says.

"I want my admissions coordinator to be familiar with certain aspects of PDPM, because we really need to be assessing and documenting conditions prior to the MDS completion if we're going to be able to support the coding decisions of that five-day assessment," Wilkes says.

For example, Section K is not new to the MDS, but PDPM marks the first time it will be tied to reimbursement. The pre-admission coordinators should:

- Look for swallowing disorders and mechanically altered diets
- Gather as much clinical documentation about the condition as possible from the hospital or other healthcare providers
- Give nurses a heads up about the condition so that they can assess that condition and include it in their documentation

To ensure your admissions team does not miss any comorbidities, create a checklist of items they should identify as they review the records. The tool can be as simple as listing the 50 nontherapy ancillary services and speech language pathology components CMS has provided, Wilkes says.

Include a step to the primary diagnosis

It is vital that the pre-admission process kicks off a series of check-ins in which the interdisciplinary team (IDT) meets and discusses the primary diagnosis, Wilkes says.

The importance of having the most specific and accurate primary diagnosis coded on the MDS cannot be emphasized enough. However, many SNFs are not in the habit of documenting and attaining the most accurate diagnosis.

"Currently, many providers tend to take what is on that hospital discharge summary. That's not always the appropriate admitting diagnosis for the SNF and it may not map to the most appropriate clinical category," Wilkes says.

By starting the conversation about the primary diagnosis early, the MDS coordinator has more time to query the physician for additional information that will lead to the most accurate and specific ICD-10 code describing the patient's condition.

All members of the IDT should be aware of and confirm the primary diagnosis that the MDS coordinator will submit on the MDS for the initial assessment, Wilkes says.

Simplify data collection

SNFs need a strong pre-admission processes that efficiently gathers patients' clinical data from the hospital and other providers in the community.

Providers can streamline the process for data collection by setting up a referral email address that hospitals and other entities will use to send pre-admit documents, Underwood says.

This way, all information is in one place and can be easily tracked.

Program the system so that every time you receive information from a referral source, it sends an automatic email response listing all the items you require for a complete referral. That way, the source can send any additional information they did not include in the initial packet.

Enter the information gathered into your software using the pre-admission bed hold feature. Although

this is a lot of work, it will increase the speed with which the clinical team will be able to access the patient's clinical information.

"If that patient gets admitted, it will populate into the medical record," Underwood says, adding that the time saved will help ensure that all the information needed for a comprehensive 5-day assessment is available to the clinical team.

Ask the hospital for the final abstracted chart

When creating the list of information that the admission team should collect from the hospital, include the hospital's abstracted chart, Underwood says.

"It's the final coded record, so it gives you the final DRGs, ICD-10 codes and procedure codes that the hospital billed for that claim," Underwood says.

This gives MDS coordinators a starting point for determining the ICD-10 codes applicable to the patient's stay, Underwood explains.

The business office can also use this information to start projecting revenue.

Adjust how you estimate revenue pre-admission

PDPM makes it more difficult for business office staff to predict revenue prior to admission because reimbursement is directly linked to the patient's clinical conditions. It is near impossible to achieve an accurate projection until the clinical team can perform their assessments.

"You do not have the luxury in today's world to wait or day or two for your clinical staff to do that," Underwood says.

Instead, providers should develop a calculation worksheet that uses the clinical records provided by the hospital with the referral to generate the potential HIPPS code for the patient and determine the HIPPS payment for that patient, Underwood says.

Do not forget to review referral processes

As facilities evaluate their pre-admission process, they should also use the opportunity to implement a robust referral process. A sound admission process typically starts with having a sound referral process, Underwood says.

First, establish an admission phoneline and staff it 24 hours a day. This way, you do not lose anytime in gathering information. The person on-call review information in the referral package and request missing information immediately or inform the referrer what information your facility requires; Underwood says.

Create a schedule designating a primary point person who is accountable and responsible for answering the referral phone. The referral coverage schedule should also list a backup person who can field any overflow calls.

Set the expectation that the on-call person should forward the calls to a cell phone if he or she is not at their desk. Pass the phone around to whomever is on-call, Underwood suggests.

Not only does a robust referral process beneficial for PDPM, but it also helps fill the beds

"If skilled nursing providers want high occupancy, they need sophisticated and responsive referral systems that will set them apart from the competition down the street," Underwood says.

Unanswered phone calls from referral sources is one of the most common causes of referral losses. You cannot pick up admits if you're not picking up the phone, says Underwood.

Handling the initial referral properly is important even if that patient is not admitted. If the patient and referral source are happy with the way you handled the first referral, they are likely to return to your facility in the future if the patient has another event requiring SNF care, Underwood says.

Build relationships with referral sources

Reach out and reconnect with common referral sources and discharging hospitals. Many may not know about PDPM, so it will be helpful to discuss with them the information the new information you will need from them.

"Currently, you may be getting two pages from them, or 676 pages of patient records. Neither is going to work in PDPM," Wilkes says.

Also inform your contacts that you will need patient information much more quickly once PDPM goes into effect. This way, they are not surprised when you start requesting much shorter turnaround times. Additionally, if they understand why you need the information so quickly, they maybe more likely to fulfill the request within the timeframe you request, Wilkes adds. ■

Expert Q&A

Understand pre-dispute binding arbitration agreements

CMS has reversed the ban on pre-dispute binding arbitrations. Here's what SNFs need to know as they consider whether to revise their contracts to include language on arbitration.

In July, CMS issued a final rule allowing SNFs to include pre-dispute binding arbitration agreements in their admission contracts.

The rule, "Medicare and Medicaid Programs; Revision of Requirements for Long Term Care Facilities: Arbitration Agreements (CMS-3342-F)," overturns a 2016 rule prohibiting pre-dispute binding arbitration agreements in SNF admission contracts. According to CMS, the 2016 rule was unenforceable due to legal challenges and a subsequent injunction.

"A U.S. District Court issued a preliminary injunction based on a complaint filed by the American Health Care Association and a group of member nursing homes. Following that, CMS directed state survey agencies not to enforce the 2016 rule," explains Jerri Lynn Ward, JD, co-founder of Garlo Ward, P.C.

Likely, CMS saw the potential that the plaintiffs would prevail and obtain a permanent injunction and wanted to get ahead of that by withdrawing the 2016 rule, says Ward.

CMS says that lifting the ban on arbitration agreements supports patients and SNFs by allowing both parties to choose the method of dispute resolution they want.

The rule also puts some important patient protections into place, says **Todd J. Selby,** healthcare attorney with Hall, Render, Killian, Heath & Lyman, P.C.

The rule prohibits SNFs from:

- Requiring residents to sign the arbitration agreement as a condition for receiving care. Providers cannot turn away patients who do not sign the agreement.
- Including language in the agreements that prevents residents or anyone else from communicating with federal, state, or local officials.

CMS requires SNF providers to inform patients and their representatives that they are not required to sign the pre-dispute binding arbitration agreement.

"CMS has struck a middle ground with this rule by allowing arbitration agreements but also putting requirements in place that safeguard resident rights," says Selby.

With pre-dispute binding arbitration agreements firmly allowed by CMS, many SNF providers may consider including them in their admission contracts.

BALTC sat down with Selby (TS) and Ward (JW) to find out what providers need to know as they determine whether they want to utilize binding arbitration agreements.

What is a pre-dispute binding arbitration agreement?

JW: A pre-dispute arbitration agreement is an agreement made by the parties to arbitrate, rather than resort to litigation, before any issues or problems arise. Generally, such agreements include things like where the arbitration must be conducted, under what rules it is to be conducted, whether the decision is to be in writing, and whether or not the arbitrator must provide explanations for conclusions of law and fact. It can have clauses pertaining to whether costs, expenses, and attorney's fees can be awarded for the prevailing party, among other types of clauses. CMS has promulgated required provisions that must be included, such as a provision that the arbitrator be neutral and agreed upon by both parties and held at a venue convenient to both parties.

In light of this new rule, what should SNFs consider as they decide whether to implement a binding arbitration agreement?

JW: SNFs should consult with their attorneys to determine whether arbitration agreements are advantageous for their situation. In general, arbitration has the advantage of being less expensive and faster than litigation through the court system. It can be more flexible because it does not operate under the statutory and procedural rules that govern litigation. Also, with very limited exceptions, an arbitration decision is final and binding.

Nursing homes should consult with their attorneys to see if any of the above advantages do not exist in their location. The quality of the arbitrator is paramount in getting a fair result.

How can a SNF provider prove that it has informed the resident and representative that they are not required to sign the pre-dispute binding arbitration agreement?

JW: Typically, it would be part of the admission documents. However, the SNF can ask that such agreements be signed after admission.

The SNF can prove that it informed the resident and representative that signing is not required by having a provision that says they have been informed and having them initial and/or sign that provision. The SNF's attorney may have additional ideas of how to document that the resident and representative have been properly informed.

TS: SNFs could have an addendum to their admission agreement that outlines the terms for the arbitration. The addendum could include a clause that says they were notified that they were not required to sign the arbitration agreement.

How should SNFs handle patients who choose not to sign the arbitration agreement?

TS: SNFs should have a process in place to track residents who refuse to sign the agreement in case there is ever an issue or a surveyor comes in and wants to see your process. That way, you will also have a record of who refused to have their disputes litigated through arbitration.

SNFs could have patients who do not accept the arbitration agreement sign a document stating that they had the opportunity to litigate their disputes in arbitration but are waiving their right to do so.

That document could also be part of what you show a surveyor if he or she asks to see your process for alerting patients that they do not have to sign the arbitration agreement. Having patients sign something stating they refused their right to arbitration is pretty good proof that you told them they did not have to sign the arbitration agreement.

What should SNFs consider if they choose to offer patients arbitration agreements?

TS: If you do present an arbitration agreement to patients, you want to make it consistent with the theme of the Requirements of Participation (ROPs), which focuses on patient protections. The pre-dispute arbitration agreement needs to be written in language that the resident and their representative can understand. You cannot have a bunch of legal jargon in that so that somebody does not understand what they are signing.

The rule states that SNFs must grant residents a 30-day calendar period during which they may rescind their agreement to arbitrate. When does that period begin?

JW: The 30-day cooling-off period would start on the date of the signature. ■

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Consolidated billing: Understanding inclusions and exclusions

Knowing the difference between inclusions and exclusions in consolidated billing (CB) can be extremely confusing for SNFs. Let's first break down the basics. Included refers to items or services that are included in CB and for which the SNF must pay the outside vendor for specific services the vendor provides. Excluded refers to items or services that are excluded from CB and may be billed by the outside vendor directly to Medicare Part B. Sometimes these items or services are also referred to as carve-outs.

Excluded providers include:

- Physicians
- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Certified nurse midwives
- Qualified psychologists
- Certified registered nurse anesthetists

These providers can bill Medicare Part B separately for their services. They primarily bill for physician services, which includes evaluation and management (E&M) codes.

CMS has organized the Healthcare Common Procedure Coding System (HCPCS) codes into five major categories of services, which can be found in Chapter 6 of the CMS Medicare Claims Processing Manual. The five major categories are:

- Major Category I
  - Exclusion of Services Beyond the Scope of a SNF
- Major Category II
  - Additional Services Excluded When Rendered to Specific Beneficiaries
- Major Category III
  - Additional Excluded Services Rendered by Certified Providers
- Major Category IV
  - Additional Excluded Preventive and Screening Services
- Major Category V
  - Part B Services Included in SNF Consolidated Billing

Let's further navigate through these categories to see exactly what they mean.

Major Category I includes most complex medical procedures, which is beyond the SNF's capacity and responsibility. Services in this category are provided on an outpatient basis at a hospital. Services included in this category are:

- Emergency services
- MRI
- Cardiac catheterization
- Ambulance trips

It's important to remember that these categories have consistent rules regarding inclusion and exclusion.

Major Category II excluded services are those provided to beneficiaries who fulfill at least one of the following two criteria:

- Have end-stage renal disease (ESRD)
- Have elected hospice care with a specific licensed Medicare provider, thereby shifting certain billing responsibilities from the SNF to the chosen hospice

These criteria also underlie key requirements in the two subcategories of Category II, which are as follows:

- Dialysis, erythropoietin, Aranesp®, and other dialysis-related services for ESRD beneficiaries
- Hospice care for a beneficiary's terminal illness

Category III services may be provided by any Medicare provider licensed to provide them, except a SNF, and are excluded from the SNF prospective payment system (PPS) and CB. This category includes four subsets: certain chemotherapy drugs, chemotherapy administration, radioisotopes and their administration, and certain customized prosthetic devices.

It's important to note that all chemotherapeutic medications administered in the SNF are the SNF's

fiscal responsibility. The chemotherapy drug administered at the cancer center or other venue is only excluded if it is specifically identified as excluded on the SNF Exclusion List. SNFs should get in the habit of searching both the generic and brand name.

Category IV services are covered as Part B benefits and are not included in the SNF PPS. These services include:

- Mammography
- Vaccines (pneumococcal, flu, or hepatitis)
- Vaccine administration
- Screening pap smear and pelvic exams
- Colorectal screening services
- Prostate cancer screening
- Glaucoma screening
- Diabetic screening
- Cardiovascular screening
- Initial preventive physical exam
- Abdominal aortic aneurysm (AAA) screening

Category V includes services that are included in SNF PPS and CB for residents in a Part A stay and must be billed solely by the SNF for its Part B residents. This category applies to therapies billed.

Resources:

CMS (2019, March 1). Medicare Claims Processing Manual, Chapter 6 – SNF inpatient Part A billing and SNF consolidated billing. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf ■

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