CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 12283	**Date: October 5, 2023**
	Change Request 13271

SUBJECT: Internet Only Manual Updates to Pub. 100-02 and 100-04 to Implement Consolidated Appropriations Act 2023 Changes for Skilled Nursing Facility (SNF)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the Medicare manuals to reflect provisions of the Consolidated Appropriations Act, 2023 (Pub. L. 117–328).

EFFECTIVE DATE: January 8, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 8, 2024

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	6/20.1.1/Physician's Services and Other Professional Services Excluded From Part A PPS Payment and the Consolidated Billing Requirement

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 12283	Date: October 5, 2023	Change Request: 13271

SUBJECT: Internet Only Manual Updates to Pub. 100-02 and 100-04 to Implement Consolidated Appropriations Act 2023 Changes for Skilled Nursing Facility (SNF)

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I. GENERAL INFORMATION

A. Background: The background that led to the need for this CR is that the Medicare manuals must be updated with regard to SNF policy changes in response to the Consolidated Appropriations Act, 2023 (Pub. L. 117–328), specifically, to note the exclusion of the services of marriage and family therapists and mental health counselors from consolidated billing as of January 1, 2024.

Pub 100-04, Chapter 6, §20.1.1:

This section is revised to add marriage and family therapists and mental health counselors to the list of services excluded from consolidated billing.

B. Policy: The Consolidated Appropriations Act, 2023 (Pub. L. 117–328) is the legal policy that excluded the services of marriage and family therapists and mental health counselors from consolidated billing as of January 1, 2024. This CR updates the Medicare manuals to reflect the law.

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	
13271 - 04.1	Contractors shall be aware of the updates to Pub 100-04, Chapters 6	X	X							SNF Pricer

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13271 - 04.2	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	X	X			

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0

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

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

(Rev. 12283, Issued:10-05-2023, Effective:01-08-2024, Implementation:01-08-2024)

Except for the therapy services (see §20.5), physician's professional services and services of certain nonphysician providers listed below are excluded from Part A PPS-payment and the requirement for consolidated billing, and must be billed separately by the practitioner to the A/B MAC (B). See below for Rural Health Clinic (RHC)/Federally Qualified Health Center (FQHC) instructions.

For this purpose "physician service" means the professional services of the physician as defined under the Medicare physician Fee Schedule. For services that contain both a technical component and a professional component, the technical component, if any, must be billed by the SNF for its Part A inpatients. The A/B MAC (B) will pay only the professional component to the physician. For example, the technical component of a diagnostic radiology test (representing the performance of the procedure itself) is subject to SNF CB, whereas the professional component (representing the physician's interpretation of the test results) is excluded and, thus, remains separately billable under Part B.

- Physician's services other than physical, occupational, and speech language pathology services furnished to SNF residents;
- Physician assistants, working under a physician's supervision;
- Nurse practitioners and clinical nurse specialists working in collaboration with a physician;
- Certified nurse-midwives;
- Qualified psychologists*;*
- *Marriage and family therapists;*
- *Mental health counselors; and*
- Certified registered nurse anesthetists.

SNF CB excludes the categories of practitioner services described above, and this exclusion applies specifically to those professional services that ordinarily require performance by the practitioner personally (see the regulations at 42 CFR 411.15(p)(2)(i) and 415.102(a)(3)). This means, for example, that an otherwise bundled task (such as a routine blood draw) cannot be converted into an excluded physician service merely by having a physician perform it personally, as such a task does not ordinarily require performance by the physician. This exclusion also does not encompass services that are performed by someone else as an incident to the practitioner's professional service. Such "incident to" services remain subject to SNF CB and, accordingly, must be billed to Medicare by the SNF itself (see §10.3).

Providers with the following specialty codes assigned by CMS upon enrollment with Medicare are considered physicians for this purpose. Some limitations are imposed by §§1861(q) and (r) of the Act. These providers may bill their A/B MAC (B) directly.

Physician Specialty Codes

01 General Practice
02 General Surgery
03 Allergy/Immunology
04 Otolaryngology
05 Anesthesiology
06 Cardiology
07 Dermatology
08 Family Practice
10 Gastroenterology
11 Internal Medicine

Physician Specialty Codes

12 Osteopathic Manipulative Therapy
13 Neurology
14 Neurosurgery
16 Obstetrics Gynecology
18 Ophthalmology
19 Oral Surgery (Dentists only)
20 Orthopedic Surgery
22 Pathology
24 Plastic and Reconstructive Surgery
25 Physical Medicine and Rehabilitation
26 Psychiatry
28 Colorectal Surgery (formerly Proctology)
29 Pulmonary Disease
30 Diagnostic Radiology
33 Thoracic Surgery
34 Urology
35 Chiropractic
36 Nuclear Medicine
37 Pediatric Medicine
38 Geriatric Medicine
39 Nephrology
40 Hand Surgery
41 Optometry
44 Infectious Disease
46 Endocrinology
48 Podiatry
66 Rheumatology
69 Independent Labs
70 Multi specialty Clinic or Group Practice
76 Peripheral Vascular Disease
77 Vascular Surgery
78 Cardiac Surgery
79 Addiction Medicine
81 Critical Care (Intensivists)
82 Hematology
83 Hematology/Oncology
84 Preventive Medicine
85 Maxillofacial Surgery
86 Neuropsychiatry
90 Medical Oncology
91 Surgical Oncology
92 Radiation Oncology
93 Emergency Medicine
94 Interventional Radiology
98 Gynecological/Oncology
99 Unknown Physician Specialty

Nonphysician Provider Specialty Codes

42 Certified Nurse Midwife
43 Certified Registered Nurse Anesthetist, Anesthesia Assistants (effective 1/1/89)
50 Nurse Practitioner
62 Clinical Psychologist (billing independently)
68 Clinical Psychologist
89 Certified Clinical Nurse Specialist
97 Physician Assistant

NOTE: Some HCPCS codes are defined as all professional components in the fee schedule. Fee schedule definitions apply for this purpose.

Effective July 1, 2001, the Benefits Improvement and Protection Act (BIPA) established payment method II, in which CAHs can bill and be paid for physician services billed to their A/B MAC (A). CAHs must bill the professional fees using revenue codes 96x, 97x, or 98x on an 85x type of bill (TOB). Like professional services billed to the A/B MAC (B), the specific line items containing these revenue codes for professional services are excluded from the requirement for consolidated billing.

RHC/FQHC Instructions:

Effective January 1, 2005, section 410 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) amended the SNF consolidated billing law to specify that when a SNF's Part A resident receives the services of a physician (or another type of practitioner that the law identifies as being excluded from SNF consolidated billing) from a RHC or a FQHC, those services are not subject to CB merely by virtue of being furnished under the auspices of the RHC or FQHC. Accordingly, under section 410 of the MMA, services otherwise included within the scope of RHC and FQHC services that are also described in clause (ii) of section 1888(e)(2)(A) are excluded from consolidated billing, effective with services furnished on or after January 1, 2005. Only this subset of RHC/FQHC services may be covered and paid separately when furnished to SNF residents during a covered Part A stay (see the regulations at 42 CFR
411.15(p)(2)(xvii) and 405.2411(b)(2)). Use TOBs 71x and 73x, respectively, to bill for these RHC/FQHC services. See Pub. 100-02, Medicare Benefit Policy Manual, chapter 13 for additional information on Part B coverage of RHC/FQHC services.