CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 4409	**Date: October 4, 2019**
	Change Request 11454

SUBJECT: Manual Updates for CR11152 Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM)

I. SUMMARY OF CHANGES: This Change Request (CR) provides manual updates for SNF PDPM.

EFFECTIVE DATE: November 5, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: November 5, 2019
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 /SNF Inpatient Part A Billing and SNF Consolidated Billing/Table of Contents
R	6/10.2 - Types of Facilities Subject to the Consolidated Billing Requirement for SNFs
R	6/20.1.1 - Physician's Services and Other Professional Services Excluded From Part A PPS Payment and the Consolidated Billing Requirement
R	6/20.1.2 - Other Excluded Services Beyond the Scope of the SNF Part A Benefit
R	6/20.3 - Other Services Excluded from SNF PPS and Consolidated Billing
R	6/30.4.1 - Input/Output Record Layout
R	6/30.4.3 - Decision Logic Used by the Pricer on Claims
R	6/40.8.1 – SNF Spell of Illness Quick Reference Chart
R	6/50.7 - Retroactive Removal of Sanctions
R	6/100.1 - Swing Bed Services Not Included in the Part A PPS Rate
N	6/120 - Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM
N	6/120.1 - HIPPS Updates and Structure Changes
N	6/120.2 - Interrupted Stay Policy
N	6/120.3 - Variable Per Diem (VPD) Adjustment
N	6/120.4 - AIDS Adjustments
N	6/120.5 - Transition Claims
N	6/120.6 - Default Billing

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: 4409	Date: October 4, 2019	Change Request: 11454

SUBJECT: Manual Updates for CR11152 Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM)

EFFECTIVE DATE: November 5, 2019
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IMPLEMENTATION DATE: November 5, 2019

I. GENERAL INFORMATION

A. Background: This Change Request (CR) provides manual updates to include SNF PDPM in the Medicare Claims Processing Manual (100-04) Chapter 6.

B. Policy: These changes have been implemented with CR11152 with an October effective date.

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				Othe
		A	B	HHH		FISS	MCS	VMS	CWF	
11454 - 04.1	Contractors shall be aware of the manual updates in Chapter 6 of the Medicare Claims Processing Manual (100-04).	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibi
		A/B MAC

		A	B	H H H
	None			

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:

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

V. CONTACTS

Pre-Implementation Contact(s): Valeri Ritter, 410-786-8652 or valeri.ritter@cms.hhs.gov

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

VI. FUNDING

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

ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 6 - SNF Inpatient Part A Billing and SNF Consolidated Billing

Table of Contents
(Rev.4409, Issued: 10-04-19)

10.2 - Types of Facilities Subject to the Consolidated Billing Requirement for SNFs

(Rev.4409, Issued: 10-04-19, Effective: 11-05-19, Implementation: 11- 05-19)

Consolidated billing applies to:

- Participating SNFs;
- Short term hospitals, long term hospitals, and rehabilitation hospitals certified as swing-bed hospitals, except *critical access hospitals (*CAHs*)* certified as swing bed hospitals *(however, while a CAH's SNF-level swing bed services are not subject to consolidated billing, they remain subject to the bundling requirement for* ***hospitals****, as specified in the Medicare Claims Processing Manual, Chapter 3, §60). Rural (non-CAH) swing bed hospitals that furnish SNF-level services are subject to* ***both*** *the consolidated billing* ***and*** *hospital bundling requirements (see §100.1); accordingly, as explained in the FY 2002 SNF PPS final rule (66 FR 39593, July 31, 2001), for the small number of services (such as dialysis) that are excluded from consolidated billing but remain subject to hospital bundling, the billing responsibility would remain with the rural swing bed hospital itself (in accordance with the hospital bundling requirement), but it would use a separate inpatient Part B claim to bill for those services outside of the bundled SNF PPS rate (in recognition of their exclusion from the consolidated billing requirement)*.

But *consolidated billing* does not apply to:

- A nursing home that is not Medicare-certified, such as:
    - A nursing home that does not participate at all in either the Medicare or Medicaid programs;
    - A non-certified part of a nursing home that also includes a participating distinct part SNF unit; and
    - A nursing home that exclusively participates in the Medicaid program as an NF.
- CAHs certified as swing-bed hospitals. *However, as noted above,* CAH swing-bed services are subject to the hospital bundling requirement at section 1862(a)(14) of the Social Security Act and 42 CFR § 411.15(m).

Medicare Coordinated Care Demonstration

Services for beneficiaries covered under the Medicare Coordinated Care Demonstration will not be subject to consolidated billing. Common Working File (CWF) will appropriately edit for these codes so that the A/B MACs (B) will pay them separately.

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

(Rev.4409, Issued: 10-04-19, Effective: 11-05-19, Implementation: 11- 05-19)

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; 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
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

Physician Specialty Codes

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.

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

(Rev.4409, Issued: 10-04-19, Effective: 11-05-19, Implementation: 11-05-19)

The following services are not included in Part A PPS payment when furnished in a Medicare participating hospital or CAH and may be paid to the provider rendering them.

This exception does not apply if the service is furnished in an ambulatory surgical center (ASC) or other independent (non-hospital) facility, because it specifically addresses those services that are so far beyond the normal scope of SNF care as to require the intensity of the hospital setting in order to be furnished safely and effectively. In transmittals for Part A and B institutional billing providing the annual update list of HCPCS codes affected by SNF consolidated billing, such services are referred to as " Major Category I" of SNF consolidated billing editing. Note that of the types of services listed, only ambulatory surgeries are listed as inclusions, rather than exclusions, to consolidated billing.

- Certain cardiac catheterizations;
- Certain computerized axial tomography (CT) scans;
- Certain magnetic resonance imaging (MRIs);
- Certain ambulatory surgeries involving the use of a hospital operating room or comparable hospital facilities (i.e., the use of a gastrointestinal (GI) suite or endoscopy suite for the insertion of a percutaneous esophageal gastrostomy (PEG) tube). For Part A inpatients, the professional portion of these services is billed by the rendering practitioner to the A/B MAC (B). Any hospital outpatient charges are billed to the A/B MAC (A).
- Certain radiation therapies;
- Certain angiographies, and lymphatic and venous procedures;
- Emergency services; and
- Ambulance services when related to an excluded service within this list (see §20.3 for ambulance transportation related to dialysis services).

These relatively costly services are beyond the general scope of care in SNFs, and their receipt has the effect of temporarily suspending a beneficiary's status as a SNF "resident" for CB purposes with respect to such services. Even though it may be medically appropriate for a beneficiary to be cared for in a SNF while receiving radiation therapy, the SNF is not responsible for paying for excluded radiation therapy itself when the beneficiary receives it as a hospital outpatient. Similarly, angiography codes and codes for some lymphatic and venous procedures are considered beyond the general scope of services delivered by SNFs. The hospital or CAH must bill the A/B MAC (A) for the services. Excluded services provided to Medicare beneficiaries in swing beds subject to SNF PPS are to be billed on TOB 13x by the swing bed hospital *(see §100.1)*.

Services directly related to these services, defined as services billed for the same place of service and with the same line item date of service as the services listed below, are also excluded from SNF CB, with exceptions as listed below. This language addresses excluding as "directly related" those items and services that are so closely associated with the excluded procedure that it would actually be impossible to perform the excluded procedure itself without them, such as the anesthesia for an excluded ambulatory surgical procedure under §20.1.2.1, or an otherwise bundled diagnostic test when needed to identify the cause of (and appropriate course of treatment for) a medical emergency under §20.1.2.2.

- Note that anesthesia, drugs incident to radiology and supplies will be bypassed by enforcement edits when billed with CT Scans, Cardiac Catheterizations, MRIs, Radiation Therapies, or Angiographies or surgeries.

In general, bypasses also allow CT Scans, Cardiac Catheterization, MRI, Radiation Therapy, Angiography, and Outpatient Surgery HCPCS codes 0001T – 0021T, 0024T – 0026T, or 10021 - 69990 (except those HCPCS codes listed in Major Category I. F.) to process and pay. This includes all other revenue code lines on the incoming claim that have the same line item date of service (LIDOS).

20.3 - Other Services Excluded from SNF PPS and Consolidated Billing

(Rev.4409, Issued: 10-04-19, Effective: 11-05-19, Implementation: 11-05-19)

The following services may be billed separately under Part B by the rendering provider, supplier, or practitioner (other than the SNF that receives the Part A PPS payment) and paid to the entity that furnished the service. These services may be provided by any Medicare provider licensed to provide them, other than the SNF that receives the Part A PPS payment, and are excluded from Part A PPS payment and the requirement for consolidated billing, and are referred to as "Major Category III" for consolidated billing edits applied to claims submitted to A/B MACs (A).

- A medically necessary ambulance trip (other than a transfer to another SNF) that transports a beneficiary to the SNF for the initial admission or from the SNF following a final discharge, or that occurs pursuant to the offsite provision of Part

B dialysis services (see section 20.3.1 for additional situations involving ambulance transportation);

- Certain chemotherapy (that is, anti-cancer) drugs. The chemotherapy exclusion applies solely to the particular chemotherapy codes designated under Major Category III.A of the SNF website's A/B MAC (A) Annual Update. These same codes also appear on the list of exclusions in File 1 of the SNF website's A/B MAC (B) Annual Update (though not displayed as a separate subcategory). The excluded chemotherapy codes serve to identify those high-intensity chemotherapy drugs that are not typically administered in a SNF, are exceptionally expensive, or require special staff expertise to administer. By contrast, chemotherapy drugs that are relatively inexpensive and are administered routinely in SNFs do not qualify for this exclusion and, thus, remain subject to SNF CB. Further, this exclusion would not encompass any related items that, while commonly furnished in conjunction with chemotherapy, are not themselves inherently chemotherapeutic in nature (that is, they specifically address the side effects of the chemotherapy rather than actively fighting the cancer itself). Examples of such chemotherapy-related drugs would include anti-emetics (anti-nausea drugs), as well as drugs that function as an adjunct to an anti-emetic, such as an anti-anxiety drug that helps to relieve anticipatory nausea. Even when furnished in conjunction with a chemotherapy drug that is itself excluded (and, thus, separately payable under Part B), these related drugs would remain subject to SNF CB. Similarly, if a drug designated by one of the excluded chemotherapy codes is prescribed for a use that is not actually associated with fighting cancer, it would no longer be considered an excluded "chemotherapy" drug in such an instance, because it is not being used for a chemotherapeutic purpose within the meaning of this exclusion.

- Certain chemotherapy administration services. The chemotherapy administration codes are included in SNF PPS payment for beneficiaries in a Part A stay when performed alone or with other surgery, but are excluded if they occur with the same line item date of service as an excluded chemotherapy agent. A chemotherapy agent must also be billed when billing these services, and physician orders must exist to support the provision of chemotherapy;

- Certain radioisotope services;

- Certain customized prosthetic devices *(see §10)*;

- *The* transportation costs of electrocardiogram equipment *(HCPCS code R0076), but only with respect to those for* electrocardiogram test services *furnished during 1998*; and

- All services provided to risk-based MCO beneficiaries. These beneficiaries may be identified with a label attached to their Medicare card and/or a separate health insurance card from an MCO indicating all services must be obtained or arranged through the MCO *(as noted previously in §10, consolidated billing applies only to Medicare fee-for-service beneficiaries)*.

The HCPCS code ranges for chemotherapy, chemotherapy administration, radioisotopes, and customized prosthetic devices are set in statute. The statute also gives the Secretary authority to make modifications in the particular codes that are designated for exclusion within each of these service categories. See §10.1 above for the link to where transmittals providing current lists of HCPCS codes used for Major Category III SNF consolidated billing editing for A/B MACs (A) can be found.

30.4.1 - Input/Output Record Layout

(Rev.4409, Issued: 10-04-19, Effective: 11-05-19, Implementation: 11-05-19)

The SNF Pricer input/output file will be 300 bytes in length. The required data and format are shown below.

File Position	Format	Title	Description
1-4	X(4)	MSA	Input item: The metropolitan statistical area (MSA) code. Medicare claims processing systems pull this code from field 13 of the provider specific file.
5-9	X(5)	CBSA	Input item: Core-Based Statistical Area
10	X	SPEC-WI-IND	Input item (if applicable) :Special Wage Index Indicator Valid Values: **Y** (yes) or **N** (no)
11-16	X(6)	SPEC-WI	Input item (if applicable): Special Wage Index
17-21	X(5)	HIPPS-CODE	Input Item: Health Insurance Prospective Payment System Code – Medicare claims processing systems must copy the HIPPS code reported by the provider on each 0022 revenue code line
22-29	9(8)	FROM-DATE	Input item: The statement covers period “from” date, copied from the claim form. Date format must be CCYYMMDD.

File Position	Format	Title	Description
30-37	9(8)	THRU-DATE	Input item: The statement covers period “through” date, copied from the claim form. Date format must be CCYYMMDD.
38	X	SNF-FED-BLEND	Input Item: Effective October 1, 2017, MACs shall populate the FED PPS BLEND IND field in the PSF with a "1" to indicate the SNF did not meet the quality reporting requirements. Input item: Code for the blend ratio between federal and facility rates. For SNFs on PPS effective for cost reporting periods beginning on or after 7/1/98. Medicare claims processing systems pull this code from field 19 of the provider specific file. **Transition Codes:** Faci1ity % Federal % **1** 75 25 (1st year) **2** 50 50 (2nd year) **3** 25 75 (3rd year) **4** 0 100 (full fed rate) **NOTE**: All facilities have been paid at the full federal rate since FY 2002.
39-45	9(05)V9(02)	SNF-FACILITY RATE	Input item: Rate based on each SNF’s historical costs (from (from A/B MAC (A) audited cost reports) including exception payments. **NOTE**: All facilities have been paid at the full federal rate since FY 2002.

File Position	Format	Title	Description
46-52	X(7)	SNF-PRIN-DIAG-CODE	Input item: The principle diagnosis code, copied from the claim form. Must be three to seven positions left justified with no decimal points.
53-59	X(7)	SNF-OTHER-DIAG-CODE2	Input item: Additional Diagnosis Code, copied from the claim form, if present, must be three to seven positions left justified with no decimal points.
60-220	Defined above	Additional Diagnosis data	Input item: Up to twenty-three additional diagnosis codes accepted from claim. Copied from the claim form. Must be three to seven positions left justified with no decimal points.
221-228	9(06)V9(02)	SNF-PAYMENT RATE	*Output Item: The Calculated TOTAL amount received by the SNF based on the days received. Effective FY 2018, this amount reflects VBP adjustment.* ***NOTE:** Effective October 1, 2019, the previously calculated RUG per diem rate is replaced by the PDPM Calculated TOTAL amount received by the SNF.*
229-230	9(2)	SNF-RTC	Output item: A return code set by Pricer to define the payment circumstances of the claim or an error in input data. **Payment return code:** 00 RUG III group rate returned **Error return codes:** 20 Bad RUG code 30 Bad MSA code 40 Thru date < July 1,1998 or Invalid 50 Invalid federal blend for that

File Position	Format	Title	Description
			Year 60 Invalid federal blend 61 Federal blend = 0 and SNF Thru date < January 1, 2000 70 Invalid VBP Multiplier
231-242	S9V9(11)	VBP-MULTIPLIER	Input item: Medicare systems move this information from field 52 of the provider specific file.
243-250	S9(06)V9(02)	VBP-PAY-DIFF	Output item: The *total* SNF VBP adjustment amount, determined by subtracting the SNF VBP adjustment total payment from the SNF PPS payment that would otherwise apply to the *line.* Added to the claim as a value code QV amount. ***NOTE:*** *Effective October 1, 2019, the previously calculated VBP difference per day is replaced by the TOTAL VBP difference amount.*
251-252	*9(02)*	*SNF-PDPM-UNITS*	*Input item: The number of service units reported by the SNF on the revenue code 0022 line that is being priced.*
253-255	*9(03)*	*SNF-PDPM-PRIOR-DAYS*	*Input item: When pricing the first revenue code 0022 line on a claim, this is the number of prior SNF days identified by FISS from claims history. On later dated revenue code 0022 lines, this is the days from claims history plus any units from any earlier dated.*
256-300	*X(45)*	*FILLER*	*Blank*

Input records on claims must include all input items. Output records will contain all input and output items.

The Medicare claims processing systems will move the following Pricer output items to the claim record. The return code will be placed in the claim header. The SNF-PAYMENT-RATE amount for each HIPPS code will be placed in the rate field of the appropriate revenue code 0022 line. The Medicare claims processing systems will multiply the rate on each 0022 line by the number of units that correspond to each line. The system will sum all 0022 lines and place this amount in the "Provider Reimbursement" field minus any coinsurance due from the patient. For claims with dates of service on or after July 1, 2002, Pricer will compute payment only where the SNF-RTC is 00.

30.4.3 - Decision Logic Used by the Pricer on Claims

(Rev.4409, Issued: 10-04-19, Effective: 11-05-19, Implementation: 11-05-19)

A. Claims for services furnished prior to October 1, 2019, under RUG-IV

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 A/B MAC (A) 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 ICD-10-CM diagnosis code B20 (or, for services furnished prior to October 1, 2015, ICD-9-CM diagnosis code 042) is present, multiply (6) by 2.28.

B. Claims for services furnished on or after October 1, 2019, under the SNF PDPM

The SNF PDPM Pricer shall calculate the rate for each line item with revenue code 0022 on a SNF claim. The SNF PDPM Pricer shall determine the rate using the following information:
SNF PRICER uses the REGION IND, HIPPS CODE, QRP-IND & AIDS ADD-ON-IND to CALCULATE THE HCPPS RATES.

1. *CBSA –*
   a. *URBAN = 5 numeric characters*
   b. *RURAL = 3 spaces & 2 digit state code*
   c. *SPECIAL = APPLY SPECIAL WAGE INDEX "IN LIEU" OF CBSA WAGE INDEX*
      i. *SPECIAL = SNF-SPEC-WI-IND = '1' ON SNF-INPUT-RECORD and SNF-SPEC-WI-X = 5 numeric characters*
      ii. *CBSA-WIR-EFFDATE = '20051001'.*

2. *HIPPS CODE - 5 CHARACTERS = 4 alpha/1 numeric character. [on line item 0022]*
   Evaluate each of the 1st four characters to select component rates:

a. *Character # 1 = component rate for Physical Therapy (PT) & Occupational Therapy (OT). There are 16 PDPM Groups "A" thru "P".*
b. *Character # 2 = component rate for Speech Language Pathology (SLP). There are 12 PDPM Groups "A" thru "L".*
c. *Character # 3 = component rate for Nursing. There are 25 PDPM Groups "A" thru "Y".*
d. *Character # 4 = component for Non-Therapy Ancillary (NTA). There are 6 PDPM Groups "A" thru "F".*
e. *Character # 5 = component for Non-Case Mix (NCM) which do not impact the rates selected, but supply information about Assessment Level.*
    i. *5-day assessment = "1"*
    ii. *IPA = "0"*

3. *Non-Case-Mix component is fixed rate based on REGION-IND & QRP-IND [4 options – URBAN, RURAL, URBAN-QRP, & RURAL-QRP applied equally to each payment)*

4. *IF SNF-FED-BLEND =1 SET QRP IND TO "Y" identifies that a reduced payment component rate should be selected.*

5. *Variable Per Diem adjustment factor applies to PT/OT & NTA components only based on the day-in-stay;*

6. *Nursing component is adjusted by factor of 1.18 when AIDS Add-On-Indicator is set to 'Y' (If input field SNF-PRIN-DIAG-CODE OR [SNF-OTHER-DIAG-CODE2 thru SNF-OTHER-DIAG-CODE25] = 'B20 '.*

7. *NTA component is adjusted by reassigning a new component rate when AIDS Add-On-Indicator is set to 'Y' ((If input field SNF-PRIN-DIAG-CODE OR [SNF-OTHER-DIAG-CODE2 thru SNF-OTHER-DIAG-CODE25] = 'B20 '.*
    a. *If reported NTA group is 'NF', reassigned NTA group is 'NC'*
    b. *If reported NTA group is 'NE', reassigned NTA group is 'NB'*
    c. *If reported NTA group is 'ND', reassigned NTA group is 'NA'*
    d. *If reported NTA group is 'NC, reassigned NTA group is 'NA'*
    e. *If reported NTA group is 'NB, reassigned NTA group is 'NA'*
    f. *If reported NTA group is 'NA', no reassignment is necessary ('NA' represents the highest per diem component rate).*

8. *SNF-PDPM-UNITS & VBP-MULTIPLIER cannot be = zero*

9. *SNF-PDPM-PRIOR DAYS > 100 NF processing HALTS & an ERROR Code is placed in SNF-RTC*

On input records with TOB 21x (that is, all provider submitted claims and provider or A/B MAC (A) initiated adjustments), Pricer will perform the following calculations in numbered order
for each SNF input character:

. . . . . .

(1) Capture/select the applicable rate components associated with each HIPPS CODE character from rate tables determined by the Region IND, QRP-IND and AID Add-On IND (applies to Nursing only).

(2) Compute the PT-OT-FEE ROUNDED = HIPPS-PT-RATE-COMP + HIPPS-OT-RATE-COMP.

*(3) Compute the PT-OT-PORTION ROUNDED = PT-OT-FEE * PT-OT-UTIL. (Utilization Days for PT-OT is determined by summing the PT-OT Variable Per Diem factors for Total Days (CURRENT-DAYS + PRIOR-DAYS.)).*

*(4) Compute the NTA-PORTION ROUNDED = HIPPS-NTA-RATE-COMP * NTA-UTIL. (Utilization Days for NTA category is determined by summing the NTA Variable Per Diem factors for Total Days (CURRENT-DAYS + PRIOR-DAYS.).*

*(5) Compute NURS-SLP-NCM-PORTION ROUNDED = (HIPPS-NURSE-RATE-COMP + HIPPS-SLP-RATE-COMP + HIPPS-NCM-RATE-COMP) * CURRENT-DAYS (or SNF-PDPM-UNITS).*

(6) Compute TOT-PDPM-CASEMIX-PERDIEM = (PT-OT-PORTION + NTA-PORTION + NURS-SLP-NCM-PORTION).
ALL 3 PORTIONS ARE ADDED TOGETHER TO GET THE TOTAL CASE MIX PER DIEM.

*(7) Compute LABOR-PORTION ROUNDED = (TOT-PDPM-CASEMIX-PERDIEM * PERCENT-2020-LABOR).*

*(8) Compute LABOR-ADJUSTED ROUNDED = (LABOR-PORTION * AREA-WAGE-INDEX).*

*(9) Compute NON-LABOR-PORTION ROUNDED = (TOT-PDPM-CASEMIX-PERDIEM * PERCENT-2020-NLABOR)*

(10) Compute TOTAL-LABOR-ADJ-RATE ROUNDED = (LABOR-ADJUSTED + NON-LABOR-PORTION).

(11) Compute TOTAL-CALC-PAYMENT-RATE ROUNDED = TOTAL-LABOR-ADJ-RATE.

(12) Apply the VBP (Value Based Purchasing Factor).
*Compute SNF-PAYMENT-RATE ROUNDED = VBP-MULTIPLIER * TOTAL-CALC-PAYMENT-RATE.*

(13) Obtain the VBP PAY Difference

Compute VBP-PAY-DIFF ROUNDED = SNF-PAYMENT-RATE - TOTAL-CALC-PAYMENT-RATE.

40.8.1 – SNF Spell of Illness Quick Reference Chart

(Rev.4409, Issued: 10-04-19, Effective: 11-05-19, Implementation: 11-05-19)

Level of Care	*Patient's Medicare SNF Part A Benefits Are Exhausted*	*Patient Is In Medicare Certified Area of the Facility **	*If in non-Medicare Area, the Facility Meets the Definition of a SNF ***	*Is the Inpatient Spell of Illness Continued?*	*Billing Action*
Medicare Skilled	*YES*	*YES*	*N/A*	*YES*	*Submit Monthly Covered Claim.*
	NO	*YES*	*N/A*	*YES*	*Submit Monthly Covered Claim.*
	YES	*NO*	*YES*	*YES*	*Submit Monthly Covered Claim.*
	NO	*NO*	*YES*	*YES*	*Patient should be returned to certified area for Medicare to be billed. Submit Monthly Covered Claim.*
	NO	*NO*	*NO*	*NO*	*Facility should determine whether it would be appropriate to send patient back to a certified area for Medicare coverage.*
Not Medicare Skilled	*YES*	*NO*	*NO*	*NO*	*Do not submit claim if pt came in non-skilled. Otherwise, submit no-pay claim w/ discharge status code when patient leaves the certified area.*

	YES	*YES*	*N/A*	*NO*	*Do not submit claim if pt came in non-skilled. Otherwise, submit no-pay claim w/ discharge status code when patient leaves the certified area.*
	NO	*YES*	*N/A*	*NO*	*Do not submit claim if pt came in non-skilled. Otherwise, submit no-pay claim w/ discharge status code when patient leaves the certified area.*
	NO	*NO*	*YES*	*NO*	*Do not submit claim if pt came in non-skilled. Otherwise, submit no-pay claim w/ discharge status code when patient leaves the certified area.*
	YES	*NO*	*YES*	*NO*	*Do not submit claim if pt came in non-skilled. Otherwise, submit no-pay claim w/ discharge status code when patient leaves the certified area.*

** Whether the facility considers a patient's bed in the certified area to be a Medicare bed or not has no effect on whether the spell of illness is continued and has no effect on the SNF's action.*

*** In some states, licensing laws for all nursing homes have incorporated requirements of the basic SNF definition (Social Security Act §1819(a)(1)). When this is the case, any nursing home in such a state would be considered to meet this definition (see CMS Internet-Only Manual, Pub. 100-7, Chapter 2, §2164 at www.cms.hhs.gov/manuals/ on the CMS website).*

50.7 - Retroactive Removal of Sanctions

(Rev.4409, Issued: 10-04- 19, Effective: 11-05-19, Implementation: 11-05-19)

PM AB-01-131

Occasionally, resolution between the State Agency and the SNF is reached after the payment ban has been imposed, and the ban is removed retroactive to its effective date. If bills were denied before notice was received that the ban had been reversed, they should be reprocessed and paid. When reprocessing bills, MDS assessments are needed to support the *case-mix classification* group billed.

Beneficiaries and providers may request A/B MACs (A) to reopen and process bills denied as a result of a misunderstanding of the sanction requirements. These reopenings shall be done on a request basis only, and will be limited to service dates on and after January 1, 1999.

100.1 - Swing Bed Services Not Included in the Part A PPS Rate

(Rev.4409, Issued: 10-04-19, Effective: 11-05-19, Implementation: 11-05-19)

PM A-02-016

For their SNF-level inpatients, rural (non-CAH) swing bed *hospitals must submit all* services *that are not specifically excluded from consolidated billing on their Part A swing bed bill (TOB 18x). However, they* are eligible for additional payment *outside the bundled SNF PPS rate* for *those* services that are excluded from the SNF Part A consolidated billing requirements. *Further, because the swing bed hospital itself still remains* subject to the hospital bundling requirements specified in §1862(a)(14) of the Act and in 42 CFR 411.15(m), *it retains the Medicare billing responsibility for any excluded services to which the hospital bundling provision applies. Accordingly, it would use a separate inpatient Part B claim to bill for such services (see §10.2 of this chapter)*.

As noted above, if a swing bed hospital furnishes a service or supply to a beneficiary receiving SNF-level services, which is excluded from the Part A PPS rate, the swing bed hospital may submit a separate bill to the A/B MAC (A) for the SNF PPS-excluded service. This bill must use TOB 13x with all appropriate revenue codes, HCPCS codes, and line item date of service billing information and will be paid as *inpatient* Part B services under the Outpatient Prospective Payment System (OPPS). *(By contrast, those services bundled into the SNF PPS rate may not be billed separately, and must all be included on the Part A swing bed bill (TOB 18x).)* A list of services that are excluded from the SNF PPS rate is found in §§20.1 - 20.4 above.

Likewise, swing bed hospitals may file bills with the A/B MAC (A) for Part B Ancillary services furnished to beneficiaries who are not in a Part A PPS swing bed stay. Such claims are billed as inpatient Part B services, and are paid under the OPPS.

120 - Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM)

(Rev.4409, Issued: 10-04-19, Effective: 11-05-19, Implementation: 11-05-19)

SNFs billing on Type of Bill (TOB) 21X and rural hospital (non-CAH) swing-bed providers billing on TOB 18X (subject to SNF PPS), will be subject to these requirements. Currently, under the SNF PPS, revenue code 0022 indicates that this claim is being paid under the SNF PPS. This revenue code can appear on a claim as often as necessary to indicate different Health Insurance Prospective Payment System (HIPPS) Rate Code(s) and assessment periods. The HCPCS/Rates field must contain a 5-digit "HIPPS Code". Under the previous case-mix classification model, the Resource Utilization Groups, version 4 (RUG-IV), the first three positions of the code contained the RUG group, and the last two positions of the code contained a 2-digit assessment indicator (AI) code.

120.1 - HIPPS Updates and Structure Changes

(Rev.4409, Issued: 10-04-19, Effective: 11-05-19, Implementation: 11-05-19)

Under PDPM, the HIPPS code is structured differently, as a result of there being five case-mix adjusted rate components under the revised model. The first position represents the Physical and Occupational Therapy case-mix group. The second position represents the Speech-Language Pathology case-mix group. The third character represents the nursing case-mix group. The fourth character represents the Non-Therapy Ancillary (NTA) case-mix group. The fifth character represents the AI code. CMS would note that this also affects the number of potentially valid HIPPS codes under PDPM, as compared to RUG-IV.

The PPS assessment schedule under PDPM is also significantly different from that used under RUG-IV. The only assessments under PDPM that would produce a HIPPS code would be the initial Medicare ("5-day") PPS assessment, which follows the same schedule as under the previous RUG-IV model, and the optional Interim Payment Assessment (IPA), which may be completed at any point during a PPS stay.

The initial SNF PDPM HIPPS Codes can be found online at:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/HIPPSCodes.html

Note: AAA00 default will be replaced with ZZZZZ effective October 1, 2019.

120.2 - Interrupted Stay Policy

(Rev.4409, Issued: 10-04-19, Effective: 11-05-19, Implementation: 11-05-19)

PDPM includes an interrupted stay policy, which would combine multiple SNF stays into a single stay in cases where the patient's discharge and readmission occurs within a prescribed window (i.e., interruption window), similar to that which exists currently in many other Medicare inpatient facilities. Specifically, if a patient in a covered Part A SNF stay is discharged from the SNF but returns to the SNF no later than 12:00am of the third consecutive calendar day after having left Part A coverage then this would be considered a continuation of the same SNF stay. In such cases, no new patient assessments are required and the variable per diem adjustment is not reset. If the patient returns to the same SNF outside the interruption window, or returns to a different SNF, then this would be considered a new stay.

The interruption window begins on the first non-covered day following a Part A-covered SNF stay and ends at 12:00am on the third consecutive non-covered day. The first non-covered day may be different depending on if the patient leaves the facility or simply leaves Part A coverage.

The day of discharge (date could be different if the patient leaves the facility or simply leaves Part A coverage) is the FROM date and the last day the patient is not in the SNF at midnight is the THROUGH date. Occurrence span code 74 should be reported for each interruption of more the ONE day.

The interrupted stay would be recorded on the claim in the same manner as is done for the IRF PPS , and as further discussed in the examples below.

Examples:

1) Patient is admitted to SNF on 11/07/19 and is in a covered Part A stay. Patient is discharged from the SNF and admitted to the hospital on 11/20/19. Patient is readmitted to the same SNF on 11/25/19 and is in a covered Part A stay. The readmission is a new stay because more than 3 days have passed from the date the patient was discharged from the SNF and the date the patient was readmitted to the same SNF; New stay

Assessment Schedule: Reset; stay begins with new 5-day assessment

Variable Per Diem (VPD): Reset: stay begins on Day 1 of VPD Schedule

2) Patient is admitted to SNF on 11/07/19 and in a covered Part A stay. The patient is discharged from Part A on 11/20/19 but remains in the facility. The patient returns to a covered Part A stay on 11/22/19. This is a continuation of a previous stay because the patient returned to a covered Part A stay within 3 days of being discharged from a covered Part A stay.

Continuation of previous stay

Assessment Schedule: No PPS assessments required, IPA optional

VPD: Continues from Day 14 (Day of Part A Discharge)

***Billing Example**: Patient is admitted to SNF on 10/1/2019 and discharged to home on 12/25/2019, with an interrupted stay to an IPPS on 10/20/2019-10/22/2019. This was an admission to an IPPS on 10/20/2019-10/22/2019*

10/1/2019 – 10/31/2019 first interim claim,

Claim must be billed with occurrence span code 74 and occurrence span dates 10/20 – 10/21/2019 to represent the interrupted stay

11/1/2019 – 11/30/2019 second interim claim,

12/1/2019 – 12/25/2019 final interim claim,

(Occurrence span code 74 only appears on the claim in which its dates fall within the statement covers period – in this example only on October claim)

- *Accommodation revenue code 018x is reported during the interrupted stay and is when the beneficiary is not present at the midnight census taking time.*
- *Occurrence span code 74 and date range for the interruption*

Days for the interruption shall be reported as non-covered, not to exceed 3 days or it will be considered a new admission

A Medicare day begins, stating that accordingly, in order to ensure consistency with that approach, we proposed to revise § 411.15(p)(3)(iv) to specify that for consolidated billing purposes, a beneficiary's ''resident'' status ends whenever he or she is formally discharged (or otherwise departs) from the SNF, unless he or she is readmitted (or returns) to that or another SNF ''before the following midnight.'' To ensure consistency with this definition of a Medicare day, as found in the CFR, the interrupted stay policy described in the manual uses the same concept of "before midnight" as the regulatory text cited above.

Finally, as we have defined the interruption window in both rulemaking and in our education materials as a "three-day window," terminating the window at 12:00 on the third day would effectively make the interruption window a two day window, which would be inconsistent with the stated policy.

On the SNF Medicare bill, the presence of occurrence span code 74 indicates an interrupted stay has occurred. Report occurrence span code 74 with the From and Through dates of the interruption in the stay. The day of discharge from the SNF is the FROM date and the last day the patient is not in the SNF at midnight is the THROUGH date. Report accommodation revenue code 18X (leave of absence) and the quantity of leave days. Occurrence span code 74 should be reported for each interruption of more than 1 day along with the dates of each interruption. Revenue code 018X should reflect the total number of days for all occurrence span code 74 entries. In other words, revenue code 018X should be listed on one line, with all interrupted days included in the units column. No charges should be added to this charge line.

120.3 - Variable Per Diem (VPD) Adjustment

(Rev.4409, Issued: 10-04-19, Effective: 11-05-19, Implementation: 11-05-19)

The Social Security Act requires that Medicare Part A-covered SNF stays be paid on a per-diem basis. PDPM SNF PPS per diem payments will be reduced according to a prescribed schedule, referred to as the VPD adjustment. Specifically, the PDPM provides for an adjustment factor that is applied to certain components and changes the per diem rate over the course of the stay.

Thus, under PDPM, the per diem rate for a given day of the SNF PPS stay may be different from the prior day, depending on an adjustment factor that may be applied against the SNF PPS rate connected with the HIPPS code. Moreover, the VPD schedule applies only to the PT, OT, and NTA components of the per diem rate, with different schedules for the PT/OT components than for the NTA component. A similar adjustment exists under the Inpatient Psychiatric Facility (IPF) PPS.

For the PT, OT, and NTA components, the case-mix adjusted per diem rate is multiplied against the variable per diem adjustment factor, following a schedule of adjustments for each day of the patient's stay

VPD Adjustment Schedules

PT & OT Components

Day in Stay	***Adjustment Factor***	***Day in Stay***	***Adjustment Factor***
1-20	*1.00*	***63-69***	*0.86*
21-27	*0.98*	***70-76***	*0.84*
28-34	*0.96*	***77-83***	*0.82*
35-41	*0.94*	***84-90***	*0.80*
42-48	*0.92*	***91-97***	*0.78*

49-55	*0.90*	***98-100***	*0.76*
56-62	*0.88*		

NTA Component

Day in Stay	***Adjustment Factor***
1-3	*3.00*
4-100	*1.00*

120.4 - AIDS Adjustments

(Rev.4409, Issued: 10-04-19, Effective: 11-05-19, Implementation: 11-05-19)

As under the previous RUG-IV model, patients with a "B20" ICD-10 diagnosis code on the SNF claim, meaning the patient has AIDS/HIV, receive an adjustment factor for their PPS rate. Under PDPM, the adjustment factor is different from that used under RUG-IV. Rather than a 128 percent adjustment for the entire PPS per diem rate, the adjustment under PDPM is an increase of 18 percent in the nursing component of the per diem rate and a reclassification under the NTA component to a higher rate category. All other adjustment factors, such as adjustments for geographic variation in wage costs, remain the same under PDPM as under the previous RUG-IV model.

120.5 - Transition Claims

(Rev.4409, Issued: 10-04-19, Effective: 11-05-19, Implementation: 11-05-19)

With regard to transition between RUG-IV and PDPM, a hard transition between the two systems has been implemented, such that days paid under RUG-IV would stop on September 30, 2019 and days would be paid under PDPM beginning October 1, 2019.
In order to receive a RUG-IV HIPPS code that can be billed for services furnished prior to October 1, 2019, providers must use an assessment with an ARD set for on or prior to September 30, 2019.
If the patient's stay begins on or after October 1, 2019, then the provider would begin with the 5-day assessment, as usual.

For patients admitted prior to October 1, 2019, but whose stays continue past this date, in order to receive a PDPM HIPPS code that can be used to bill for services furnished on or after October 1, 2019, providers must complete an IPA with an ARD no later than October 7, 2019 (i.e., transitional IPA):

October 1, 2019, will be considered Day 1 of the VPD schedule under PDPM, even if the patient began their stay prior to October 1, 2019.

Any "transitional IPAs" with an ARD after October 7, 2019, will be considered late and relevant penalty for late assessments would apply (described below).

120.6 - Default Billing

(Rev.4409, Issued: 10-04-19, Effective: 11-05-19, Implementation: 11-05-19)

As under RUG-IV, there may be instances in which providers may bill the "default" rate on a SNF claim (e.g., when an MDS assessment is considered late).

- *The default rate refers to the lowest possible per diem rate.*

- *The default code under PDPM is ZZZZZ, as compared to the default code under RUG-IV of AAA00.*
- *Billing the default code under PDPM represents the equivalent of billing the following PDPM groups:*
  PT Payment Group: TP

  OT Payment Group: TP

  SLP Payment Group: SA

  Nursing Payment Group: PA1

  NTA Payment Group: NF