

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-04 Medicare Claims Processing</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 10569</b>	<b>Date: January 14, 2021</b>
	<b>Change Request 11992</b>

**Transmittal 10448, dated November 6, 2020, is being rescinded and replaced by Transmittal 10569, dated, January 14, 2021 to add business requirement 11992.3.1. All other information remains the same.**

**SUBJECT: Updates to Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) Claims**

**I. SUMMARY OF CHANGES:** This Change Request (CR) contains updates/corrections to the SNF PDPM claims to adhere to current policy.

**EFFECTIVE DATE: April 1, 2021**

*\*Unless otherwise specified, the effective date is the date of service.*

**IMPLEMENTATION DATE: April 5, 2021**

*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.

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
R	6/40.3.2 - Patient Readmitted Within 30 Days After Discharge
R	6/40.6 - Total and Noncovered Charges

**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**



Number	Requirement	Responsibility								Other
		A/B MAC			D M E	Shared- System Maintainers				
		A	B	H H H		F I S S	M C S	V M S	C W F	
	Date of Service (DOS) 10/1/2019 or greater									
11992.2	Contractors shall not apply SNF Consolidated Billing (CB) edits when OSC 74 is present on the claim indicating an interrupted stay effective October 1, 2019.									X
11992.3	Contractors shall pass prior days of 0 into the SNF PRICER when a revenue code 0022 line corresponds to an occurrence code 50 date, which is the day after the Through date of an OSC 76 period.  Note: The through date of the OSC 76 plus one day will be used as a new admission date for payment purposes and will pay at day 1 of the VPD. Revenue code 0022 lines correspond to occurrence code 50 dates in line item sequence (e.g. if there are 3 occurrence code 50 dates on the claim with dates 10/1, 10/10 and 10/25, the 10/10 occurrence code 50 date corresponds to the second 0022 line).					X				
11992.3.1	Contractors shall assign a new claim level reason code to assign: <ul style="list-style-type: none"> <li>Dates of service on or after 10/1/19</li> <li>SNF (TOB 21X) or swing bed (TOB 18X) claim, excluding MA claims</li> <li>Occurrence Span Code 76 is present and either an Occurrence Code 50 date is not equal to the Thru Date of the Occurrence Span Code 76 plus one day or the Occurrence Code 50 is missing</li> <li>This reason code will not assign if Occurrence Span Code 76 is not present or when the Occurrence Span Code 76 Thru Date is equal to the Thru Date of the claim.</li> </ul>					X				
11992.4	Contractors shall calculate the prior days value to pass into the SNF PRICER for claims subject to SNF PPS					X				

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared- System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
	<p>(excluding CAH), effective October 1, 2019 as follows:</p> <p>Add the cost report days for claims with the same date of admission with dates of service prior to the from date of the currently being priced claim. This count shall <b>exclude</b> cancel claims, MA claims with condition code 04 and claims (with the same admission date) with dates of service after the from date of this claim, and days that occurred before the occurrence span code 76 Through date on any claim in the admission.</p> <p>Note: The day after the through date of the OSC 76 will be considered the new admission date for payment purposes and should be paid a VPD day 1.</p>									

### III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
11992.5	<p>MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the “MLN Matters” listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.</p>	X				

### IV. SUPPORTING INFORMATION

**Section A: Recommendations and supporting information associated with listed requirements:**

*"Should" denotes a recommendation.*

<b>X-Ref Requirement Number</b>	<b>Recommendations or other supporting information:</b>
2	Edits already identified are 7251, 7558, 7261, and 7275.
1	Edit already identified is 5601.

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

**V. CONTACTS**

**Pre-Implementation Contact(s):** Valeri Ritter, 410-762-8652 or [valeri.ritter@cms.hhs.gov](mailto: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**

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

### 40.3.2 - Patient Readmitted Within 30 Days After Discharge

*(Rev.10569, Issued: 01-14-21, Effective: 04-01-21, Implementation: 04-05-21)*

A patient is deemed not to have been discharged if the time between SNF discharge and readmission to the same or another SNF is within 30 days. (See the Medicare Benefit Policy Manual, Chapter 8, "Coverage of Extended Care Services (SNF) Under Hospital Insurance," §20.2.) However, if more than 30 days elapse after the patient's discharge from a participating SNF or after his/her transfer to a nonparticipating part of the institution, the patient must again meet the 3-day hospital stay requirement to become eligible for SNF benefits. When a discharge bill has been sent and the patient is readmitted to the SNF within 30 days, the SNF must submit another bill, which shows the current admission date and the following additional data. • The SNF must complete condition code "57" on the claim to indicate the patient previously received Medicare covered SNF care within 30 days of the current SNF admission. • The SNF must complete occurrence span code "70" to indicate the qualifying stay dates for a hospital stay of at least 3 days which qualifies the patient for payment of the SNF level of care services billed on the claim. If a discharge bill has not been sent at the time of readmission, the SNF must submit an interim bill with occurrence code "74" to show the from/through dates of the leave of absence (the period the patient was not in the facility) and the number of noncovered days. *For claims that contain both covered days and noncovered days, and those noncovered days are the responsibility of the beneficiary (e.g., days submitted for noncovered level of care), the provider should append span code 76 to indicate the days the beneficiary is liable.*

### 40.6 - Total and Noncovered Charges

*(Rev.10569, Issued: 01-14-21, Effective: 04-01-21, Implementation: 04-05-21)*

ASC X12 837 Institutional Claim See the related implementation guide on the official Washington Publishing Company website. Form CMS -1450 For each cost center for which a separate charge is billed (type of accommodation or ancillary), a revenue code is assigned and is entered on the claim with the related charges. On Form CMS-1450 the appropriate numeric revenue code is entered in FL 42 to explain each charge in FL 47. Additionally, there is no fixed "Total" line in the charge area. Instead, revenue code "0001" is always entered last in FL 42. Thus, the adjacent charge entry, in FL 47, is the sum of charges billed. This is also the same line on which noncovered charges, if any, in FL 48, are summed. The total charge for all services, covered and noncovered, will generally be shown. See §40.6.1 below, for certain exceptions. In the "noncovered charges" column (FL48) enter the amount of any noncovered charge except where: • The A/B MAC (A) has notified the SNF that payment can be made under the limitation of liability provisions; and • A payer primary to Medicare is involved. (See the Medicare Secondary Payer [MSP] Manual, Chapter 3, "MSP Provider Billing Requirements," and Chapter 4, "Contractor Prepayment Processing Requirements.") Where a bill is submitted for a period including both covered and noncovered days (e.g., days submitted for noncovered level of care), the SNF must list the charges for noncovered days under noncovered charges. Refer to the Medicare Claims Processing Manual, Chapter 25 for further information about completing the claim. *For claims that contain both covered days and noncovered days, and those noncovered days are the responsibility of the beneficiary (e.g., days submitted for noncovered level of care), the provider should append span code 76 to indicate the days the beneficiary is liable.*