CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4491	**Date: January 9, 2020**
	Change Request 11513

Transmittal 2379, dated November 1, 2019, is being rescinded and replaced by Transmittal 4491, January 9, 2020, to change the CR type from a One Time Notification to a Standard CR type, which adds a manual attachment that updates chapter 6 of CMS publication 100-04. This correction also revises the background section and adds two new requirements (11513.4 and 11513.5). All other information remains the same.

SUBJECT: Updates to CR 11152 Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM)

I. SUMMARY OF CHANGES: This Change Request (CR) contains updates to the default Health Insurance Prospective Payment System (HIPPS) code for SNF PDPM claims.

EFFECTIVE DATE: April 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 6, 2020

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	6/30 - Billing SNF PPS Services
R	6/40.8 - Billing in Benefits Exhaust and No-Payment Situations
R	6/90.2 - Medicare Billing Requirements for Beneficiaries Enrolled in MA Plans

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: 4491	Date: January 9, 2020	Change Request: 11513

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I. GENERAL INFORMATION

A. Background: This Change Request (CR) implemented changes to the Skilled Nursing Facility (SNF) Prospective Payment System (PPS), specifically implementing changes required for the Patient Driven Payment Model (PDPM). This CR is applicable to the Fiscal Intermediary Shared System (FISS) and the Common Working File (CWF). SNFs billing on Type of Bill (TOB) 21X and hospital swing bed providers billing on TOB 18X (subject to SNF PPS), will be subject to these requirements. CR 11152 erroneously omitted the default Health Insurance Prospective Payment System (HIPPS) code from the CR. This CR will implement change to include the instructions to bypass certain SNF PDPM edits.

B. Policy: No policy changes exist with this CR.

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	
11513.1	Contractors shall bypass the edit that requires an occurrence code 50 for each 0022 revenue code on TOB 021x for Demo 31 (VA demonstration) claims for all dates of service.					X				
11513.2	Contractors shall update the edit that ensures a default HIPPS code on VA demonstration claims to terminate AAA00 October 1, 2019 and add ZZZZZ effective October 1, 2019.	X				X				
11513.3	The VA contractors shall discontinue the workaround currently in place for this edit effective with the implementation of this CR.	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11513.4	Contractors shall bypass the edit that requires an occurrence code 50 for each 0022 revenue code on TOB 021x and 018X for the default HIPPS ZZZZZ claims for dates of service on and after October 1, 2019.					X				
11513.5	The contractors shall discontinue the workaround currently in place for this edit effective with the implementation of this CR.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
11513.6	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.	X				

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
2	The reason code is 34951

X-Ref Requirement Number	Recommendations or other supporting information:
1	The reason code is 31742
4	The reason code is 31742

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

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

30 - Billing SNF PPS Services

(Rev. 4491, Issued: 01-09- 20, Effective: 04-01-20, Implementation: 04-06-20)

SNFs and hospital swing bed providers are required to report inpatient Part A PPS billing data as follows. Refer to the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the Form CMS-1450 Data Set," for a description of claim data elements.

- In addition to the required fields identified in Chapter 25, SNFs must also report occurrence span code "70" to indicate the dates of a qualifying hospital stay of at least three consecutive days which qualifies the beneficiary for SNF services.

- Separate bills are required for each Federal fiscal year for admissions that span the annual update effective date (October 1).

- Use Type of Bill 21X for SNF inpatient services or 18X for hospital swing bed services.

- Revenue Code 0022. This code 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 HIPPS Rate Code(s) and assessment periods.

- Effective for claims with dates of service on or after January, 1 2011, there must be an occurrence code 50 (assessment date) for each assessment period represented on the claim with revenue code 0022. The date of service reported with occurrence code 50 must contain the ARD. An occurrence code 50 is not required with default HIPPS code AAAxx (where 'xx' equals varying digits) *or ZZZZZ October 1, 2019 and after.* In addition, for OMRA related AIs 05, 06, 0A, 0B, 0C, 12, 13, 14, 15, 16, 17, 1A, 1B, 1C, 24, 25, 26, 2A, 2B, 2C, 34, 35, 36, 3A, 3B, 3C, 44, 45, 46, 4A, 4B, 4C, 54, 55, 56, 5A, 5B, 5C where 2 HIPPS may be produced by one assessment, providers need only report one occurrence code 50 to cover both HIPPS codes. *As of October 1, 2019 SNF PDPM changes are effective.*

- HCPCS/Rates field must contain a 5-digit "HIPPS Code". The first three positions of the code contain the RUG group and the last two positions of the code contain a 2-digit assessment indicator (AI) code. See Chapter 6 of the MDS RAI manual for valid RUG codes and AI codes. *As of October 1, 2019 SNF PDPM changes are effective.*

- SNF and SB PPS providers must bill the HIPPS codes on the claim form in the order in which the beneficiary received that level of care.

- Service Units must contain the number of covered days for each HIPPS rate code.

NOTE: Fiscal Intermediary Shared System (FISS) requirement:

The sum of all covered units reported on all revenue code 0022 lines should be equal to the covered days field less the number of days reported in an OSC 77. (**NOTE**: The covered units field is utilized in FISS and has no mapping to the 837 or paper claim).

- Total Charges should be zero for revenue code 0022.

- When a HIPPS rate code of RUAxx, RUBxx, RUCxx, RULxx and/or RUXxx is present, a minimum of two rehabilitation therapy ancillary codes are required (revenue code 042x and/or, 043x and/or, 044x). When a HIPPS rate code of RHAxx, RHBxx, RHCxx, RHLxx, RHXxx, RLAxx, RLBxx, RLXxx, RMAxx, RMBxx, RMCxx, RMLxx, RMXxx, RVAxx, RVBxx, RVCxx, RVLxx, and/or RVXxx is present, a minimum of one rehabilitation therapy ancillary revenue code is required (revenue code 042x, 043x, or 044x. Bills that are missing required rehabilitation therapy ancillary revenue codes are to be returned to the SNF for resubmission. *As of October 1, 2019 SNF PDPM changes are effective.*

- The accommodation revenue code 018x, leave of absence is reported when the beneficiary is on a leave of absence and is not present at the midnight census taking time.

- Principal Diagnosis Code - SNFs enter the ICD-CM code for the principal diagnosis in the appropriate form locator. The code must be reported according to Official ICD-CM Guidelines for Coding and Reporting, as required by the Health Insurance Portability and Accountability Act (HIPAA), including any applicable guidelines regarding the use of V codes for ICD-9. The code must be the full ICD-CM diagnosis code, including all five digits (for ICD-9) or all seven digits (for ICD-10) where applicable.

    - Other Diagnosis Codes Required - The SNF enters the full ICD-CM codes for up to eight additional conditions in the appropriate form locator. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in the ICD-CM guidelines.

40.8 - Billing in Benefits Exhaust and No-Payment Situations

(Rev. 4491, Issued: 01-09- 20, Effective: 04-01-20, Implementation: 04-06-20)

An SNF is required to submit a bill for a beneficiary that has started a spell of illness under the SNF Part A benefit for every month of the related stay even though no benefits may be payable. CMS maintains a record of all inpatient services for each beneficiary, whether covered or not. The related information is used for national healthcare planning and also enables CMS to keep track of the beneficiary's benefit period. These bills have been required in two situations: 1) when the beneficiary has exhausted his/her 100 covered days under the Medicare SNF benefit (referred to below as benefits exhaust bills) and 2) when the beneficiary no longer needs a Medicare covered level of care (referred to below as no-payment bills).

For benefits exhaust bills, an SNF must submit monthly a benefits exhaust bill for those patients that continue to receive skilled care and also when there is a change in the level of care regardless of whether the benefits exhaust bill will be paid by Medicaid, a supplemental insure, or private payer. There are two types of benefits exhaust claims: 1) Full benefits exhaust claims: no benefit days remain in the beneficiary's applicable benefit period for the submitted statement covers from/through date of the claim and 2) Partial benefits exhaust claims: only one or some benefit days, in the beneficiary's applicable benefit period, remain

for the submitted statement covers from/through date of the claim. Monthly claim submission of both types of benefits exhaust bills are required in order to extend the beneficiary's applicable benefit period posted in the Common Working File (CWF). Furthermore, when a change in level of care occurs after exhaustion of a beneficiary's covered days of care, the provider must submit the benefits exhaust bill in the next billing cycle indicating that active care has ended for the beneficiary.

NOTE: Part B 22x bill types must be submitted after the benefits exhaust claim has been submitted and processed.

In addition, SNF providers must submit no-payment bills for beneficiaries that have previously received Medicare-covered skilled care and subsequently dropped to a non-covered level of care but continue to reside in a Medicare-certified area of the facility. Consolidated Billing (CB) legislation indicates that physical therapy, occupational therapy, and speech language pathology services furnished to SNF residents are always subject to SNF CB. This applies even when a resident receives the therapy during a non-covered stay in which the beneficiary who is not eligible for Part A extended care benefit still resides in an institution (or part thereof) that is Medicare-certified as a SNF. SNF CB edits require the SNF to bill for these services on a 22x (inpatient part B) bill type. **NOTE**: Unlike with benefits exhaust claims, Part B 22x bill types may be submitted prior to the submission of bill type 210 no payment claims.

If a facility has a separate, distinct non-skilled area or wing then beneficiaries may be discharged to this area using the appropriate patient discharge status code and no- payment bills would not be required. In addition, SNF CB legislation for therapy services would not apply for these beneficiaries.

No-payment bills are not required for non-skilled beneficiary admissions. As indicated above, they are only required for beneficiaries that have previously received covered care and subsequently dropped to non-covered care and continue to reside in the certified area of the facility.

NOTE: Providers may bill benefits exhaust and no payment claims using the default HIPPS code AAA00 *prior to October 1, 2019 and ZZZZZ October 1, 2019 and after*, in addition to an appropriate room & board revenue code only. No further ancillary services need be billed on these claims.

SNF providers and A/B MACs (A) shall follow the billing guidance provided below for the proper billing of benefits exhaust bills and no-payment bills.

1) SNF providers shall submit benefits exhaust claims for those beneficiaries that continue to receive skilled services as follows:

   a) Full or partial benefits exhaust claim. (Submitted monthly)

      i) Bill Type = Use appropriate covered bill type (i.e., 211, 212, 213 or 214 for SNF and 181, 182, 183 or 184 for Swing Bed (SB). **NOTE:** Bill types 210 or 180 should not be used for benefits exhaust claims submission).

      ii) Occurrence Span Code 70 with the qualifying hospital stay dates.

      iii) Covered Days and Charges = Submit all covered days and charges as if beneficiary had days available.

      iv) Value Code 09 (First year coinsurance amount) 1.00 (If applicable, the FISS will assign the correct coinsurance amount based off the CWF response).

v) Patient Status Code = Use appropriate code.

b) Benefits exhaust claim with a drop in level of care within the month; Patient remains in the Medicare-certified area of the facility after the drop in level of care.

i) Bill Type = Use appropriate bill type (i.e., 212 or 213 for SNF and 182 or 183 for SB. **NOTE:** Bill types 210 or 180 should not be used for benefits exhaust claims submission).

ii) Occurrence Span Code 70 with the qualifying hospital stay dates.

iii) Occurrence Code 22 (date active care ended, i.e., date covered SNF level of care ended) = include the date active care ended; this should match the statement covers through date on the claim.

iv) Covered Days and Charges = Submit all covered days and charges as if the beneficiary had days available up until the date active care ended.

v) Value Code 09 (First year coinsurance amount) 1.00 (If applicable, the FISS will assign the correct coinsurance amount based off the CWF response).

vi) Patient Status Code = 30 (still patient).

c) Benefits exhaust claim with a patient discharge.

i) Bill Type = 211 or 214 for SNF and 181 or 184 for SB (**NOTE:** Bill types 210 or 180 should not be used for benefits exhaust claims submission).

ii) Covered Days and Charges = Submit all covered days and charges as if beneficiary had days available up until the date active care ended.

iii) Value Code 09 (First year coinsurance amount) 1.00 (If applicable, the FISS will assign the correct coinsurance amount based off the CWF response).

iv) Patient Status Code = Use appropriate code other than patient status code 30 (still patient).

NOTE: Billing all covered days and charges allow the Common Working File (CWF) to assign the correct benefits exhaust denial to the claim and appropriately post the claim to the patient's benefit period. Benefits exhaust bills must be submitted monthly.

2) SNF providers shall submit no-payment claims for beneficiaries that previously dropped to non-skilled care and continue to reside in the Medicare-certified area of the facility using the following options.

a) Patient previously dropped to non-skilled care. Provider needs Medicare denial notice for other insurers.

i) Bill Type = 210 (SNF no-payment bill type) or 180 (SB no-payment bill type)

ii) Statement Covers From and Through Dates = days provider is billing, which may be submitted as frequently as monthly, in order to receive a denial for other insurer purposes. No-payment billing shall start the day following the date active care ended.

iii) Days and Charges = Non-covered days and charges beginning with the day after active care ended.

iv) Condition Code 21 (billing for denial).

v) Patient Status Code = Use appropriate code.

b) Patient previously dropped to non-skilled care. In these cases, the provider must only submit the final discharge bill that may span multiple months but must be as often as necessary to meet timely filing guidelines.

i) Bill Type = 210 (SNF no-payment bill type) or 180 (SB no-payment bill type)

ii) Statement Covers From and Through Dates = days billed by the provider, which may span multiple months, in order to show final discharge of the patient. No-payment billing shall start the day following the date active care ended.

iii) Days and Charges = Non-covered days and charges beginning with the day after active care ended.

iv) Condition Code 21 (billing for denial).

v) Patient Status Code = Use appropriate code other than patient status code 30 (still patient).

NOTE: No pay bills may span both provider and Medicare fiscal year end dates.

Refer to Chapter 25 for further information about billing.

90.2 - Medicare Billing Requirements for Beneficiaries Enrolled in MA Plans

(Rev.4491, Issued: 01-09- 20, Effective: 04-01-20, Implementation: 04-06-20)

If a beneficiary chooses an MA plan as his or her form of Medicare, he/she cannot look to traditional "fee for service" Medicare to pay the claim if the MA plan denies coverage.
SNF providers shall apply the following policies to MA beneficiaries who are admitted to a SNF:
• If the SNF is non-participating with the plan, the beneficiary must be notified of his or her status because he/she MAY be private pay in this circumstance, depending upon the type of MA plan in which he/she is enrolled;

• If the SNF is participating with the plan, pre-approve the SNF stay with the plan;

• If the plan denies coverage, appeal to the plan, not to the "fee for service" FI;

• Count the number of days paid by the plan as Part A days used (this IS the beneficiary's 100 days of Medicare SNF benefits);

• Submit a claim to the "fee for service" A/B MAC (A) to subtract benefit days from the CWF records. (Note: The plans do not send claims to CWF for SNF stays). Failure to send a claim to the A/B MAC (A) will inaccurately show days available.

• If a beneficiary no longer requires skilled care under the MA plan the SNF may discharge the patient using a patient status code 04. No- payment bills are not required for beneficiaries that are receiving non-skilled care and are enrolled in an MA plan. If the beneficiary again requires skilled care after a period of non-skilled care, the provider should begin a new admission claim for Medicare to continue the spell of illness.

Billing Requirements
• Submit covered claims and include a HIPPS code (use default code AAA00 *prior to 10/1/2019 and ZZZZZ after 10/1/2019)* if no assessment was done), room and board charges and condition code 0**4.**

NOTE: If the beneficiary drops his or her MA plan participation during their SNF stay, the beneficiary is entitled to coverage under Medicare FFS for the number of days available that remain out of the 100 days available under the SNF benefit.