CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 378 | **Date: NOVEMBER 26, 2004**

CHANGE REQUEST 3568

SUBJECT: Full Replacement of CR 3308, Fiscal Intermediary Shared System (FISS) Changes to Allow for Provider Liability Days on Skilled Nursing Facility (SNF) and Swing Bed Facility Inpatient Bills.

I. SUMMARY OF CHANGES: This instruction replaces Transmittal 253 dated July 23, 2004. Business requirement 3308.2 had incorrect information and was deleted. All other information remains the same

NEW/REVISED MATERIAL - EFFECTIVE DATE: January 1, 2005
***IMPLEMENTATION DATE: January 3, 2005**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 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	6/50/50.2/50.2.2/ Provider Liability Instructions

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	Business Requirements
X	Manual Instruction
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

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SUBJECT: Full Replacement of CR 3308, Fiscal Intermediary Shared System (FISS) Changes to Allow for Provider Liability Days on Skilled Nursing Facility (SNF) and Swing Bed Facility Inpatient Bills.

I. GENERAL INFORMATION

A. Background: This notification clarifies and revises CR 3308. Business requirement 3308.2 and all associated language were deleted. The FISS programming hours have previously been assigned under CR 3308, therefore, this CR has no systems impact.

Skilled Nursing Facilities (SNFs) and Swing Bed Facilities bill for provider liability periods using the occurrence span code (OSC) 77. Utilization is applied to the benefit period for days billed in an OSC 77 and therefore, must be reported in the covered days field to appropriately apply utilization to the CWF. However, for proper reimbursement, the provider liability days billed under an OSC 77 must **not** be counted in the covered units field for the health insurance prospective payment system (HIPPS) code reported on revenue code 0022 lines.

For types of bill 21x (SNF inpatient) and 18x (Swing Bed inpatient) 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. Currently, the FISS requires the sum of all the covered units reported on all revenue code 0022 lines to match the covered days field reported on the claim and does not account for days reported in the OSC 77. This instruction modifies the FISS requirement to allow the sum of all covered units reported on all revenue code 0022 lines to be less than the covered days reported on the claim by the number of days reported in the OSC 77.

B. Policy: The Skilled Nursing Facility and Swing Bed Facility instructions for reporting OSC 77 can be found in the Medicare Claims Processing Manual, Chapter 6, SNF Inpatient Part A Billing, Section 40.6.4, Bills With Covered and Noncovered Days.

C. Provider Education: A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3568.1	For types of bill 18x and 21x, FISS shall allow the sum of all **covered** units on all 0022 revenue code lines to be less than the **covered** days reported on the claim by the number of days reported in the OSC 77.					X				
3568.2	Fiscal Intermediaries holding types of bill 18x and/or 21x with days reported under an OSC 77 due to this problem shall release the claims with condition code 15 upon implementation of this instruction.	X								
3568.3	Fiscal Intermediaries shall adjust claims that were incorrectly processed prior to implementation of this instruction when brought to their attention within the timely filing period.	X								
3568.4	FIs shall be aware of a change made in the business requirements of CR 3308, and educate providers if warranted.	X								

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
N/A	

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements
N/A	

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2005 **Implementation Date:** January 3, 2005 **Pre-Implementation Contact(s):** Jason Kerr (410) 786-2123 **Post-Implementation Contact(s):** Appropriate Regional Office	**Medicare contractors shall implement these instructions within their current operating budgets.**

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

30 - Billing SNF PPS Services

(Rev.378, Issued: 11-26-04, Effective: 01-01-05, Implementation: 01-03-05)

SNF-515.3, PM A-01-056, PM A-02-016 (CR-1666)

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 UB-92 (CMS-1450) Data Set," for further information about billing, as it contains UB-92 data elements and the corresponding fields in the electronic record:

- In addition to the required fields identified in the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-92 (CMS-1450) Data Set," 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, Health Care Claim: ANSI X12N 837 I version 4010 SV201 must contain 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.

- There must be a line item on the claim for each assessment period represented on the claim with revenue code 0022. This code indicates that this claim is being paid under SNF PPS. This revenue code can appear on a claim as often as necessary to indicate different HIPPS rate code(s) and assessment periods.

- The line item date of service date must contain an assessment reference date (ARD) when FL 42 contains revenue code 0022 unless FL 44 contains HIPPS rate code AAA00. Assessment dates are reported on the ANSI X12N 837 I version 4010 using qualifier 866 in DTP01.

- HCPCS/Rates, Health Care Claim: Institutional ANSI X12N 837 I version 4010 SV202-01 must contain a ZZ qualifier and SV202-02 must contain a 5-digit "HIPPS Code" (AAA00-SSC79). The first three positions of the code contain the RUG III group and the last two positions of the code contain a 2-digit assessment indicator (AI) code. See Tables 1 and 2 below for valid RUG codes and AI codes.

- Service Units, Health Care Claim: Institutional 837 I version 4010 2400 SV205 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, Health Care Claim: Institutional ANSI X12N 837 I version 4010 2400 SV203 should be zero total charges when the revenue code is 0022.

- When a HIPPS rate code of RUAxx, RUBxx and/or RUCxx 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, RLAxx, RLBxx, RMAxx, RMBxx, RMCxx, RVAxx, RVBxx and/or RVCxx 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.

- 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.

50.2.2 - Provider Liability Billing Instructions

(Rev.378, Issued: 11-26-04, Effective: 01-01-05, Implementation: 01-03-05)

PM AB-01-131

In situations where the beneficiary was subject to the payment ban, but the provider failed to issue the proper Notification of Non-Coverage, the provider is liable for all services normally covered under the Medicare Part A benefit. Since the beneficiary is receiving benefits, the days will be considered Part A days and charged against the beneficiary's benefit period. The SNF may collect any applicable copayment amounts. These days will be charged against the patient's utilization as is currently done with other types of technical denials (i.e., late filing, late denial notices to the patient, etc.). The SNF must file a *covered* bill with the FI using occurrence span code 77 that indicates the facility is liable for the services but any applicable copayments will be charged to the beneficiary's Part A benefit period. *Furthermore, 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 provider liable days reported in the occurrence span code 77.* See §60 of Chapter 1 in this manual for detailed instructions on nonpayment billing requirements.

When the SNF is liable for the Part A stay, the SNF is required to provide all necessary covered Part A services, including those services such as therapies and radiology mandated under consolidated billing. For example, if the beneficiary goes to the hospital for a non-emergency chest x-ray, the SNF will be responsible for the outpatient hospital radiology and any ambulance charges. In this case, the SNF may not charge the beneficiary or family members for any services that, in the absence of a payment sanction, would have been covered under the Part A PPS payment.