

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2011	Date: July 30, 2010
	Change Request 7019

SUBJECT: Revised Instructions for Reporting Assessment Dates under the Inpatient Rehabilitation Facility (IRF), Skilled Nursing Facility (SNF), and Swing Bed (SB) Prospective Payment Systems (PPS)

I. SUMMARY OF CHANGES: This instruction implements a new occurrence code billing requirement for assessment-related dates. Assessment-related dates are no longer reported using date of service fields.

EFFECTIVE DATE: *January 1, 2011

IMPLEMENTATION DATE: January 3, 2011

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	3/140.2.4.3/Low-Income Patient (LIP) Adjustment: The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Inpatient Rehabilitation Facilities (IRFs) Paid Under the Prospective Payment System (PPS)
R	3/140.3.4/Payment Adjustment for Late Transmission of Patient Assessment Data
R	6/30/Billing SNF PPS Services

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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**

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

Attachment - Business Requirements

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EFFECTIVE DATE: January 1, 2011

IMPLEMENTATION DATE: January 3, 2011

I. GENERAL INFORMATION

A. Background: Current Medicare instruction requires IRF and SNF PPS providers to report assessment dates in form locator 45, Service Date, of the UB-04 form or loop 2400, DTP Assessment Date field, in the current 4010A1 837I electronic version. The DTP Assessment Date is removed from the new 837I electronic version. Because of the removal of this field providers will no longer be able to report assessment dates in the service date fields. Therefore, CMS is revising the billing instruction to now require an occurrence code 50, definition below, for reporting assessment dates for IRF, SNF, and SB PPS providers as follows:

For IRF PPS, IRFs shall begin using occurrence code 50 to report the date on which assessment data was transmitted to the CMS National Assessment Collection Database. Providers should no longer report this in the service date field on the UB-04 and the 837I electronic version for dates of service on or after January 1, 2011.

For SNF and SB PPS, providers shall append an occurrence code 50 with the assessment reference date (ARD) for each Health Insurance Prospective Payment System Code (HIPPS) reported on the claim. . Please note that HIPPS code AAAXx (where 'xx' is varying digits) does not need an accompanying occurrence code 50. SNF providers shall ensure that each HIPPS code reported on the claim are billed in the order in which that level of care is received for the month.

Occurrence Code 50: Assessment Date

Definition: Code indicating an assessment date as defined by the assessment instrument applicable to this provider type (e.g. Minimum Data Set (MDS) for skilled nursing). (For IRFs, this is the date assessment data was transmitted to the CMS National Assessment Collection Database).

B. Policy: The assessment date data element is removed from the new version of the 837I electronic format. CMS is codifying the usage of occurrence code 50 in order to eliminate electronic billing ambiguities.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)						
		A	D	F	C	R	Shared-	OTH
		/	M	I	A	H	System	ER
		B	E		R	H	Maintainers	

		M A C	M A C		R I E R	I	F I S S	M C S	V M S	C W F	
7019.1	Medicare contractors shall accept occurrence code 50 for reporting assessment date.						X			X	COB C, CEM
7019.1.1	Medicare contractors shall note all changes identified in this instruction are effective for claims with dates of service on or after January 1, 2011.	X		X			X			X	COB C
7019.2	Medicare contractors shall require occurrence code 50 to be reported on all IRF PPS 11x bill types.						X				
7019.2.1	Medicare contractors shall return to provider IRF PPS claims in which occurrence code 50 is not present	X		X							
7019.3.	Medicare contractors shall move any existing editing occurring with the revenue code 0024 service date reporting to the occurrence code 50 date.						X				
7019.3.1	Medicare contractors shall no longer require a line item date of service to be reported with revenue code 0024. (This date is now reported with occurrence code 50).						X				
7019.4	For purposes of assigning the Special Payment Indicator for the IRF PPS Pricer (to apply, or not apply, the 25% penalty for a late assessment), FISS shall adjust their logic to look at the occurrence code 50 date, instead of the service date for the Revenue Code 0024 line as is currently done.						X				
7019.5	Medicare contractors shall require an occurrence code 50 to be reported for each revenue code 0022 lines reported on SNF and SB PPS 21x and 18x bill types except for the following conditions.						X				
7019.5.1	Medicare contractors shall not require a corresponding occurrence code 50 be reported where the HIPPS code reported with the 0022 revenue code is AAxx (where 'xx' is varying digits).						X				
7019.5.2	Medicare contractors shall require only one occurrence code 50 be reported for 2 HIPPS code lines that both end in the same 2 digits. The applicable HIPPS for this bypass are: xxx05, xxx06, xxx12, xxx13, xxx14, xxx15, xxx16, xxx17, xxx24, xxx25, xxx26, xxx34, xxx35, xxx36, xxx44, xxx45, xxx46, xxx54, xxx55, xxx56 where "xxx" is varying digits.						X				
7019.5.3	Medicare contractors shall remove revenue codes 9000-9044 from any existing SNF billing edits as these codes are no longer applicable.						X				
7019.5.4	Medicare contractors shall return claims to the provider that do not meet this criterion.	X		X							
7019.6	Medicare contractors shall move any existing editing,						X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I M A C	C A R R I E R	R H H I	Shared-System Maintainers				OTH ER
						F I S S	M C S	V M S	C W F		
	reporting or transferring occurring with the revenue code 0022 service date reporting to the occurrence code 50 date.										
7019.6.1	Medicare contractors shall no longer require line item date of service to be reported with revenue code 0022. (This date is now reported with occurrence code 50).						X				
7019.7	Medicare contractors shall remove any existing editing requiring a revenue code 0022 to have a line item date of service present.									X	
7019.8	Medicare contractors shall ensure revenue code lines 0022 are maintained on the claim in the order they are submitted by the provider.						X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I M A C	C A R R I E R	R H H I	Shared-System Maintainers				OTH ER
						F I S S	M C S	V M S	C W F		
7019.9	<p>A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.</p> <p>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 one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.</p>	X		X							

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Jason Kerr, Jason.Kerr@cms.hhs.gov (for claims processing guidance);

Post-Implementation Contact(s): Appropriate Regional Office

http://www.cms.hhs.gov/RegionalOffices/01_Overview.asp

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs)*, *Regional Home Health Intermediaries (RHHIs)*, and/or *Carriers*, use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: For *Medicare Administrative Contractors (MACs)*, use the following statement:

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.

140.2.4.3 – Low-Income Patient (LIP) Adjustment: The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Inpatient Rehabilitation Facilities (IRFs) Paid Under the Prospective Payment System (PPS)

(Rev.2011, Issued: 07-30-10, Effective: 01-01-11, Implementation: 01-03-11)

The LIP adjustment accounts for differences in costs among IRFs associated with differences in the proportion of low-income patients treated. The LIP adjustment is calculated as $(1 + \text{disproportionate share hospital (DSH) patient percentage})$ raised to a power specified in the most recent IRF PPS final rule published in the Federal Register. To compute the DSH patient percentage the following formula is used:

$$\text{DSH} = \frac{\text{Medicare SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non-Medicare Days}}{\text{Total Days}}$$

This instruction provides the data for determining additional payment amounts for IRFs with low-income patients. An SSI data file below shows the latest available IRF-specific data to compute an IRF's SSI ratio for the associated specified fiscal year (FY). An IRF may use this ratio as part of the formula to estimate their LIP adjustment for a cost reporting period that begins subsequent to the FY specified by the data file. As appropriate a file will be updated annually (usually each October/November).

Patients who are enrolled in Medicare Advantage (administered through Medicare Part C) should also be included in the Medicare fraction. These days will be included in the Medicare/SSI fraction, but in order for them to be counted, the hospital must submit an informational only bill (TOB 111), which includes both Condition Code 04 and a default CMG code of A9999 on the Revenue Code 0024 line, to their Medicare contractor. This will ensure that these days are included in the IRF's SSI ratio for Fiscal Year 2007 and beyond. Teaching IRFs do not have to submit an additional bill with Condition Code 04. They already submit bills with Condition Codes 04 and 69 for Indirect Medical Education payments and CMS will use the information from these bills for the SSI ratio.

IRFs that received LIP payments during FY 2006 are also required to submit informational only bills for their Medicare Advantage patients.

Informational Only Claim Elements:

- Covered 111 TOB
- Condition Code 04
- Medicare Fee-for-Service is the primary payer
- There is no MSP
- Beneficiary's Medicare HICN
- Revenue Code 0024 *line containing* CMG A9999 and, *instead of inputting the transmission date of the IRF-PAI in the service date field (as is required for FFS claims), input the discharge date as a default for these informational only claims. The discharge date is required on informational only claims to reduce reporting burden for IRFs who may be submitting "old" informational only claims. NOTE: Effective January 1, 2011,*

do not report the service date for the revenue code 0024 line. Instead, use occurrence code 50 in place of the service date to report the default discharge date for informational only claims.

- All other required claim elements

The SSI/Medicare beneficiary data for IRF PPS is available to fiscal intermediaries (FIs) electronically and contains the name of the facility, provider number, SSI days, covered Medicare days, and the ratio of Medicare Part A patient days attributable to SSI recipients. FIs will use this information to update their provider specific file. The files are located at the following CMS Web site address:

http://www.cms.hhs.gov/InpatientRehabFacPPS/05_SSIData.asp#TopOfPage

FIs use this data to determine an initial PPS payment amount, and if applicable, to determine a final outlier payment amount for IRFs whose discharges are during a specific cost reporting period. FIs make a determination of the amount of this percentage to compute the final LIP adjustment which allows the year-end settlement of a facility's cost report. When the FI settles a cost report for a specific fiscal year, that settled cost report will determine the final SSI ratio that is associated with that cost report. The FI uses the most recently settled SSI ratio to settle the current cost report. Once the final SSI ratio is determined for the actual fiscal year the cost report corresponds to, a retrospective adjustment may be made to account for the difference between the actual lip adjustment amount and the initial PPS lip adjustment payment amount.

A - Clarification of Allowable Medicaid Days in Calculating the Disproportionate Share Variable

Background

Under the IRF PPS, facilities receive additional payment amounts to account for the cost of furnishing care to low-income patients. This is done by making adjustments to the prospective payment rate. Under §1886(d)(5)(F) of the Act, the Medicare DSH percentage is made up of two computations. The results of these two computations are added together to determine the DSH percentage. First, the patient days of patients who, during a given month, were entitled to both Medicare Part A and SSI (excluding those patients who received only State supplementation), is divided by the number of covered patient days utilized by patients under Medicare Part A for that same period. Second, a determination is made regarding the patient days associated with beneficiaries who were eligible for medical assistance (Medicaid) under a State plan approved under Title XIX but who were not entitled to Medicare Part A (See 42 CFR 412.106(b)(4)) is determined. This number is divided by the total number of patient days for that same period. The SSI data is updated on an annual basis and these data are one of the components used to determine the DSH variable that is part of the appropriate LIP adjustment for each IRF.

Included Days

In calculating the number of Medicaid days, the hospital must determine whether the patient was eligible for Medicaid under a State plan approved under Title XIX on the day of service. If the

patient was so eligible, the day counts in the Medicare disproportionate share adjustment calculation. The statutory formula for "Medicaid days" reflects several key concepts. First, the focus is on the patient's eligibility for Medicaid benefits as determined by the State, not the hospital's "eligibility" for some form of Medicaid payment. Second, the focus is on the patient's eligibility for medical assistance under an approved Title XIX State plan, not the patient's eligibility for general assistance under a State-only program. Third, the focus is on eligibility for medical assistance under an approved Title XIX State plan, not medical assistance under a State-only program or other program. Thus, for a day to be counted, the patient must be eligible on that day for medical assistance benefits under the Federal-State cooperative program known as Medicaid (under an approved Title XIX State plan). In other words, for purposes of the Medicare disproportionate share adjustment calculation, the term "Medicaid days" refers to days on which the patient is eligible for medical assistance benefits under an approved Title XIX State plan. The term "Medicaid days" does not refer to all days that have some relation to the Medicaid program, through a matching payment or otherwise; if a patient is not eligible for medical assistance benefits under an approved Title XIX State plan, the patient day cannot become a "Medicaid day" simply by virtue of some other association with the Medicaid program.

Medicaid days, for purposes of the Medicare disproportionate share adjustment calculation, include all days during which a patient is eligible, under a State plan approved under Title XIX, for Medicaid benefits, even if Medicaid did not make payment for any services. Thus, Medicaid days include, but are not limited to, days that are determined to be medically necessary but for which payment is denied by Medicaid because the provider did not bill timely, days that are beyond the number of days for which a State will pay, days that are utilized by a Medicaid beneficiary prior to an admission approval but for which a valid enrollment is determined within the prescribed period, and days for which payment is made by a third party. In addition, we recognize in the calculation days that are utilized by a Medicaid beneficiary who is eligible for Medicaid under a State plan approved under Title XIX through a managed care organization (MCO) or health maintenance organization (HMO). However, in accordance with 42 CFR 412.106(b)(4), a day does not count in the Medicare disproportionate share adjustment calculation if the patient was entitled to both Medicare Part A and Medicaid on that day. Therefore, once the eligibility of the patient for Medicaid under a State plan approved under Title XIX has been verified, the FI must determine whether any of the days are dual entitlement days and, to the extent that they are, subtract them from the other days in the calculation.

Excluded Days

Many States operate programs that include both State-only and Federal-State eligibility groups in an integrated program. For example, some States provide medical assistance to beneficiaries of State-funded income support programs. These beneficiaries, however, are not eligible for Medicaid under a State plan approved under Title XIX, and, therefore, days utilized by these beneficiaries do not count in the Medicare disproportionate share adjustment calculation. If a hospital is unable to distinguish between Medicaid beneficiaries and other medical assistance beneficiaries, then it must contact the State for assistance in doing so.

In addition, if a given patient day affects the level of Medicaid DSH payments to the hospital but the patient is not eligible for Medicaid under a State plan approved under Title XIX on that day, the day is not included in the Medicare DSH calculation.

It should be noted that the types of days discussed above are not necessarily the only types of excluded days. See the chart below, which summarizes some, but not necessarily all, of the types of days to be excluded from (or included in) the Medicare DSH adjustment calculation.

To provide consistency in both components of the calculation, any days that are added to the Medicaid day count must also be added to the total day count, to the extent that they have not been previously so added.

Regardless of the type of allowable Medicaid day, the hospital bears the burden of proof and must verify with the State that the patient was eligible under one of the allowable categories during each day of the patient's stay. The hospital is responsible for and must provide adequate documentation to substantiate the number of Medicaid days claimed. Days for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid cannot be counted.

Types of Days Included/Excluded in the Medicare DSH Adjustment Calculation

Type of Day	Description	Eligible Title XIX Day
General Assistance Patient Days	Days for patients covered under a State-only (or county-only) general assistance program (whether or not any payment is available for health care services under the program). These patients are not Medicaid-eligible under the State plan	No
Other State-Only Health Program Patient Days	Days for patients covered under a State-only health program. These patients are not Medicaid-eligible under the State plan	No
Charity Care Patient Days	Days for patients not eligible for Medicaid or any other third-party payer, and claimed as uncompensated care by a hospital. These patients are not Medicaid-eligible under the State plan.	No
Actual 1902(r)(2) and 1931(b) Days	Days for patients eligible under a State plan based on a 1902(r)(2) or 1931(b) election. These patients are Medicaid-eligible under the Title XIX State plan under the authority of these provisions, which is exercised by the State in the context of the approved State plan.	Yes
Medicaid Optional Targeted Low-Income Children (CHIP-related) Days	Days for patients who are Title XIX-eligible and who meet the definition of "optional targeted low-income children" under §1905(u)(2). The difference between these children and other Title XIX children is the enhanced FMAP rate available to the State. These children are fully Medicaid-eligible under the State plan.	Yes

Type of Day	Description	Eligible Title XIX Day
Separate CHIP Days	Days for patients who are eligible for benefits under a non-Medicaid State program furnishing child health assistance to targeted low-income children. These children are, by definition, not Medicaid-eligible under a State plan.	No.

140.3.4 - Payment Adjustment for Late Transmission of Patient Assessment Data

(Rev.2011, Issued: 07-30-10, Effective: 01-01-11, Implementation: 01-03-11)

In accordance with the regulations, Medicare (Part A fee-for-service) patient assessment data, collected through the inpatient rehabilitation facility patient assessment instrument (IRF-PAI), must be transmitted to the CMS National Assessment Collection Database by the 17th calendar day from the date of the patient's discharge. Under 412.614(d)(2), if the actual transmission date is later than 10 calendar days from the mandated transmission date, the patient assessment data is considered late and the IRF receives a payment rate that is 25 percent less than the payment rate associated with the case-mix group (CMG). Therefore, if the IRF transmits the patient assessment data 28 calendar days or more from the date of discharge, with the discharge date itself starting the counting sequence, the penalty is applied.

A. How the penalty is determined. In accordance with the regulations, inpatient rehabilitation facility-patient assessment instrument (IRF-PAI) data collected on a Medicare Part A fee-for-service inpatient must be transmitted to the CMS National Assessment Collection Database by the 17th calendar day from the date of the inpatient's discharge. Under the IRF prospective payment system regulations, if the actual transmission date is later than 10 calendar days from the mandated transmission date, the IRF-PAI data is considered late and the IRF receives a payment rate that is 25 percent less than the payment rate associated with the case-mix group (CMG). Therefore, if the IRF transmits the patient assessment data 28 calendar days or more from the date of discharge, with the discharge date itself starting the counting sequence, the penalty is applied.

B. Claim coding requirement: *Effective for dates of service prior to January 1, 2011, when Medicare Part A fee-for-service is the primary payer revenue code line 0024, Field Locator 45 (or electronic equivalent), Service Date, when entered by the provider or CMS adjustment process, will equal the date on which the final assessment was transmitted to the CMS National Assessment Collection Database. This field is mandatory on all discharge IRF PPS claims, whether the IRF-PAI was transmitted late or not. Effective for dates of service on or after January 1, 2011, the service date for revenue code line 0024 shall no longer be billed to convey the date the assessment data was transmitted to the CMS National Assessment Collection Database. Instead, Occurrence Code 50 shall be billed to communicate the date on which the assessment was transmitted.*

Transmission of the IRF-PAI data record 28 or more calendar days after the discharge date specified on the claim will result in the claim incurring the 25 percent late IRF-PAI data transmission penalty. If the provider does not complete this field accurately and the IRF-PAI

data record is transmitted 28 calendar days or more from the date of discharge, CMS will utilize a post-payment review process to identify claims subject to the late penalty and institute an adjustment process to correct payment. Complete details of the CMS post-payment review process will be determined at a later date.

The following modifications were made to the IRF Pricer to account for the payment adjustment:

Under the inputs to Pricer, the "payment modification flag" has been changed to "special payment indicator." This is an alpha-numeric field with valid entries of 0 - 3 currently.

The shared systems will set the payment modification flag to:

1 = If the claim has Condition Code 66 entered

2 = If the IRF-PAI data record transmission date present on the revenue code line with 0024, *or the date for occurrence code 50*, is 28 calendar days or more from the date of discharge on this claim. *(The transmission date shall be reported on the revenue code 0024 line when prior to January 1, 2011. The transmission date shall be reported for occurrence code 50 on or after January 1, 2011.)*

3 = Both 1 and 2 above apply, or

0 = Default value

Under Pricer outputs, Pricer returns a "penalty amount" field. When applicable, the amount in this field will equal 25 percent of the total payment amount computed by Pricer. The total payment amount field will be then be reduced by the penalty amount so that the final total payment amount output by Pricer will be 75 percent of the total payment amount due the provider.

Return codes 10 - 17 identify claims where there was a penalty and mirror return codes 00 – 07.

C. Waiver of the penalty. Under the regulations CMS may waive the penalty specified above in section A. The following describes when the penalty may be waived:

(1) When CMS or the FI determines that a claim the IRF submitted should not be subject to the payment penalty specified above in section A because CMS or the FI has determined that due to an extraordinary situation the IRF could not comply with the requirement specified above in section A. Only CMS, or the FI acting on behalf of CMS, can determine if a situation encountered by an IRF is extraordinary and qualifies as a situation for waiver of the penalty.

(2) When Medicare Part A fee-for-service is not the primary payer.

30 - Billing SNF PPS Services

(Rev.2011, Issued: 07-30-10, Effective: 01-01-11, Implementation: 01-03-11)

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-04 (CMS-1450) Data Set," for further information about billing, as it contains UB-04 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-04 (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 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 AAxx (where 'xx' equals varying digits). In addition, for OMRA related AIs 05, 06, 12, 13, 14, 15, 16, 17, 24, 25, 26, 34, 35, 36, 44, 45, 46, 54, 55, 56 where 2 HIPPS may be produced by one assessment, providers need only report one occurrence code 50 to cover both HIPPS codes.

- 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 Tables 1 and 2 below for valid RUG codes and AI codes.
- *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.
- 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. The code must be the full ICD-CM diagnosis code, including all five digits 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.

NOTE: Information regarding the form locator numbers that correspond to these data element names and a table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25.