CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2245	**Date: June 17, 2011**
	Change Request 7339

Transmittal 2239, dated June 14, 2011, is rescinded and replaced by Transmittal 2245 to replace the word "and" with the word "or" in the second sentence of the second bullet in section 30.4. All other information remains the same.

SUBJECT: Manual Clarifications for Skilled Nursing Facility (SNF) Part A Billing

I. SUMMARY OF CHANGES: This instruction provides various clarifications for SNF Part A billing.

EFFECTIVE DATE: August 1, 2011
IMPLEMENTATION DATE: August 1, 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	6/30/Billing SNF PPS Services
R	6/30.4/Coding PPS Bills for Ancillary Services
R	6/40.2/Reprocessing Inpatient Bills in Sequence
R	6/40.3.5.2/Leave of Absence
R	6/80/Billing Related to Physician's 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

Pub. 100-04	Transmittal: 2245	Date: June 17, 2011	Change Request: 7339

Transmittal 2239, dated June 14, 2011, is rescinded and replaced by Transmittal 2245 to replace the word "and" with the word "or" in the second sentence of the second bullet in section 30.4. All other information remains the same.

SUBJECT: Manual Clarifications for Skilled Nursing Facility (SNF) Part A Billing

EFFECTIVE DATE: August 1, 2011

IMPLEMENTATION DATE: August 1, 2011

I. GENERAL INFORMATION

A. Background: CMS is including the following clarifications to Chapter 6, SNF Inpatient Part A Billing, of the claims processing manual:

- In all cases where an End of Therapy (EOT) – Other Medicare Required Assessment (OMRA) is completed, SNF providers shall report Occurrence Code 16 to indicate the last day of therapy services for the billed claim,
- Units reporting requirements when billing therapy revenue codes 042x, 043x and 044x,
- Reprocessing inpatient bills in sequence and;
- Additional leave of absence guidance.

B. Policy: There are no policy changes with this instruction.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7339.1	Medicare contractors shall make providers aware of the clarifications provided in the updated manual sections attached to this instruction.	X		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7339.2	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. 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.	X		X							

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

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

V. CONTACTS

Pre-Implementation Contact(s): Jason Kerr, 410 786 2123 or Jason.Kerr@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs)*:
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)*:

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.

30 - Billing SNF PPS Services

(Rev.2245, Issued: 06-17-11, Effective: 08-01-11, Implementation: 08-01-11)

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 AAAxx (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.

- *In all cases where an End of Therapy-OMRA is completed, SNFs must submit occurrence code 16, date of last therapy, to indicate the last day of therapy services (e.g. physical therapy, occupational, and speech language pathology) for the beneficiary*.

- 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.

30.4 - Coding PPS Bills for Ancillary Services

(Rev.2245, Issued: 06-17-11, Effective: 08-01-11, Implementation: 08-01-11)

When coding PPS bills for ancillary services associated with a Part A inpatient stay, the traditional revenue codes will continue to be shown, e.g., 0250 - Pharmacy, 042x - Physical Therapy, in conjunction with the appropriate entries in Service Units and Total Charges.

- SNFs are required to report the number of units based on the procedure or service.

- *For therapy services, that is revenue codes 042x, 043x, and 044x, units represent the number of calendar days of therapy provided. For example, if the beneficiary received physical therapy, occupational therapy or speech-language pathology on May 1, that would be considered one calendar day and would be billed as one unit.*

- SNFs are required to report the actual charge for each line item, in Total Charges.

40.2 - Reprocessing Inpatient Bills in Sequence

(Rev.2245, Issued: 06-17-11, Effective: 08-01-11, Implementation: 08-01-11)

When a beneficiary experiences multiple admissions (to the same or different facilities) during a benefit period, claims are processed by CWF in the same order that they are received, regardless of the dates on which expenses were incurred. This first-in-first-out method of processing requests for payment facilitates prompt handling of claims.

If a SNF, any beneficiary, or secondary insurer have increased liability as a result of CWF's first-in/first-out (FI/FO) processing, the SNF must notify the FI/MAC to arrange reprocessing of all affected claims. This approach is not applicable if the liability stays the same, e.g., if the coinsurance or deductible amounts are applied on the second stay instead of the first, but there is no issue with regard to the effective date of supplementary coverage or if the beneficiary is responsible for payment of the first claim instead of the second.

The FI/MAC will verify and cancel any bills posted out-of-sequence and request that any other FI/MAC involved also cancel any affected bills. The FI/MAC will reprocess all bills in the benefit period in the sequence of the beneficiary's stays to properly allocate days where payment is made in full by Medicare and to identify those days where the beneficiary is required to pay coinsurance.

40.3.5.2 - Leave of Absence

(Rev.2245, Issued: 06-17-11, Effective: 08-01-11, Implementation: 08-01-11)

A leave of absence for the purposes of this instruction is a situation where the patient is absent, but not discharged, for reasons other than admission to a hospital, other SNF, or distinct part of the same SNF. If the absence exceeds 30 consecutive days, the 3-day prior stay and 30-day transfer requirements, as appropriate, must again be met to establish re-entitlement to SNF benefits.

Leave of absence (LOA) days are shown on the bill with revenue code 018X and LOA days as units. However, charges for *LOA* days are shown as zero on the bill, and the SNF cannot bill the beneficiary for them *except as specified in Chapter 1 of this manual at §30.1.1.1*. Occurrence span code 74 is used to report the *LOA* from and through dates.

80 - Billing Related to Physician's Services

(Rev.2245, Issued: 06-17-11, Effective: 08-01-11, Implementation: 08-01-11)

Normally physicians are responsible for billing for their own services.

The services of facility-based physicians (e.g., those on a salary or percentage arrangement, lessors of departments, etc., whether or not they bill patients directly) include two distinct elements - the professional component and the provider component.

The professional component of facility-based physicians' services includes services directly related to the medical care of the individual patient. SNFs cannot bill for the professional components of physician services, these must be billed under a physician provider number to the carrier. The technical component *(e.g. the component representing the performance of the diagnostic procedure itself)* of physician services delivered to SNF inpatients are bundled into the Part A PPS payment and not paid separately.

A - Podiatry Services

Covered professional services rendered by facility-based podiatrists to individual patients are covered only as physicians' services under Part B. Note that certain foot care services are excluded under both Part A and Part B. Payments to podiatrists for noncovered services are not allowable Medicare costs regardless of whether the podiatrist's professional services are covered under Part B.