mln BOOKLET
KNOWLEDGE • RESOURCES • TRAINING

PRINT-FRIENDLY VERSION

SNF BILLING REFERENCE

Target Audience: Medicare Fee-For-Service Providers

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

TABLE OF CONTENTS

Medicare Part A covers skilled nursing and rehabilitation care in a Medicare-certified Skilled Nursing Facility (SNF) or Swing Bed hospital under certain conditions for a limited time. Learn about:

- Medicare-covered SNF stays
- SNF payment
- SNF billing requirements
- Resources

When we use "you" in this publication, we are referring to SNF providers.

MEDICARE-COVERED SNF STAYS

Skilled Services

Skilled nursing and skilled rehabilitation services are furnished according to physician orders that:

- Require the skills of qualified technical or professional health personnel, such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, and speech-language pathologists or audiologists
- Must be provided directly by, or under the general supervision of, these skilled nursing or skilled rehabilitation personnel to ensure the safety of the beneficiary and achieve medically desired results

Skilled services must be:

- Ordered by a physician
- Performed by, or under the supervision of, professional or technical personnel
- Rendered for an ongoing condition for which the beneficiary also received inpatient hospital services or for a new condition that arose during the SNF care for that ongoing condition

Coverage Requirements

Medicare Advantage, 1876 Cost, or PACE Plans typically waive the 3-day hospitalization requirement. While MA plans must cover the same number of SNF days available under Original Medicare, they may cover more SNF days than Original Medicare.

In addition, MA plans may have different benefit periods. Each MA plan's Evidence of Coverage describes its coverage of all Medicare benefits, including SNF coverage. Most MA plans furnish SNF coverage through network providers paid according to their contracts. Non-network SNFs should confirm MA coverage with the enrollee's MA plan. They are paid at the Original Medicare payment rate consistent with MA regulations in the Code of Federal Regulations (CFR) at 42 CFR Section 422.214.

An enrollee in Original Medicare must meet these conditions to qualify for Medicare Part A-covered SNF services:

- He or she was an inpatient of a hospital for a medically necessary stay of at least 3 consecutive days (counting the day of admission, but not counting the day of discharge or any preadmission time spent in the emergency room or in outpatient observation). This requirement may be waived for enrollees of a Medicare Advantage, 1876 Cost, or PACE Plan.
- He or she transferred to a Medicare-certified SNF within 30 days after discharge from the hospital unless both of these are true:
  - His or her condition makes it medically inappropriate to begin an active course of treatment in a SNF immediately after discharge
  - It is medically predictable at the time of the hospital discharge that he or she will require covered care within a predetermined time period and the care begins within that time frame
- He or she requires skilled nursing services or skilled rehabilitation services on a daily basis which, as a practical matter, can be provided only in a SNF on an inpatient basis.
- As a practical matter, the daily skilled services can be provided only in a SNF on an inpatient basis if:
  - They are not available on an outpatient basis in the beneficiary's area
  - When compared to an inpatient setting, transportation to a facility would be:
    - An excessive physical hardship
    - Less economical
    - Less efficient or effective
- The services are reasonable and necessary for the treatment of the beneficiary's illness or injury and are reasonable in terms of duration and quantity.

Exhausted Part A Benefit

3-DAY PRIOR HOSPITALIZATION

The beneficiary can meet the 3 consecutive day stay requirement by staying 3 consecutive days in one or more hospitals. The day of admission, but not the day of discharge, is counted as a hospital inpatient day. Time spent in observation, or in the emergency room prior to admission, does not count toward the 3-day qualifying inpatient hospital stay.

3-DAY STAY WAIVER

Certain SNFs that have a relationship with Shared Savings Program (SSP) Accountable Care Organizations (ACOs) may waive the SNF 3-day rule. For more information, refer to Shared Savings Program (SSP) Accountable Care Organization (ACO) Qualifying Stay Edits. Most MA plans waive the 3-day hospitalization requirement.

For each benefit period, Medicare Part A covers up to 20 days of care in full. After that, Medicare Part A covers up to an additional 80 days, with the beneficiary paying coinsurance for each day. After 100 days, the SNF coverage available during that benefit period is "exhausted," and the beneficiary pays for all care, except certain Medicare Part B services. For more information about beneficiary coverage, costs, and care in a SNF, refer to Section 2, pages 50–52 of Your Medicare Benefits.

Benefit Period

SNF coverage is measured in benefit periods (sometimes called "spells of illness"), which begin the day the Medicare beneficiary is admitted to a hospital or SNF as an inpatient and ends after he or she has not been an inpatient of a hospital or received skilled care in a SNF for 60 consecutive days. Once the benefit period ends, a new benefit period begins when the beneficiary has an inpatient admission to a hospital or SNF. New benefit periods do not begin due to a change in diagnosis, condition, or calendar year.

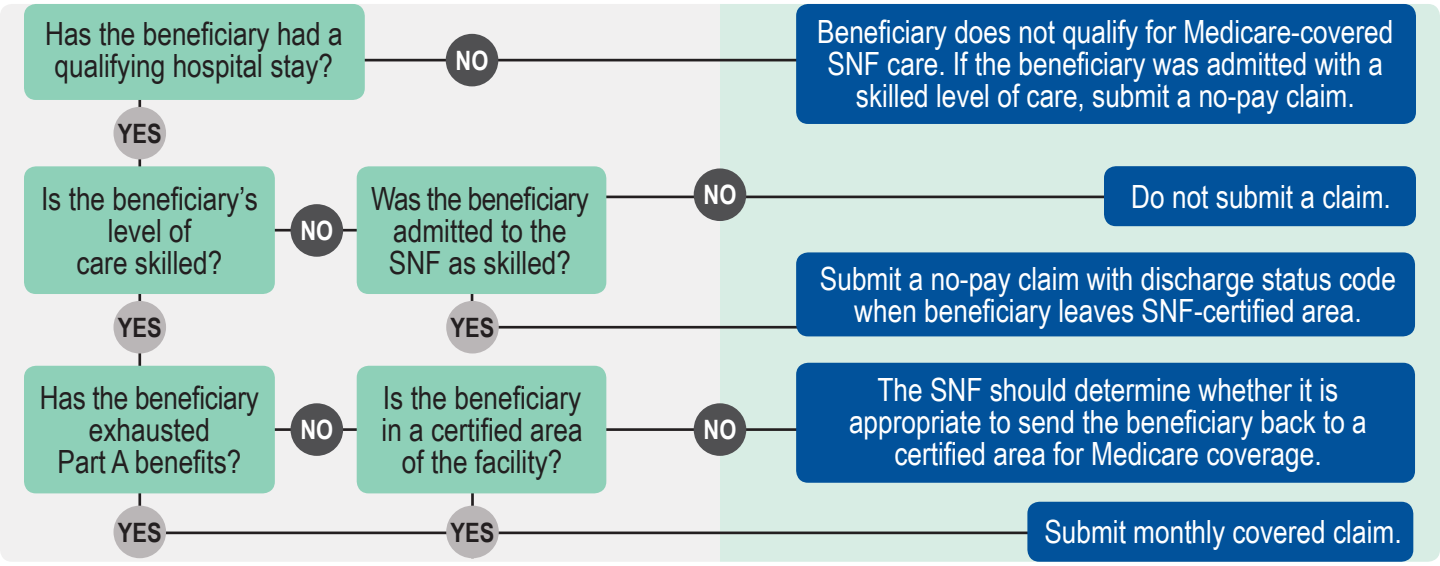
It is important for SNFs to understand the benefit period concept because sometimes the SNF must submit claims even when they do not expect to receive payment, which ensures proper tracking of the benefit period in the Common Working File (CWF) (for more information, see the Special Billing Situations section).

THE CWF

Tracks the SNF benefit period and has information about Medicare beneficiaries that Medicare Administrative Contractor (MAC) claims processing systems access to ensure proper payment of claims.

Figure 1 describes the relationships between coverage; skilled care; the benefit period; and what type of claim, if any, to submit to Medicare.

Figure 1. Summary of SNF Coverage and Billing



Communicating with Beneficiaries

Providers should communicate with beneficiaries about:

- Whether SNF care is right for them – Skilled care is furnished to improve or maintain the beneficiary's current condition or prevent or slow further deterioration of the beneficiary's condition. For more information, refer to Manual Updates to Clarify Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT) Coverage Pursuant to *Jimmo* vs. *Sebelius*.
- SNF coverage requirements – Determine if the beneficiary meets SNF coverage requirements prior to ordering SNF care. If the SNF care may be denied as not medically reasonable and necessary or is considered custodial care, tell them that Medicare Part A may not cover the SNF care and give them a Fee-For-Service (FFS) Skilled Nursing Facility Advance Beneficiary Notice (SNFABN), Form CMS-10055. The SNFABN is necessary for the SNF to transfer potential financial liability to the beneficiary, in this particular case. Effective April 30, 2018, providers must use the SNFABN, which CMS revised to replace the five denial letters and the Notice of Exclusions from Medicare Benefits Skilled Nursing Facility (NEMB-SNF), Form CMS-20014. For more information, visit the FFS SNFABN webpage or the Medicare Learning Network (MLN) Matters® article Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN).

It is important to note that for items or services paid under Medicare Part B that may be denied under certain circumstances (that is, not medically reasonable and necessary), SNFs should issue the ABN, Form CMS-R-131 to transfer potential financial liability to the beneficiary.

SNF PART B BILLING

You must bill some services to Part B. Bill repetitive services monthly or at the conclusion of treatment. Bill one-time services when the service is completed.

Refer to Chapter 7 of the Medicare Claims Processing Manual for more information.

SNF PAYMENT

Medicare Part A

The SNF Prospective Payment System (PPS) pays all SNF Part A inpatient services. Part A payment is primarily based on the case-mix classification assigned to the beneficiary following required Minimum Data Set (MDS) 3.0 assessments. As part of the Resident Assessment Instrument (RAI), the MDS 3.0 is a data collection tool that:

- Classifies the beneficiary into a group based on the average resources needed to care for someone with similar needs
- Provides a core set of screening, clinical, and functional status elements, including common definitions and coding categories
- Standardizes communication about resident problems and conditions.

For more information, refer to the Medicare-Required SNF PPS Assessments tool.

Consolidated Billing (CB)

GENERAL PAYMENT TIPS

- Medicare will not pay under the SNF PPS unless you bill a covered day
- Medicare only allows ancillary charges for covered days and those included in the PPS rate

Payment for most beneficiary services in a Medicare-covered Part A SNF stay, including most services provided by entities other than the SNF, are included in a bundled prospective payment. The SNF must bill these bundled services to the MAC in a consolidated bill. If you or your entity provided services subject to CB and are not a SNF, do not bill Medicare. Bill the SNF for payment.

CB RESOURCES

For more information on CB resources, take the SNF CB web-based training course on the Medicare Learning Network® (MLN) Learning Management System. To determine how CB applies to specific services, refer to the flow charts in the Skilled Nursing Facility Prospective Payment System booklet.

Medicare Part B

Medicare Part B may pay for:

- Outpatient services furnished to beneficiaries who are not inpatients of a SNF
- Services excluded from SNF PPS and SNF CB
- Certain "medical and other health services" furnished to beneficiaries residing in a SNF whose Part A benefits are exhausted or who are not otherwise entitled to payment under Part A

SNF BILLING REQUIREMENTS

SNFs bill Medicare Part A using Form CMS-1450 (also called the UB-04) or its electronic equivalent. Send claims in order, monthly, and upon the beneficiary's:

- Drop from skilled care
- Discharge
- Benefit period exhaustion

NOTE: When a beneficiary's benefits exhaust, follow the guidance in Table 3 to ensure the claims processing system accurately tracks the benefit period.

For general information on billing with Form CMS-1450, refer to Chapter 25 of the Medicare Claims Processing Manual. In addition to the fields required for all claims, SNFs must populate the elements in Table 1 for Part A claims.

Table 1. SNF Billing Requirements

UB-04 Field	Report
FL 04 Type of Bill (TOB)	21X for SNF inpatient services. 18X for swing bed services.
FL 06 Statement Covers Period – From/Through	The "From" date must be the admission date or, for a continuing stay bill, the day after the "Through" date on the prior bill. The "Through" date is the last day of the billing period.
FL 31–FL 34 Occurrence Code/Date	50 with the Assessment Reference Date (ARD) for each assessment period represented on the claim with revenue code 0022 (not required for the default Health Insurance Prospective Payment System [HIPPS] code).
FL 35 & FL 36 Occurrence Span Code – From/Through	70 with the dates of the 3-day qualifying stay.
FL 42 Revenue Code	0022 to indicate you are submitting the claim under the SNF PPS. You can use this revenue code as often as necessary to indicate different rate codes and periods.
FL 44 HCPCS/Rate/HIPPS Code	HIPPS rate code (a five-digit code consisting of a three-digit RUG code and a two-digit Assessment Indicator [AI] code).* Must be in the same order the beneficiary received that level of care. Certain HIPPS rate codes require additional rehabilitation therapy ancillary revenue codes. The MAC returns claims for resubmission when these corresponding codes are missing.
FL 46 Units of Service	The number of covered days for each HIPPS rate code.
FL 47 Total Charges	Zero for 0022 revenue code lines.
FL 67 Principal Diagnosis Code	International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) code for the principal diagnosis.
FL 67A–FL 67Q Other Diagnoses	ICD-10-CM codes for up to eight additional conditions.

* The AI code describes the assessment that determined the RUG code. For a full explanation about required assessments, refer to Chapter 6, Section 30 of the Medicare Claims Processing Manual.

Billing Tips

- Bill in order. MACs return a continuing stay bill if the prior bill has not processed. If you previously submitted the prior bill, hold the returned continuing stay bill until you receive the Remittance Advice for the prior bill.
- Generally, the day of discharge or death, or a day when a beneficiary begins a leave of absence (LOA), is not counted as a utilization day.
- If a beneficiary is discharged and returns before the following midnight, Medicare does not count this as a discharge.
- The HIPPS rate code appearing on the claim must match the assessment transmitted and accepted by the State where the facility operates. For more information, visit the HIPPS Codes webpage.

For assistance with other billing situations, contact your MAC.

Special Billing Situations

Certain situations require variations from the billing practices we discuss above. In some cases, Medicare requires you to submit a claim even though you do not expect payment (no-pay claim). Tables 2–7 provide additional information to help you decide how to bill Part A for various situations. Remember, you must provide adequate supporting documentation for services reported on claims.

Readmission Within 30 Days

Readmission occurs when the beneficiary is discharged and then readmitted to the SNF, needing skilled care, within 30 days after the day of discharge. Such a beneficiary can then resume using any available SNF benefit days, without the need for another qualifying hospital stay. The same is true if the beneficiary remains in the SNF for custodial care after a covered stay and then develops a new need for skilled care within 30 consecutive days after the first day of noncoverage.

Table 2. Readmission Within 30 Days Situations

If…	Then…
You sent a discharge claim prior to readmission	Submit another bill and report: • The current stay admission date • Condition code 57 • Occurrence span code 70 with the qualifying hospital stay dates
The beneficiary is readmitted before you send a discharge claim	Submit an interim bill and report: • The current stay admission date • Condition code 57 • Occurrence span code 70 with the qualifying hospital stay dates • Occurrence span code 74 showing the LOA "From" and "Through" dates and the number of noncovered days

When Benefits Exhaust

When benefits exhaust, continue submitting monthly bills if the beneficiary remains in a Medicare-certified area of the facility. Benefits can exhaust:

- **Fully** – The beneficiary had no benefit days available between the "From" and "Through" dates on the claim
- **Partially** – The beneficiary had some benefit days available between the "From" and "Through" dates on the claim

Table 3. Benefits Exhaust Situations

If…	Then…
The beneficiary moves to a non-Medicare-certified area of the institution	Discharge the beneficiary using the appropriate discharge status code. If appropriate, the claims processing system applies an A3 occurrence code with the last day when benefits were available. Report: • Appropriate covered TOB (not 210 or 180) • HIPPS AAA00 • Occurrence span code 70 with qualifying hospital stay dates • All covered days and charges • Value code 09 with $1.00 • Appropriate patient status code Do not submit Part B services with TOB 22X until the benefits exhaust claim processes. Submit any Part B services provided after skilled care ended, including therapy, on a TOB 22X.
The beneficiary drops to a nonskilled level of care while benefits are exhausted and remains in a Medicare-certified area of the institution	Report: • Appropriate TOB (SNF: 212, 213; Swing Bed: 182, 183) • Occurrence span code 70 with qualifying hospital stay dates • Occurrence code 22 with date covered SNF care ended • Value code 09 with $1.00 • Patient status code 30 Submit any Part B services provided after skilled care ended, including therapy, on a TOB 22X.
The beneficiary drops to a nonskilled level of care while benefits are exhausted and moves to a non-Medicare-certified area of the institution or otherwise discharges	Report: • TOB 211 or 214 for SNFs and 181 or 184 for swing beds • Value code 09 with $1.00 • Appropriate patient status code (other than 30) Submit any Part B services provided after skilled care ended, including therapy, on a TOB 23X.

No Payment Billing

For no payment billing, the beneficiary drops to a nonskilled level of care and remains in a Medicare-certified area of the institution.

Table 4. No Payment Billing Situations

If…	Then…
If you need a denial notice so another insurer will pay, send the initial no-payment claim with the "From" date as the date SNF care ended. Then, continue to send claims as often as monthly.	Report: • All days and charges as noncovered, beginning the day following the day SNF care ended • Condition code 21 • Appropriate patient status code • TOB 210 for SNFs or 180 for swing beds • HIPPS AAA00 Submit any Part B services provided after skilled care ended, including therapy, on a TOB 22X.
If no denial notice is needed, send only one final discharge claim. The claim may span both the SNF and Medicare fiscal year end dates.	Report: • "From" date as the day SNF care ended • "Through" date as the date of discharge • All days and charges as noncovered, beginning the day following the day SNF care ended • Condition code 21 • Appropriate patient status code (other than 30) • TOB 210 for SNFs or 180 for swing beds • HIPPS AAA00 Submit any Part B services provided after skilled care ended, including therapy, on a TOB 22X.

Expedited Review Results

Provider-initiated discharges for coverage reasons associated with SNF and inpatient swing bed claims require an expedited determination notice. A Medicare beneficiary, or a representative, can appeal provider service terminations to a Quality Improvement Organization (QIO) through the Expedited Determinations process.

QIOs must also inform the beneficiary of the right to an expedited reconsideration by the Qualified Independent Contractor (QIC) and how to request a timely expedited reconsideration.

You must report the outcomes of expedited determinations on the claim. For more information about expedited determinations, refer to Expedited Determinations for Provider Service Terminations.

Table 5. Expedited Review Results Situations

If…	Then…

QIO/QIC upholds the discharge decision	Report:
	• A discharge for the billing period that precedes the determination
	• Condition code C4
	• If the beneficiary is liable for any care days, report:
	  ◦ Occurrence span code 76 with the days the beneficiary incurred liability
	  ◦ Zero charges for the beneficiary-liable days
	  ◦ Modifier –TS for any HCPCS codes for those days

The QIO/QIC authorizes continued coverage with no specific end date	Report: • A continuing claim for the current billing or certification period • Condition code C7
The QIO/QIC authorizes continued coverage only for a limited period of time, and the time extends beyond the end of the normal billing or certification period	Report: • A continuing claim for the current billing or certification period • Condition code C3 • Occurrence span code M0 with the beginning date of QIO/QIC-approved coverage and the claim “Through” date

Table 5. Expedited Review Results Situations (cont.)

If…	Then…
The QIO/QIC authorizes continued coverage only for a limited period of time, and the time does not extend beyond the end of the normal billing or certification period	Report: • A discharge claim • Condition code C3 • Occurrence span code M0 with the beginning and end dates of QIO/QIC-approved coverage
The provider is liable due to failure to give timely information to the QIO/QIC or to provide valid notice to the beneficiary	Report services as noncovered with modifier –GZ

Noncovered Days

The beneficiary does not meet Medicare SNF coverage requirements.

Table 6. Noncovered Days Situations

If…	Then…
The beneficiary is liable	Report occurrence span code 76 Submit the claim as covered if the care is skilled
The SNF is liable	Report occurrence span code 77 Submit the claim as covered if the care is skilled

Other SNF Billing Situations

Table 7. Other SNF Billing Situations

Situation	If…	Then…
No Qualifying Hospital Stay	The beneficiary is admitted as needing skilled care but does not have a qualifying hospital stay, which includes persons who were initially admitted as skilled, following a qualifying hospital stay, dropped to a nonskilled level of care for more than 30 days (thus ending their connection to the original qualifying hospital stay), and then becoming skilled again without a new qualifying hospital stay	Bill normally, but do not report occurrence span code 70
Same Day Transfer	The beneficiary is admitted to the SNF and is expected to remain overnight but transfers before the following midnight to a Medicare-participating facility	Report: • The same admission, "From" and "Through" dates • Zero ("0") covered days • Condition code 40
LOA	The beneficiary leaves the SNF but is not admitted as an inpatient to any other facility	Report: • Revenue code 018X • Number of LOA days as units • Zero charges • Occurrence span code 74 showing "From" and "Through" dates for the LOA and the number of noncovered days
Forced Discharge	The beneficiary leaves the SNF and is admitted as an inpatient to another facility	Bill as a discharge. If the beneficiary is readmitted to the SNF within 30 days, follow the instructions for "Readmission Within 30 Days" in Table 2.
Nonskilled Discharge	The beneficiary drops to a nonskilled level of care and moves to a non-Medicare-certified area of the institution	Discharge the beneficiary on a final discharge claim. Submit services rendered after discharge on a TOB 23X.

Table 7. Other SNF Billing Situations (cont.)

Situation	If…	Then…
Demand Billing	The SNF believes covered skilled care is no longer medically necessary, and the beneficiary disagrees	Report: • Condition code 20 • Occurrence code 22 with the date SNF care ended or occurrence code 21 with the date the utilization review notice was received
Medicare Advantage (MA) Plan Information-Only Billing	The beneficiary is enrolled in an MA Plan	Submit information-only claims to Medicare so that the CWF can track the benefit period Report: • Appropriate HIPPS code based on assessment or HIPPS AAA00 if no assessment was done • Room and board charges • Condition code 04
Disenroll From MA Plan and convert to FFS while SNF inpatient	The beneficiary meets the level of care criteria through the effective date of disenrollment	Medicare waives the requirement for a qualifying hospital stay, and the beneficiary is eligible for the number of days remaining out of the 100-day benefit period for that stay minus the days Original Medicare would have covered while the beneficiary was enrolled in the MA Plan Report condition code 58
Disenroll from MA Plan after SNF discharge and converts to FFS	The beneficiary is readmitted under 30-day rule	All requirements for FFS, including qualifying 3-day hospital stay, must be met; providers may charge beneficiaries for SNF coinsurance Report condition code 58
Disenroll from MA Plan	The beneficiary disenrolls from the MA Plan **before admission** to the SNF	All requirements for FFS, including qualifying 3-day hospital stay, must be met Report condition code 58

RESOURCES

Table 8. Resources

Resource	Website
MDS 3.0	CMS.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30.html
Medicare Benefit Policy Manual	Chapter 8 CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf
Billing Information for Rural Providers and Suppliers, Skilled Nursing Facility section	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243515.html
Medicare Claims Processing Manual	Chapter 6 CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf Chapter 7 CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c07.pdf
Medicare Shared Savings Program Toolkit	CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/for-acos/application-toolkit.html
MLN Matters® Article, Manual Updates to Clarify Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT) Coverage Pursuant to *Jimmo* vs. *Sebelius*	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8458.pdf
MLN Matters Article, Overview of the Skilled Nursing Facility Value-Based Purchasing Program	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1621.pdf
MLN Matters Article, Skilled Nursing Facility Value-Based Purchasing Program Updated	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE18003.pdf

Table 8. Resources (cont.)

Resource	Website
Skilled Nursing Facility Center	CMS.gov/Center/Provider-Type/Skilled-Nursing-Facility-Center.html
SNF CB	CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/ConsolidatedBilling.html
SNF Consolidated Billing Web-Based Training Course	Learner.MLNLMS.com
SNF PPS, including charts with information on determining whether institutional or professional services are included or excluded from CB	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243671.html
Swing Bed Services	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243409.html

Table 9. Hyperlink Table

Embedded Hyperlink	Complete URL
42 CFR Section 422.214	https://www.ecfr.gov/cgi-bin/text-idx?SID=f292115c63a24f59af34ae15ed13c712&mc=true&node=se42.3.422_1214&rgn=div8
Chapter 6, Section 30 of the Medicare Claims Processing Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf
Chapter 7 of the Medicare Claims Processing Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c07.pdf
Chapter 25 of the Medicare Claims Processing Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c25.pdf
Contact Your MAC	http://go.cms.gov/MAC-website-list
Expedited Determinations for Provider Service Terminations	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7903.pdf
FFS SNFABN	https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-SNFABN-.html
Form CMS-R-131	https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html

Table 9. Hyperlink Table (cont.)

Embedded Hyperlink	Complete URL
HIPPS Codes	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/HIPPSCodes.html
Manual Updates to Clarify Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT) Coverage Pursuant to *Jimmo vs. Sebelius*	https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/mm8458.pdf
Medicare Learning Network® (MLN) Learning Management System	https://learner.mlnlms.com
Medicare-Required SNF PPS Assessments	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN909067.html
Shared Savings Program (SSP)	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram
Shared Savings Program (SSP) Accountable Care Organization (ACO) Qualifying Stay Edits	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9568.pdf
Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)	https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS019508.html
Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN)	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10567.pdf
Skilled Nursing Facility Prospective Payment System	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243671.html
Your Medicare Benefits	https://www.medicare.gov/Pubs/pdf/10116-Your-Medicare-Benefits.pdf