CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4077	**Date: June 26, 2018**
	Change Request 10555

Transmittal 4040, dated April 27, 2018, is being rescinded and replaced by Transmittal 4077, dated, June 26, 2018 to revise elements of the file layout within the Internet Only Manual attachment. All other information remains the same.

SUBJECT: Revision to the Skilled Nursing Facility (SNF) Pricer to Support Value-Based Purchasing (VBP)

I. SUMMARY OF CHANGES: This Change Request (CR) revises the record layout for the SNF Pricer interface to support Value-Based Purchasing.

EFFECTIVE DATE: October 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 1, 2018

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	6/30.4.1/Input/Output Record Layout
R	6/40.8/Billing in Benefits Exhaust and No-Payment Situations

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: 4077	Date: June 26, 2018	Change Request: 10555

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SUBJECT: Revision to the Skilled Nursing Facility (SNF) Pricer to Support Value-Based Purchasing (VBP)

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I. GENERAL INFORMATION

A. Background: In the FY 2018 Skilled Nursing Facility (SNF) Prospective Payment System (PPS) final rule, CMS finalized policy to implement SNF Value-Based Purchasing (VBP). The requirements below make the revisions needed to the SNF Pricer program to accept the necessary adjustment factor to apply the SNF VBP adjustment and to capture the adjusted amount on the claim record.

CMS will notify MACs of the payment adjustment factors for each SNF via Technical Direction Letter (TDL). MAC requirements below provides instruction to the MACs regarding the actions to take when further instruction is received later this year, so they can prepare the correct procedures to implement the payment adjustments.

B. Policy: The SNF VBP Program was authorized by the Protecting Access to Medicare Act (PAMA) of 2014, and rewards SNFs with incentive payments for the quality of care they provide to Medicare beneficiaries. Section 215 of this law added subsections (g) and (h) to Section 1888 of the Social Security Act. Section 1888 (g) authorizes new quality measures for SNFs based on the rate of hospital readmissions of Medicare beneficiaries discharged to a SNF. Section 1888 (h) authorizes a value-based purchasing program in which Medicare payments to SNFs will be adjusted based on their performance scores on the quality measures established in Section 1888 (g).

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	
10555.1	The contractor shall modify the input/output record to SNF Pricer to reflect the revised record layout in the Medicare Claims Processing Manual, chapter 6, section 30.4.1.					X				
10555.2	The SNF Pricer shall multiply the SNF PPS payments otherwise due, after all other payment adjustments are									SNF Pricer

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	applied, by the SNF VBP adjustment factor.									
10555.3	The SNF Pricer shall return a SNF VBP adjusted payment amount in the existing SNF PAYMENT RATE output field.									SNF Pricer
10555.4	The SNF Pricer shall subtract the calculated SNF-PAYMENT RATE amount before the VBP-MULTIPLIER from the SNF PAYMENT RATE with the VBP-MULTIPLIER applied and return the result in the VBP-PAY-DIFF amount field of the output record.									SNF Pricer
10555.5	The SNF Pricer shall assign a new return code 70 to indicate that zeros were passed into the PRICER for the VBP adjustment. NOTE: New RTC 70 = INVALID VBP MULTIPLIER									SNF Pricer
10555.6	The contractor shall assign a new reason code when the return code created under 10555.5 is returned by the SNF PRICER.					X				
10555.7	The contactor shall suspend the claim for investigation to determine the VBP value to enter on the provider specific file.	X								
10555.8	The contractor shall store the VBP adjustment on the claim record in the current VBP adjustment claim field. Note: The VBP adjustment is stored on the inpatient provider specific record.					X				
10555.9	The contractor shall add a new field at the line level of the claim record to store the VBP-PAY-DIFF amount returned by the SNF Pricer. FISS shall display the new line level field on the claim screen.					X				
10555.10	The contractor shall mutiply the VBP-PAY-DIFF amount returned from Pricer by the covered units reported for each HIPPS code to identify the total VBP adjustment amount for each HIPPS code line.					X				
10555.10.1	The contractor shall sum the calculated VBP adjustment amount for each HIPPS code line and					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	place this amount on the claim as a value code QV amount. NOTE: This may be a positive or negative amount.									
10555.11	The contractor shall store the amount reported for value code QV in the VBP Adjustment Amount field on the claim record.					X				
10555.12	The contractor shall ensure payer-only code QV is not passed to COB contractors (NOTE: payer-only codes are used for internal payer purposes only).					X				
10555.13	The contractor shall enter each SNF VBP adjustment factor in the provider specific file for SNFs upon receipt of a list of adjustment factors from CMS.	X								
10555.13.1	The contractor shall enter an adjustment factor of one digit and eleven decimal places (e.g. 1.07257764235 for a positive adjustment or 0.98201090235 for a negative adjustment).	X								
10555.14	The contractor shall ensure the SNF VBP adjustment factor is reported in the inpatient Provider Specific File record in data element 52, "VBP ADJ".	X								
10555.15	The contractor shall update the inpatient Provider Specific File (PSF) record with the VBP Adjustment value.	X								
10555.15.1	The contractor shall create the PSF record with an effective date of 10/01/18.	X								
10555.15.2	The contractor shall update the VBP ADJ field with the value provided by CMS.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility		
		A/B MAC	DME	CED

		A	B	H H H	M A C	I
	None					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Valeri Ritter, 410-786-8652 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

30 - Billing SNF PPS Services

(Rev.4077; Issued: 06-26-18; Effective: 10-01-18; Implementation: 10-01-18)

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). 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.

- 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.

- 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 for ICD-*10*. The code must be the full ICD-CM diagnosis code, including all five digits (for ICD-*10* 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.

30.4.1 - Input/Output Record Layout

(Rev.4077; Issued: 06-26-18; Effective: 10-01-18; Implementation: 10-01-18)

The SNF Pricer input/output file will be *300* bytes in length. The required data and format are shown below.

File Position	Format	Title	Description
1-4	X(4)	MSA	Input item: The metropolitan statistical area (MSA) code. Medicare claims processing systems pull this code from field 13 of the provider specific file.
5-9	X(5)	CBSA	Input item: Core-Based Statistical Area
10	X	SPEC-WI-IND	Input item (if applicable) :Special Wage Index Indicator Valid Values: **Y** (yes) or **N** (no)
11-16	X(6)	SPEC-WI	Input item (if applicable): Special Wage Index
17-21	X(5)	HIPPS-CODE	Input Item: Health Insurance Prospective Payment System Code – Medicare claims processing systems must copy the HIPPS code reported by the provider on each 0022 revenue code line
22-29	9(8)	FROM-DATE	Input item: The statement covers period “from” date, copied from the claim form. Date format must be CCYYMMDD.
30-37	9(8)	THRU-DATE	Input item: The statement covers period “through” date, copied from the claim form. Date format must be CCYYMMDD.
38	X	SNF-FED-BLEND	*Input Item: Effective October 1, 2017, MACs shall populate the FED PPS BLEND IND field in the PSF with a "1" to indicate the SNF did not meet the quality reporting requirements.*

File Position	Format	Title	Description
			Input item: Code for the blend ratio between federal and facility rates. For SNFs on PPS effective for cost reporting periods beginning on or after 7/1/98. Medicare claims processing systems pull this code from field 19 of the provider specific file. **Transition Codes:** Faci1ity % Federal % **1** 75 25 (1st year) **2** 50 50 (2nd year) **3** 25 75 (3rd year) **4** 0 100 (full fed rate) **NOTE**: All facilities have been paid at the full federal rate since FY 2002.
39-45	9(05)V9(02)	SNF-FACILITY RATE	Input item: Rate based on each SNF's historical costs (from (from A/B MAC (A) audited cost reports) including exception payments. **NOTE**: All facilities have been paid at the full federal rate since FY 2002.
46-52	X(7)	SNF-PRIN-DIAG-CODE	Input item: The principle diagnosis code, copied from the claim form. Must be three to seven positions left justified with no decimal points.
53-59	X(7)	SNF-OTHER-DIAG-CODE2	Input item: Additional Diagnosis Code, copied from the claim form, if present, must be three to seven positions left justified with no decimal points.
60-220	Defined above	Additional Diagnosis data	Input item: Up to twenty-three additional diagnosis codes accepted from claim. Copied from the claim form. Must be three to seven positions left justified with no decimal points.
221-228	9(06)V9(02)	SNF-PAYMENT RATE	Output item: Calculated per diem amount received by the SNF that includes a base payment amount adjusted for local wages and the clinical characteristics of individual patients.
229-230	9(2)	SNF-RTC	Output item: A return code set by Pricer to define the payment circumstances of the claim or an error in input data. **Payment return code:** 00 RUG III group rate returned **Error return codes:** 20 Bad RUG code

File Position	Format	Title	Description
			30 Bad MSA code 40 Thru date < July 1,1998 or Invalid 50 Invalid federal blend for that Year 60 Invalid federal blend 61 Federal blend = 0 and SNF Thru date < January 1, 2000 *70 Invalid VBP Multiplier*
231-242	*S9V9(11)*	*VBP-MULTIPLIER*	*Input item: Medicare systems move this information from field 52 of the provider specific file.*
243-250	*S9(06)V9(02)*	*VBP-PAY-DIFF*	*Output item: The SNF VBP adjustment amount, determined by subtracting the SNF VBP adjustment total payment from the SNF PPS payment that would otherwise apply to the claim. Added to the claim as a value code QV amount.*
251-300	*X(50)*	*FILLER*	*Blank*

Input records on claims must include all input items. Output records will contain all input and output items.

The Medicare claims processing systems will move the following Pricer output items to the claim record. The return code will be placed in the claim header. The SNF-PAYMENT-RATE amount for each HIPPS code will be placed in the rate field of the appropriate revenue code 0022 line. The Medicare claims processing systems will multiply the rate on each 0022 line by the number of units that correspond to each line. The system will sum all 0022 lines and place this amount in the "Provider Reimbursement" field minus any coinsurance due from the patient. For claims with dates of service on or after July 1, 2002, Pricer will compute payment only where the SNF-RTC is 00.

40.8 - Billing in Benefits Exhaust and No-Payment Situations

(Rev.4077; Issued: 06-26-18; Effective: 10-01-18; Implementation: 10-01-18)

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 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 *patient status code 30 if still interim billing or* appropriate code other than patient status code 30 *if discharging*.

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

Refer to Chapter 25 for further information about billing.