DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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MLN Matters® Number: MM8997 Revised

Related Change Request (CR) #: CR 8997

Related CR Release Date: April 3, 2015

Effective Date: June 15, 2015

Related CR Transmittal #: R3230CP and R204BP

Implementation Date: June 15, 2015

Updates to the Medicare Internet-Only Manual Chapters for Skilled Nursing Facility (SNF) Providers

Note: This article was revised on April 8, 2015, to reflect the revised CR8997 issued on April 3. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries who are in a Skilled Nursing Facility (SNF).

Provider Action Needed

Change Request (CR) 8997 updates sections of the "Medicare Benefit Policy Manual" and the "Medicare Claims Processing Manual" in regards to SNF policy and billing. If you

provide services to Medicare beneficiaries in a SNF stay, information in CR8997 could impact your payments.

Background

Change Request 8997 updates two chapters of the "Medicare Claims Processing Manual" and one chapter of the "Medicare Benefit Policy Manual". The following summarizes these manual updates:

"Medicare Benefit Policy Manual," Chapter 8:

Section 20.2.3 (Readmission to SNF):

- If an individual who is receiving covered post-hospital extended care, leaves a SNF and is readmitted to the same or any other participating SNF for further covered care within 30 days of the last covered skilled day, the 30-day transfer requirement is considered to be met; and

- **The same is true if the beneficiary remains in the SNF to receive custodial care following a covered stay, and subsequently develops a renewed need for covered care there within 30 consecutive days.** Thus, the period of extended care services may be interrupted briefly and then resumed, if necessary, without hospitalization preceding the **resumption of** SNF **coverage.**

"Medicare Claims Processing Manual," Chapter 6:

Section 20.1.1.2 - Hospital's "Facility Charge" in Connection with Clinic Services of a Physician

- When a beneficiary receives clinic services from a hospital-based physician, the physician in this situation would bill his or her own professional services directly to the Part B **MAC** and would be reimbursed at the facility rate of the Medicare physician fee schedule--which does not include overhead expenses.

- The hospital historically has submitted a separate Part B "facility charge" for the associated overhead expenses to its Part A **MAC**. The hospital's facility charge does not involve a separate service (such as a diagnostic test) furnished in addition to the physician's professional service; rather, it represents solely the overhead expenses associated with furnishing the professional service itself.

- Accordingly, hospitals bill for "facility charges" under the physician evaluation and management (E&M) codes in the range of 99201-99245 **and G0463 (for hospitals paid under the Outpatient Prospective Payment System).**

- E&M codes, representing the hospital's "facility charge" for the overhead expenses associated with furnishing the professional service itself, are excluded from SNF Consolidated Billing (CB). Effective for claims with dates of service on or after January 1, 2006, Medicare's Common Working File will bypass CB edits when billed with revenue code 0510 (clinic visit) with an E&M HCPCS code in the range of 99201-99245 **and, effective January 1, 2014 with HCPCS code G0463.**

Section 30.1 - Health Insurance Prospective Payment System (HIPPS) Rate Code:

- The HIPPS rate code consists of the three-character resource utilization group (RUG) code that is obtained from the "Grouper" software program followed by a 2 digit assessment indicator (AI) that specifies the type of assessment associated with the RUG code obtained from the Grouper. **Providers may access the Resident Assessment Instrument (RAI) manual located at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html** on the Centers for Medicare & Medicaid Services (CMS) website.

Section 30.2: - Coding PPS Bills for Ancillary Services

When coding PPS bills for ancillary services associated with a Part A inpatient stay, the traditional revenue codes will continue to be shown, for example, 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.

Section 30.3: Adjustment Requests

Adjustment requests based on corrected assessments must be submitted within 120 days of the service "through" date. The "through" date will be used to calculate the period during which adjustment requests may be submitted based on corrected RAI assessments. The "through" date indicates the last day of the billing period for which the HIPPS code is billed. Adjustment requests based on corrected assessments must be submitted within 120 days of the "through" date on the bill. For HIPPS changes resulting from an MDS correction, providers must append a condition code D2 on their adjustment claim. An edit is in place to limit the time for submitting this type of adjustment request to 120 days from the service "through" date.

CMS expects that most HIPPS code corrections will be made during the course of the beneficiary's Medicare Part A stay. Therefore, providers that routinely submit corrections after the beneficiary's Part A stay has ended may be subject to focused medical review.

Adjustment requests to change a HIPPS code may not be submitted for any claim that has already been medically reviewed. This applies whether or not the medical review was performed either pre- or post-payment. All adjustment requests submitted are subject to medical review. Information regarding medical review is located in the "Medicare Program Integrity Manual."

Section 40.3.5.2 - Leave of Absence:

- 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 section 30.1.1.1. Occurrence span code 74 is used to report the LOA from and through dates.

- Providers should review the RAI manual to clarify situations where an LOA is not appropriate, for example observation stays in a hospital lasting greater than 24 hours.

Medicare Claims Processing Manual, Chapter 13:

Section 90.5 (Transportation of Equipment Billed by a SNF to a MAC):

- When a SNF resident receives a portable x-ray service during the course of a Medicare-covered stay in the SNF, only the service's professional component (representing the physician's interpretation of the test results) is a separately billable physician service under Part B (see section 20 of Chapter 6).

- By contrast, the technical component representing the procedure itself, including any associated transportation and setup costs, would be subject to consolidated billing (CB) (the SNF "bundling" requirement for services furnished to the SNF's Part A residents), and must be included on the SNF's Part A bill for the resident's covered stay (Bill Type 21x) rather than being billed separately under Part B.

Additional Information

The official instruction for CR8997 was issued to your MAC via two transmittals. The first transmittal updates the "Medicare Claims Processing Manual" and it is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3230CP.pdf** on the CMS website. The second updates the "Medicare Benefit Policy Manual" and it is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R204BP.pdf** on the CMS website. If you

have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work?