

Medicare Claims Processing Manual

Chapter 6 - SNF Inpatient Part A Billing

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10 - Skilled Nursing Facility (SNF) Prospective Payment System (PPS) and Consolidated Billing Overview

(Rev.)

SNF-515, PM A-02-016 (CR 1666)

All SNF inpatient services are paid under a prospective payment system (PPS). Under SNF PPS, beneficiaries must meet the regular eligibility requirements for a SNF stay. That is, the beneficiary must have been an inpatient of a hospital for a medically necessary stay of at least three consecutive calendar days. In addition, the beneficiary must have been transferred to a participating SNF within 30 days after discharge from the hospital, unless the patient's condition makes it medically inappropriate to begin an active course of treatment in an SNF within 30 days after hospital discharge, and it is medically predictable at the time of the hospital discharge that the beneficiary will require covered care within a predetermined time period. (See the Medicare Benefit Policy Manual, Chapter 8, "Coverage of Extended Care Services Under Hospital Insurance," §20.2, for further information on the 30-day transfer requirement and exception.) To be covered, the extended care services must be needed for a condition which was treated during the patient's qualifying hospital stay, or for a condition which arose while in the SNF for treatment of a condition for which the beneficiary was previously treated in a hospital.

Also under SNF PPS all Medicare covered Part A services that are considered within the scope or capability of SNFs are considered paid in the PPS rate. In some cases this means that the SNF must obtain some services that it does not provide directly. Neither the SNF nor another provider or practitioner may bill the program for the services under Part B, except for services specifically excluded from PSS payment and associated consolidated billing requirements.

Any DME or oxygen furnished to inpatients under a Part A spell of illness is included in the SNF PPS rate. The definition of DME in [§1861\(n\)](#) of the Social Security Act (the Act) provides that DME is covered by Part B only when intended for use in the home, which explicitly does not include a SNF. This definition applies to oxygen also. (See the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Service," §110.)

Prosthetics and orthotic devices are included in the Part A PPS rate unless specified as being outside the rate. Those that are considered outside the PPS rate are billed by the qualified outside entity that furnished the service. That entity bills its normal contractor.

Services that are not considered to be furnished within SNF PPS are identified in sections §§20. These may be billed separately under Part B. Some services must be billed by the SNF. (This is referred to as "consolidated billing.") Some services may be billed by the rendering provider (SNF or otherwise). These are discussed further in §§20.

20 - Coverage and Patient Classification

(Rev.)

SNF-515.1, PM A-02-016

SNF services included in PPS are post-hospital SNF services for which benefits are provided under Part A (the hospital insurance program) and all items and services which, prior to July 1, 1998, had been paid under Part B (the supplementary medical insurance program) but furnished to SNF residents during a Part A covered stay. These services (other than the exclusions) are considered included in the PPS rate and, therefore, may not be billed separately by any other provider.

Certain other services are excluded from SNF PPS and must be billed separately by the rendering provider/supplier.

In addition, certain services are excluded from the SNF PPS only when furnished on an outpatient basis by a hospital or a critical access hospital.

The SNF Help File provides guidance about these services to intermediaries, carriers, SNFs, and suppliers. The file lists services by HCPCS code and describes their status with respect to whether the service is included in SNF PPS or can be billed separately. For separately billable services, the file also describes whether the SNF is required to bill or whether the rendering provider/supplier may bill.

Click [here](#) to view the file.

The SNF PPS incorporates adjustments to account for facility case mix, using the system for classifying residents based on resource utilization known as Resource Utilization Groups, Version III (RUG-III). A case-mix adjusted payment system measures the intensity of care (e.g., hours of nursing or therapy time needed per day) and services required (e.g., requirement of a ventilator) for each resident and then translates it into a

specific payment level. The Resident Assessment Instrument (RAI) is the software that contains utilization guidelines for completing the RAI, the Minimum Data Set (MDS), quarterly review criteria, correction request forms, corresponding instruction materials, and guidelines for encoding, correcting, and electronically transmitting RAI information to the state. Facilities will utilize information from the most recent version of the RAI, to classify residents into the RUG-III groups.

The Minimum Data Set (MDS) contains a core set of screening, clinical, and functional status elements, including common definitions and coding categories that form the basis of a comprehensive assessment. Section [1888\(e\)\(7\)](#) of the Act requires assessments be made using the MDS on a predetermined schedule for purposes of Medicare payment (see Medicare Assessment Schedule chart below). The software programs used by providers to assign patients to appropriate RUG-III groups based on the MDS 2.0, called groupers, are available from many software vendors. A grouper can also be accessed directly by providers from CMS' Web site at: <http://www.cms.hhs.gov/medicaid/mds20/default.asp>. Other software and data related to SNF Prospective Payment System (PPS) can also be accessed on CMS' Web site at: <http://www.cms.hhs.gov/medicaid/mds20/default.asp>.

For Medicare billing purposes, there is a payment code associated with each of the 44 RUG-III groups, and each assessment applies to specific days within a resident's SNF stay. SNFs that fail to perform assessments timely are paid a default payment for the days of a patient's care for which they are not in compliance with this schedule. Facilities will send each beneficiary's MDS assessment to the State and claims for Medicare payment to the intermediary on a 30-day cycle.

When the initial Medicare-required, 5-day assessment results in a beneficiary being correctly assigned to one of the highest 26 of the 44 RUG-III groups, this effectively creates a presumption of coverage for the beneficiary from admission up to, and including, the assessment reference date for that assessment. The coverage that arises from this presumption remains in effect for as long thereafter as it continues to be supported by the actual facts of the beneficiary's condition and care needs. However, this administrative presumption does not apply to any of the subsequent assessments.

For a beneficiary assigned to one of these upper 26 groups, the required initial certification essentially serves to verify the correctness of the beneficiary's assignment to that particular RUG-III group. RUG-III hierarchy categories that qualify for the administrative presumption of coverage in connection with the initial Medicare-required, 5-day assessment (assuming services provided are reasonable and necessary) include:

1. Rehabilitation;
2. Extensive Care;
3. Special Care; or
4. Clinically Complex.

A beneficiary who is assigned to any of the lower 18 of the 44 RUG-III groups on the initial Medicare-required, 5-day assessment (or to **any** RUG-III group on a subsequent assessment) is not automatically classified as meeting or not meeting the SNF level of care definition. Instead, the beneficiary must receive an individual level of care determination using existing administrative criteria and procedures.

Medicare Assessment Schedule

PM A-02-016

Medicare MDS Assessment Type	Assessment Window (including authorized grace days)	Number of Days Authorized for Coverage and Payment
5-day	Days 1 - 8*	14
14-day	Days 11 - 19	16
30-day	Days 21 - 34	30
60-day	Days 50 - 64	30
90-day	Days 80 - 94	10

*If a patient expires or transfers to another facility before the 5 day assessment is completed, the facility must still prepare an MDS as completely as possible for the RUG-III classification and Medicare payment purposes. Otherwise the days will be paid at the default rate.

20.1 - Payment Provisions

(Rev.)

SNF-515.2

Section 1888(e) of the BBA of 1997 provides the basis for the establishment of the per diem Federal payment rates applied under PPS to SNFs that received their first payment from Medicare on or after October 1, 1995. A transition period applied for those SNFs that first accepted payment under the Medicare program prior to October 1, 1995. The BBA sets forth the formula for establishing the rates as well as the data on which they are based. In addition, this section prescribes adjustments to such rates based on geographic variation and case-mix and the methodology for updating the rates in future years. For the initial period of the PPS beginning on July 1, 1998 and ending on September 30, 1999, all payment rates and associated rules were published in the Federal Register before May 12, 1998, (63 FR 26252). For each succeeding fiscal year, the rates are to be published in the Federal Register before August 1 of the year preceding the affected fiscal year.

The Federal rate incorporates adjustments to account for facility case mix using RUG-III, the patient classification system used under the national PPS. A case-mix adjusted payment system measures the intensity of care (e.g., hours of nursing or therapy time needed per day) and services required (e.g., requirement of a ventilator) for each resident and then translates it into a specific payment level. RUG-III is a 44-group patient classification system that provides the basis for the case-mix payment indices (or relative payment weights) used both for standardization of the Federal rates and subsequently to establish case-mix adjustments to the rates for patients with different service use. SNFs use information from the most recent version of the Resident Assessment Instrument version 2.0 to classify residents into one of 44 RUGS-III groups. SNFs complete these assessments according to an assessment schedule specifically designed for Medicare payment, that is on the 5th, 14th, 30th, 60th, and 90th days after admission to the SNF. For Medicare billing purposes, there is a Health Insurance PPS (HIPPS) rate code associated with each of the 44 RUG-III groups, and each assessment applies to specific days within a resident's SNF stay. SNFs that fail to perform assessments timely are paid a default payment for the days of a patient's care for which they are not in compliance with this schedule.

Annual regulatory updates to the SNF PPS rate are published in the Federal Register and then posted on the CMS Web site at : [cms.hhs.gov/providers/snfpps](https://www.cms.hhs.gov/providers/snfpps) (look for the publications heading).

20.2 - Services Included in the Part A PPS Rate and Cannot Be Billed Separately by the SNF.

(Rev.)

SNF-515.6

All Medicare covered services rendered a SNF resident during a Part A PPS stay are included in the SNF PPS payment except for the exclusions listed in the SNF Help File. Click [here](#) to view the file. This file lists services by HCPCS code and describes their status with respect to whether the service is included in SNF PPS or can be billed separately. For separately billable services the file also describes whether the SNF is required to bill or whether the rendering provider/supplier may bill.

Services paid under Part A (e.g., included in the PPS rate) may not also be paid under Part B. The following subsections lists the types of services that may not be billed under Part B for SNF residents for whom Part A payment may be made. See the Help File for related HCPCS codes.

Any service included in the SNF PPS rate that is billed separately will not be paid separately, or payment will be recovered if already paid at the time of the SNF billing.

20.3 - Other Services Not Included in the Part A PPS Rate and Not Billable by the SNF

(Rev.)

SNF-516

Physical, occupational, and speech-language therapy services furnished during a Part A PPS stay are always included in the PPS rate, even when performed by a type of practitioner (such as a physician) whose services would otherwise be excluded from the rate. Physical, occupational, and speech-language therapy services (other than audiology services, which are considered diagnostic tests rather than therapy services) furnished to a SNF resident during a noncovered stay must still be billed by the SNF itself

See the Medicare Claims Processing Manual, Chapter 5, "Outpatient Rehabilitation Services," for Part B therapy billing instructions.

The following services are beyond the scope of the SNF Part A benefit and excluded from SNF PPS and consolidated billing. They may be paid to the practitioner or provider that renders them. The SNF may not bill excluded services separately under Part B for its inpatients entitled to Part A benefits. They are billed separately by the rendering provider/supplier/practitioner to the carrier or intermediary. The services are described in below. Procedure codes, usually HCPCS, representing these excepted services are updated as frequently as quarterly in Program Memoranda available on the CMS Web site: <http://cms.hhs.gov/manuals/cmstoc.asp> and are updated to the SNF Help File.

Practitioner Services

Services from the following rendering practitioners, are paid separately to them (i.e., are not included in the PPS rate). These services are billed separately to the Part B carrier. Respiratory therapy services are included in the PPS rate except for the professional's component. Professional components of the following services are also excluded:

- Physician's services other than physical, occupational, and speech-language therapy services furnished to SNF residents;
- Physician assistants, not employed by the SNF, working under a physician's supervision;
- Nurse practitioners and clinical nurse specialists, not employed by the SNF, working in collaboration with a physician;
- Certified nurse-midwives;
- Qualified psychologists; and
- Certified registered nurse anesthetists;

Other Services

The following services are billed separately under Part B by the rendering provider, supplier or practitioner (e.g., exempted under Part A SNF PPS), and may be paid to the entity that furnished the service. These services may be provided by any Medicare provider licensed to provide them, except a SNF, and are excluded from SNF PPS and consolidated billing. HCPCS code ranges for chemotherapy, chemotherapy administration, radioisotopes, and customized prosthetic devices are set in statute. This statute also gives the Secretary authority to make modifications in the particular codes that are designated for exclusion within each of these service categories; accordingly, the minor and conforming changes in coding that appear in the instruction are made under that authority.

- Certain dialysis services and supplies, including any related necessary ambulance services;
- Home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies are not included in the SNF Part A PPS rate. They may be billed separately to the Intermediary by the hospital or ESRD facility as appropriate; dialysis supplies and equipment may be billed to the DMERC by the supplier. Institutional dialysis services billed only by a RDF are identified by type of bill 72X. Services for Method 2 ESRD beneficiaries billed by a RDF must be accompanied by the dialysis related diagnosis code 585. RDFs, or suppliers only when billing for home dialysis services for beneficiaries who reside in the SNF, use the following revenue codes for such billing:
- Erythropoietin (EPO) for certain dialysis patients, subject to methods and standards for its safe and effective use (see [42 CFR 405.2163\(g\) and \(h\)](#));
- Hospice care related to a beneficiary's terminal condition; Hospice services for terminal conditions are identified with the following bill types: 81X or 82X.
- An ambulance trip (other than a trip to or from another SNF) that transports a beneficiary to the SNF for the initial admission or from the SNF following a final discharge;
- Certain chemotherapy and chemotherapy administration services; These codes are included in SNF PPS payment for beneficiaries in a Part A stay when performed alone or with other surgery, but are excluded if they occur with the same line item date of service as an excluded chemotherapy agent. A chemotherapy agent must also be billed when billing these services, and physician orders must exist to support the provision of chemotherapy.
- Certain radioisotope services; and
- Certain customized prosthetic devices.

Specific HCPCS codes describing these services are found in later sections.

The Part A SNF benefit is limited to services that are reasonable and necessary to "diagnose or treat" a condition that has already manifested itself and, thus, does not include screening services (which detect the presence of a condition that is still in an asymptomatic stage) or preventive services (which are aimed at avoiding the occurrence of a particular condition altogether). Coverage of screening and preventive services (e.g., pneumococcal pneumonia vaccine, influenza vaccine, hepatitis vaccine) is a separate Part B inpatient benefit when rendered to beneficiaries in a covered Part A stay. They are excluded from Part A PPS and are covered under Part B in addition to the PPS rate. They must not be included on the SNF PPS bill. However, they remain subject to consolidated billing and, thus, must be billed separately by the SNF under Part B. Accordingly, even though the SNF itself must bill for these services, it would submit a separate Part B inpatient bill for them rather than including them on its global Part A bill. These must be billed with a 22X type of bill.

See the Medicare Claims Processing Manual, Chapter 18, "Preventive Services" for applicable HCPCS codes.

The following services are not included in SNF PPS when furnished in a Medicare participating hospital or critical access hospital and may be paid to the provider/supplier rendering them. This exception does not apply if the service is furnished in an ambulatory surgical center (ASC) or other independent (non-hospital) facility.

- Certain Cardiac catheterizations;
- Certain Computerized axial tomography (CT) scans;
- Certain Magnetic resonance imaging (MRIs);
- Certain Ambulatory surgeries involving the use of a hospital operating room; For Part A inpatients the professional portion of these services are billed by the rendering practitioner to the carrier. Any hospital outpatient charges are bundled to the SNF.
- Certain Radiation therapies;
- Certain Angiographies;
- Certain Angiographies, and lymphatic and venous procedures;
- Emergency services;
- Ambulance services when related to an excluded service within this list; and
- Ambulance transportation related to dialysis services.

These relatively costly services are beyond the general scope of care in SNFs. Even though it may be medically appropriate for a beneficiary to be cared for in a SNF while receiving radiation therapy, the SNF is not responsible for paying for radiation therapy

itself when the beneficiary receives it as a hospital outpatient. Similarly, angiography codes and codes for some lymphatic and venous procedures are considered beyond the general scope of services delivered by SNFs.

The hospital or CAH must bill the intermediary for the services. Emergency services are defined by the presence of revenue code 45x on the claim.

Other services are defined by the following HCPCS codes. Any other services (defined by other HCPCS codes) must be bundled back to the SNF and the hospital must look to the SNF for payment.

Other services excluded from SNF PPS

- For services furnished during 1998 only, the transportation costs of electrocardiogram equipment for electrocardiogram test services; and
- All services provided to risk based MCO beneficiaries. These beneficiaries may be identified with a label attached to their Medicare card and/or a separate health insurance card from an MCO indicating all services must be obtained or arranged through the MCO.

20.3.1 - Physician's Services and Other Professional Services Excluded From SNF Part A PPS

(Rev.)

SNF-516.1

Except for the therapy services, the professional component of physician services and services of certain nonphysician providers listed below are excluded from the SNF Part A PPS rate and must be billed separately by the physician to the carrier.

For this purpose "physician service" means the professional component of the service. The technical component, if any, must be billed by the SNF for its Part A inpatients. The carrier will pay only the professional component to the physician.

Providers with the following specialty codes assigned by CMS upon enrollment with Medicare are considered physicians for this purpose. Some limitations are imposed by [§§1861\(q\) and \(r\)](#) of the Act. These providers may bill their carrier directly.

Physician Specialty Codes

- | | |
|-----------------------|--------------------|
| 01 General Practice | 02 General Surgery |
| 03 Allergy/Immunology | 04 Otolaryngology |
| 05 Anesthesiology | 06 Cardiology |

Physician Specialty Codes

07 Dermatology	08 Family Practice
10 Gastroenterology	11 Internal Medicine
12 Osteopathic Manipulative Therapy	13 Neurology
14 Neurosurgery	16 Obstetrics Gynecology
18 Ophthalmology	19 Oral Surgery (Dentists only)
20 Orthopedic Surgery	22 Pathology
24 Plastic and Reconstructive Surgery	25 Physical Medicine and Rehabilitation
26 Psychiatry	28 Colorectal Surgery (formerly Proctology)
29 Pulmonary Disease	30 Diagnostic Radiology
33 Thoracic Surgery	34 Urology
35 Chiropractic	36 Nuclear Medicine
37 Pediatric Medicine	38 Geriatric Medicine
39 Nephrology	40 Hand Surgery
41 Optometry	44 Infectious Disease
46 Endocrinology	48 Podiatry
66 Rheumatology	69 Independent Labs
70 Multi specialty Clinic or Group Practice	76 Peripheral Vascular Disease
77 Vascular Surgery	78 Cardiac Surgery
79 Addiction Medicine	81 Critical Care (Intensivists)
82 Hematology	83 Hematology/Oncology
84 Preventive Medicine	85 Maxillofacial Surgery
86 Neuropsychiatry	90 Medical Oncology
91 Surgical Oncology	92 Radiation Oncology

Physician Specialty Codes

93 Emergency Medicine

94 Interventional Radiology

98 Gynecological/Oncology

99 Unknown Physician Specialty

Nonphysician Provider Specialty Codes

42 Certified Nurse Midwife

43 Certified Registered Nurse Anesthetist,
Anesthesia Assistants (effective 1/1/89)

50 Nurse Practitioner

62 Clinical Psychologist (billing
independently)

68 Clinical Psychologist

89 Certified Clinical Nurse Specialist

97 Physician Assistant

NOTE: Some HCPCS codes are defined as all professional components in the fee schedule. Fee schedule definitions apply for this purpose.

20.3.2 - Ambulance Services

(Rev.)

SNF-516.2

Ambulance services included in SNF PPS may be billed in revenue code 054x for covered Part A stays. The following ambulance transportation and related ambulance services for residents in a Part A stay are not included in the PPS rate. They may be billed as Part B services by the supplier in only the following situations.

- The ambulance trip is to the SNF for admission (the second character (destination) of any ambulance HCPCS modifier is N (SNF) other than modifier QN, and the date of service is the same as the SNF 21X admission date.);
- The ambulance trip is from the SNF to home (the first character (origin) of any HCPCS ambulance modifier is N (SNF)), and date of ambulance service is the same date as the SNF through date and the SNF patient status is other than 30.;
- The ambulance trip is to a hospital based or nonhospital based ESRD facility (either one of any HCPCS ambulance modifier codes is G (Hospital based dialysis facility) or J (Non-hospital based dialysis facility));
- The ambulance trip is from the SNF to a hospital for an inpatient admission;

- The ambulance trip is from the SNF to any destination other than another SNF, and the beneficiary does not return to that or any other SNF by midnight of that same day; and
- Ambulance service associated with.

Effective April 1, 2002, payment is under the ambulance fee schedule.

See Chapter 15 for Ambulance Services.

20.3.3 - Chemotherapy, Chemotherapy Administration, and Radioisotope Services

(Rev.)

SNF-516.4

These services may be provided by any Medicare provider licensed to provide them, except a SNF, and are excluded from SNF PPS and consolidated billing.

- HCPCS code ranges for chemotherapy, chemotherapy administration, radioisotopes, and customized prosthetic devices are set in statute. This statute also gives the Secretary authority to make modifications in the particular codes that are designated for exclusion within each of these service categories; accordingly, the minor and conforming changes in coding that appear in the instruction are made under that authority.

A. Chemotherapy

J9000	J9001	J9010	J9015	J9017	J9020	J9040	J9045	J9050
J9060	J9062	J9065	J9070	J9080	J9090	J9091	J9093	J9094
J9095	J9096	J9097	J9100	J9110	J9120	J9130	J9140	J9150
J9151	J9160	J9170	J9180	J9181	J9182	J9185	J9200	J9201
J9206	J9208	J9211	J9230	J9245	J9265	J9266	J9268	J9270
J9280	J9290	J9291	J9293	J9300	J9310	J9320	J9340	J9350
J9355	J9357	J9360	J9370	J9375	J9380	J9390	J9600	

B. Chemotherapy Administration

These codes are included in SNF PPS payment for beneficiaries in a Part A stay when performed alone or with other surgery, but are excluded if they occur with the same line item date of service as an excluded chemotherapy agent. A chemotherapy agent must

also be billed when billing these services, and physician orders must exist to support the provision of chemotherapy.

36260	36261	36262	36489	36491	36530	36531	36532	36533
36534	36535	36640	36823	96405	96406	96408	96410	96412
96414	96420	96422	96423	96425	96440	96445	96450	96520
96530	96542	Q0083	Q0084	Q0085				

C. Radioisotopes

79030	79035	79100	79200	79300	79400	79420	79440
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20.3.4 - Certain Customized Prosthetic Devices

(Rev.)

SNF-516.5

The following customized prosthetic devices that meet the requirements for Part B coverage are not included in the Part A PPS rate and are excluded from consolidated billing. The supplier furnishing the services must bill them.

K0556	K0557	K0558	K0559						
L5050	L5060	L5100	L5105	L5150	L5160	L5200	L5210	L5220	L5230
L5250	L5270	L5280	L5301	L5311	L5321	L5331	L5341	L5500	L5505
L5510	L5520	L5530	L5535	L5540	L5560	L5570	L5580	L5585	L5590
L5595	L5600	L5610	L5611	L5613	L5614	L5616	L5617	L5618	L5620
L5622	L5624	L5626	L5628	L5629	L5630	L5631	L5632	L5634	L5636
L5637	L5638	L5639	L5640	L5642	L5643	L5644	L5645	L5646	L5647
L5648	L5649	L5650	L5651	L5652	L5653	L5654	L5655	L5656	L5658
L5660	L5661	L5662	L5663	L5664	L5665	L5666	L5668	L5670	L5671
L5672	L5674	L5675	L5676	L5677	L5678	L5680	L5682	L5684	L5686
L5688	L5690	L5692	L5694	L5695	L5696	L5697	L5698	L5699	L5700

L5701	L5702	L5704	L5705	L5706	L5707	L5710	L5711	L5712	L5714
L5716	L5718	L5722	L5724	L5726	L5728	L5780	L5782	L5785	L5790
L5795	L5810	L5811	L5812	L5814	L5816	L5818	L5822	L5824	L5826
L5828	L5830	L5840	L5845	L5846	L5847	L5848	L5850	L5855	L5910
L5920	L5925	L5930	L5940	L5950	L5960	L5962	L5964	L5966	L5968
L5970	L5972	L5974	L5975	L5976	L5978	L5979	L5980	L5981	L5982
L5984	L5985	L5986	L5988	L5989	L5990	L5995	L6050	L6055	L6100
L6110	L6120	L6130	L6200	L6205	L6250	L6300	L6310	L6320	L6350
L6360	L6370	L6400	L6450	L6500	L6550	L6570	L6580	L6582	L6584
L6586	L6588	L6590	L6600	L6605	L6610	L6615	L6616	L6620	L6623
L6625	L6628	L6629	L6630	L6632	L6635	L6637	L6638	L6640	L6641
L6642	L6645	L6646	L6647	L6648	L6650	L6655	L6660	L6665	L6670
L6672	L6675	L6676	L6680	L6682	L6684	L6686	L6687	L6688	L6689
L6690	L6691	L6692	L6693	L6700	L6705	L6710	L6715	L6720	L6725
L6730	L6735	L6740	L6745	L6750	L6755	L6765	L6770	L6775	L6780
L6790	L6795	L6800	L6805	L6806	L6807	L6808	L6809	L6810	L6825
L6830	L6835	L6840	L6845	L6850	L6855	L6860	L6865	L6867	L6868
L6870	L6872	L6873	L6875	L6880	L6881	L6882	L6920	L6925	L6930
L6935	L6940	L6945	L6950	L6955	L6960	L6965	L6970	L6975	L7010
L7015	L7020	L7025	L7030	L7035	L7040	L7045	L7170	L7180	L7185
L7186	L7190	L7191	L7260	L7261	L7266	L7272	L7274	L7362	L7364
L7366									

20.3.5 - ESRD Services

(Rev.)

SNF-516.6, PM A-02-118

Home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies are not included in the SNF Part A PPS rate. They may be billed separately to the Intermediary by the hospital or ESRD facility as appropriate.

Specific coding is used to differentiate dialysis and related services that are excluded from SNF consolidated billing for ESRD beneficiaries in three cases:

1. When the services are provided in a RDF (including ambulance services);
2. Home dialysis when the SNF constitutes the home of the beneficiary; and
3. When the drug EPO is used for ESRD beneficiaries. Note that SNFs may not be paid for home dialysis supplies.

20.3.5.1 - Coding Applicable to Services Provided in a Renal Dialysis Facility (RDF)

(Rev.)

Institutional dialysis services billed only by a RDF are identified by type of bill 72X. Services for Method 2 ESRD beneficiaries billed by a RDF must be accompanied by the dialysis related diagnosis code 585.

20.3.5.2 - Coding Applicable to Services Provided in a RDF or SNF as Home

(Rev.)

RDFs, or suppliers only when billing for home dialysis services for beneficiaries who reside in the SNF, use the following revenue codes for such billing:

- 825 - Hemodialysis OPD/Home Support Services;
- 835 - Peritoneal OPD/Home Support Services;
- 845 - Continuous Ambulatory Peritoneal Dialysis OPD/Home Support Services;
or
- 855 - Continuous Cycling Peritoneal Dialysis OPD/Home Support Services.

HCPCS codes recognized for use with these revenue codes are:

Dialysis Supplies

A4651	A4652	A4653	A4656	A4657	A4660	A4663	A4670*	A4680
A4690	A4706	A4707	A4708	A4709	A4712	A4714	A4719	A4720
A4721	A4722	A4723	A4724	A4725	A4726	A4730	A4736	A4737
A4740	A4750	A4755	A4760	A4765	A4766	A4770	A4771	A4772
A4773	A4774	A4802	A4860	A4870	A4890	A4911	A4913**	A4918
A4927	A4928	A4929	A4930	A4931				

* Not covered by Medicare.

** A4913 is a carrier priced code not billed by SNFs.

Dialysis Equipment

E1500	E1510	E1520	E1530	E1540	E1550	E1560	E1570	E1575
E1580	E1590	E1592	E1594	E1600	E1610	E1615	E1620	E1625
E1630	E1632	E1635	E1636	E1637	E1638**	E1639	E1699*	

* E1699 is a carrier priced code not billed by SNFs.

** E1638 is being deleted starting 2003, so a 3-month grace period for billing will last into March 2003.

20.3.5.3 - Coding Applicable to EPO Services

(Rev.)

EPO is a drug Medicare approved for use by ESRD beneficiaries. Intermediary EPO claims for ESRD beneficiaries are identified with the following revenue codes when services are provided in RDF:

- 634 (EPO with less than 10,000 units); and
- 635 (EPO with 10,000 or greater units).

30 - Billing SNF PPS Services

(Rev.)

SNF-515.3, PM A-01-056, PM A-02-016 (CR1666)

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-92 Data Set," for further information about billing, as it contains UB-92 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-92 Data Set," SNFs must also report occurrence span code "70" to indicate the dates of a hospital stay of at least three 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, (Record Type (RT) 60, field 5), ASC X-12N 837 Health Care Claim 2-395-SV201, and Health Care Claim: ASC X-12N 837 version 4010 SV201 must contain 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.
- There must be a line item on the claim for each assessment period represented on the claim with revenue code 0022. This code indicates that this claim is being paid under SNF PPS. This revenue code can appear on a claim as often as necessary to indicate different HIPPS Rate Code(s) and assessment periods.
- HCPCS/Rates, (RT 60, field 6), ASC X-12N 837 Health Care Claim 2-395-SV201-02, and Health Care Claim: Institutional ASC X-12N 837 version 4010 SV201-02 must contain a 5-digit "HIPPS Code" (AAA00-SSC78). The first three positions of the code contain the MDS RUG-III group and the last two positions of the code contain a 2-digit assessment indicator code. See Tables 1 and 2 below for valid RUG codes and assessment indicator codes.
- Service Units, (RT 60, field 9), Medicare A 837 Health Care Claim version 3051, 2-395-SV205, and Health Care Claim: Institutional 837 version 4010 2400 SV205 must contain the number of covered days for each HIPPS rate code. The number of units for revenue codes 0022 must equal to the number of covered days minus leave of absence days shown with revenue code 018x.

- Total Charges, (RT 60, field 10), ASC X-12 837 Health Care Claim version 3051, 2-395-SV203, and Health Care Claim: Institutional ASC X-12N 837 version 4010 2400 SV203 should be zero total charges when the revenue code is 0022.
- When a HIPPS rate code of RUAxx, RUBxx and/or RUCxx 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, RLAxx, RLBxx, RMAxx, RMBxx, RMCxx, RVAxx, RVBxx and/or RVCxx 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.

TABLE 1 HIPPS RATE CODES

The HIPPS rate code is obtained from the grouper, which is a software module embedded in the software used to support the RAI and MDS (NOTE: MDS and RAI explained in [§§20](#)) The 5-digit HIPPS code must be present for a SNF claim to be paid. Each SNF PPS HIPPS code is comprised of three digits representing the RUG III code, and two for the assessment indicator as presented in the two following tables.

AAA (the default code)

BA1, BA2, BB1, BB2

CA1, CA2, CB1, CB2, CC1, CC2

IA1, IA2, IB1, IB2

PA1, PA2, PB1, PB2, PC1, PC2, PD1, PD2, PE1, PE2

RHA, RHB, RHC, RLA, RLB, RMA, RMB, RMC, RUA, RUB, RUC, RVA, RVB, RVC

SE1, SE2, SE3, SSA, SSB, SSC

TABLE 2 HIPPS ASSESSMENT INDICATOR CODES (effective July 1, 2002)

Code	Definition
00	Default code
01	5-day Medicare-required assessment/not an initial admission assessment

Code	Definition
02	30-day Medicare-required assessment
03	60-day Medicare-required assessment
04	90-day Medicare-required assessment
05	Readmission/Return Medicare-required assessment
07	14-day Medicare-required assessment/not an initial admission assessment
08	Off-cycle Other Medicare-required assessment (OMRA)
11	5-day (or readmission/return) Medicare-required assessment AND initial admission assessment
17	14-day Medicare-required assessment AND initial admission assessment. This code is used to signify that the bill is based on an MDS that is satisfying two requirements: the clinical requirement for an Initial Admission Assessment and the Medicare payment requirement for a 14-day assessment
18	OMRA replacing 5-day Medicare-required assessment. This code is used to signify that the bill is based on an OMRA that was performed within the window of a Medicare required 5-day assessment and "replaces" the Medicare required 5-day assessment. This combination of assessment type is extremely rare and accordingly, this code will not likely be used often.
19	Special payment situation - 5 day assessment (effective July 1, 2002)
28	OMRA replacing 30-day Medicare-required assessment. This code is used to signify that the bill is based on an OMRA that was performed within the window of a Medicare required 30-day assessment and "replaces" the Medicare required 30-day assessment.
*29	Special payment situation - 30 day assessment (effective July 1, 2002)
30	Off-cycle Significant Change assessment (SCSA). This code is used to signify that the bill is based on a SCSA performed for clinical reasons as required by OBRA 1987. As defined in the "Long Term Care Resident Assessment Instrument User's Manual, MDS 2.0", a SCSA is appropriate if there is a consistent pattern of change, with either 2 or more areas of decline or two or more areas of improvement in the beneficiary's clinical status.

Code	Definition
31	Significant Change assessment replacing 5-day Medicare-required assessment. This code is used to signify that the bill is based on a SCSA that was performed for clinical reasons within the window of a Medicare required 5-day assessment and "replaces" the Medicare-required 5-day assessment.
32	Significant Change assessment replacing 30-day Medicare-required assessment. This code is used to signify that the bill is based on a SCSA that was performed within the assessment window for a readmission/return assessment and will "replace" the readmission/return assessment.
33	Significant Change assessment replacing 60-day Medicare-required assessment
34	Significant Change assessment replacing 90-day Medicare-required assessment
35	Significant Change assessment replacing a readmission/return Medicare-required assessment
37	Significant Change assessment replacing 14-day Medicare-required assessment
38	Effective 10-01-2000, OMRA replacing 60-day Medicare-required assessment. Prior to 10-01-2000, "38" included both that the bill was based on either a SCSA only or on a SCSA that was also used to satisfy the requirement for an OMRA. See §30 for off-cycle SCSA.
*39	Special payment situation - 60 day assessment (effective July 1, 2002)
40	Off-cycle Significant Correction assessment of a Prior Assessment (outside assessment window). This code is used to signify that the bill is based on a SCPA that was performed for clinical reasons.
41	Significant Correction of a Prior Assessment replacing a 5-day Medicare-required assessment
42	Significant Correction of a Prior Assessment replacing 30-day Medicare-required assessment
43	Significant Correction of a Prior Assessment replacing 60-day Medicare-required assessment
44	Significant Correction of a Prior Assessment replacing 90-day Medicare-required assessment

Code	Definition
45	Significant Correction of a Prior Assessment replacing a readmission/return assessment. This code is used to signify that the bill is based on a SCPA that was performed within the assessment window of a readmission/return assessment and "replaces" the readmission/return assessment.
47	Significant Correction of a Prior Assessment replacing 14-day Medicare-required assessment
48	OMRA replacing 90-day Medicare-required assessment. This code is used to signify that the bill is based on an OMRA that was performed within the assessment window of a 90-day Medicare required assessment and "replaces" the Medicare required 90-day assessment.
*49	Special payment situation - 90 day assessment (effective July 1, 2002)
54	90-day Medicare assessment that is also a quarterly assessment
78	OMRA replacing 14-day Medicare-required assessment. This code is used to signify that the bill is based on an OMRA that was performed within the assessment window of a 14-day Medicare required assessment and "replaces" the Medicare-required 14-day assessment.
*79	Special payment situation - 14 day assessment (effective July 1, 2002)

*In some situations, beneficiaries may change payer source after admission, but fail to notify the provider in a timely manner, e.g., disenrollment from an HMO, disenrollment from a hospice, change in Medicare payer status from secondary to primary, etc. Problems may also occur in payment ban situations where the SNF may not receive timely notification that a payment ban has been lifted. In these cases, the provider may not have completed the RAI assessments needed for Medicare billing. New assessment indicator codes were established for these special payment situations.

There are three types of assessments. Medicare required assessments, off-cycle assessments, and a Significant Correction of a Prior Assessment. The Medicare required assessments are those scheduled for the 5th, 14th, 30th, 60th, and 90th days of the Medicare Part A covered stay. **Off-Cycle** assessments include the Other Medicare required assessment (OMRA) and the Significant Change in Status Assessment (SCSA). In addition, the Significant Correction of a Prior Assessment (SCPA) is now designated as an off-cycle assessment. Thus, it must be used to "replace" a Medicare-required assessment when the timing and type of assessment being corrected warrant the use of this assessment type, and the assessment reference date of the SCPA falls at the time that a Medicare-required assessment is due to be performed.

A Significant Change in Status Assessment (SCSA) is completed when triggered by the guidelines in the current version of the "Resident Assessment Instrument, User's Manual, Minimum Data Set," Version 2.0.

An Other Medicare Required Assessment (OMRA) is completed only when a beneficiary discontinues **all** occupational, physical, and/or speech therapy.

A Significant Correction of Prior Assessment (SCPA) is performed when a major error has occurred, defined as an error that resulted in an assessment that did not reflect the resident's status and; therefore, a care plan derived from it would not address the resident's needs.

SCPAs are only performed to correct major errors in comprehensive assessments, that is, RAI assessments that include care planning and Resident Assessment Protocols. Comprehensive assessments may be either the 5 day or the 14 day assessment, and, the quarterly assessment (which may coincide with the 90 day). An SCPA may never be performed to correct regularly scheduled Medicare assessments (5-day, 14-day, 30-day, etc.) since none of those are comprehensive RAI assessments.

EXAMPLE 1

A facility realized that the Initial Admission Assessment performed regarding a Medicare beneficiary contained clinical information that was erroneous and did not accurately reflect that beneficiary's needs or his care plan. The facility realizes that it must do a new assessment, an SCPA to have an accurate RUG for this beneficiary. The date chosen for the assessment reference date for the SCPA was one of the days in the assessment window for the 30-day Medicare assessment. In this situation, the SCPA replaces the 30-day assessment. The rate of payment changes on the assessment reference date (ARD) of the SCPA.

NOTE: The assessment reference date (ARD) is the date the assessment was performed.

Assessment indicator codes are only used for billing Medicare for covered SNF Part A stays. To the extent possible, every combination of reasons for MDS assessment relevant for Medicare payment has been captured by the HIPPS assessment indicator codes. However, to avoid undue complexity and because the information is not relevant for payment, there are some combinations that are not specifically identifiable using the codes. This means that although there are instances in which all of the information contained on the MDS is not captured by the HIPPS assessment indicator code, it is still an accurate code for billing purposes. For example, "08" indicates that the bill is based on an MDS assessment performed to fulfill the Medicare requirement for an OMRA 8-10 days after the discontinuation of all rehabilitation therapy. From the standpoint of Medicare payment, it does not matter if the MDS (the required OMRA) was also used to fulfill the clinical requirement for an SCSA or a Quarterly. For this reason, the assessment indicator code "08" is used for billing several different combinations of reasons for assessment, as can be seen in Table 2. The important information for the payer is that the facility performed the required MDS in a timely manner, and that the payment rate changes as of the assessment reference date (ARD) of the assessment. Please note that several assessment indicator codes (i.e., "05", "01", "11", and "07"), like "08", are used in multiple situations, but always to convey the most important

information from a billing standpoint. See Tables 2 and 3 for a display of combinations of reasons for assessment and the appropriate assessment indicator code to use for billing.

TABLE 3 - ASSESSMENT INDICATOR CODES

Assessment Indicator	Medicare 5-Day		Medicare 30-Day		Medicare 60-Day	
	AIa	HIPPS	AI	HIPPS	AI	HIPPS
Initial Admissions	01	11	--	--	--	--
Annual	02	01	02	02	02	03
Significant Change in Status - SCSAs	03	31	03	32	03	33
Significant Correction of Prior Fulls	04	41	04	42	4	43
Quarterly	05	01	05	02	05	03
Significant Correction of Prior Quarterly	10	41	10	42	10	43
None of the Above	00	01	00	02	00	03

TABLE 4 - ASSESSMENT INDICATOR CODES (Continued with 90 days)

Reason for Assessment	Medicare 90-Day		Readmission/Return		Medicare 14-Day	
	AI	HIPPS	AI	HIPPS	AI	HIPPS
Initial Admissions	--	--	01	11	01	17
Annual	02	04	02	05	02	07
Significant Change in Status- SCSAs	03	34	03	35	03	37
Significant Correction of Prior Fulls	04	44	04	45	04	47
Quarterly	05	54	05	05	05	07
Significant Correction of Prior Quarterly	10	44	10	45	10	47
None of the Above	00	04	00	05	00	07

TABLE 5 - ASSESSMENT INDICATOR CODES (Continued with OMRA)

Reason for Assessment	Other Medicare Required OMRA	
	AI	HIPPS
Initial Admissions	01	08
Annual	02	08
Significant Change in Status- SCSAs	03	08
Significant Correction of Prior Fulls	04	08
Quarterly	05	08
Significant Correction of Prior Quarterly	10	08
None of the Above	00	08

TABLE 6 - ASSESSMENT INDICATOR CODES FOR BILLING WHEN THERE ARE TWO MEDICARE REASONS FOR ASSESSMENT

Reason for Assessment	Medicare 5-Day	Medicare 14-Day	Medicare 30-Day	Medicare 60-Day	Medicare 90-Day	Readmission Return Assessment	SCSA	SCPA
Other State required Assessment*	01	07	02	03	04	05	30	40
OMRA	18	78	28	38	48	18	08	08
No reason for assessment in AA8b	N/A	N/A	N/A	N/A	N/A	N/A	30	40

*This item of the RAI is not used in every State and has no implications for Medicare billing. It is shown here only in the interest of providing clear and complete information.

30.1 - Billing Based on Off-Cycle MDS Assessments

(Rev.)

PM-A-01-56, PM-A-01-124 (CR1655)

If an off-cycle assessment is performed within the assessment window of a Medicare-required assessment, it must replace the Medicare required assessment. Payment will change effective with the ARD of the off-cycle assessment that replaces the Medicare required assessment and will continue until the next Medicare required assessment or off-cycle assessment, whichever occurs first. This policy is applied when there is a single off-cycle assessment that is performed within the Medicare required assessment window. However, when the ARD of the "replacement" (or off-cycle) assessment is on one of the grace days, the payment rate changes on the day it would have changed based on the regularly schedule assessment.

EXAMPLE 1

If the ARD of an OMRA is set on day 22 of the Part A covered stay, which is within the assessment window for setting the ARD for the 30-day Medicare required assessment, it must replace the 30-day Medicare required assessment. Payment will change on day 22, the ARD of the OMRA, and will continue until the next Medicare required assessment or off-cycle assessment, whichever occurs first.

EXAMPLE 2

If the ARD of an OMRA is set for day 32 of the stay and the OMRA is replacing the Medicare 30-day assessment, then the payment will change as of day 31, as if it were a regularly scheduled 30-day assessment. The payment rate changes retrospectively in this case because otherwise, there is no appropriate rate to bill for day 31. Payment based on the 14-day assessment may only go through day 30.

While not a common occurrence, there may be situations in which multiple assessments are performed within one Medicare required assessment window. In these instances, the off-cycle assessment with an ARD closest to, **and before**, the date on which the Medicare required assessment is due (i.e., day 5, day 14, day 30, day 60 or day 90) is the assessment that must replace the Medicare required assessment. Any other assessment performed in the assessment window must be billed as a stand-alone assessment and cannot replace the Medicare required assessment.

If there is one off-cycle assessment within the assessment window and another off-cycle assessment performed with an ARD on a grace day, the assessment with the grace day ARD must be billed separately as an off-cycle assessment and cannot replace the Medicare required assessment. The assessment with the ARD closest to, **and before**, the date on which the assessment was due must replace the assessment. In this case, there was an off-cycle assessment with an ARD before the assessment due date, therefore, that assessment is the replacement assessment. The assessment with an ARD in the grace period must be separately shown on the bill. There is no longer a Medicare assessment to be replaced. The required Medicare assessment was already replaced by the assessment that was performed within the assessment window and before the due date.

EXAMPLE 3

A SNF sets the ARD for a SCSA on day 22 of the covered stay. The beneficiary is "grouped" into a rehabilitation RUG. Therapy ends on day 24, and the SNF performs an OMRA with an ARD of day 33. The SNF must use the SCSA with the ARD of day 22 of the covered stay to replace the Medicare required assessment. This assessment must be used as the replacement assessment because its ARD is within the assessment window for the Medicare required assessment and is before the date on which the Medicare required assessment is due. The OMRA with an ARD that fell on day 33 of the stay cannot replace the Medicare required assessment since it already has been replaced by the SCSA. Payment to the SNF will change on day 22 (the ARD of the SCSA), since the SCSA must be used to replace the Medicare required assessment, and then again on day 33 of the covered stay, based on the OMRA. The payment associated with the RUG code derived from the OMRA will continue until the next Medicare required assessment or off-cycle assessment, whichever occurs first.

30.2 - Coding PPS Bills for Ancillary Services

(Rev.)

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. Specific instructions for reporting units are contained in the specific section for the procedure or service.
- SNFs are required to report the actual charge for each line item, in Total Charges.

30.3 - Adjustment to Health Insurance Prospective Payment System (HIPPS) Codes Resulting From Minimum Data Set (MDS) Corrections

(Rev.)

SNF-515.5, PMs A- 00-46 and A-01-121, CR 1224

The MDS is an assessment tool completed by facility clinical staff that is transmitted electronically to state agencies and then transferred to CMS, and is used to determine a RUG-III code. The 3-digit RUG-III code and the 2-digit assessment indicator make up the HIPPS code that appears on the bill, and is used to determine the payment rate for the SNF PPS. Effective for services provided on and after June 1, 2000, SNFs must submit adjustment requests to reflect corrections to the RAI that result in changes to the RUG-III code (i.e., the first three digits of the HIPPS code).

When SNF PPS was implemented in July 1998, there were limited options for facilities to correct an incorrect response in the RAI record that was used to calculate the RUG-III group, even when that error resulted in an incorrect payment rate. Instructions on the types of errors SNFs may correct within the RAI are available at <http://cms.hhs.gov/medicaid/mds20/default.asp> under Data Specifications. The document is titled "March 2000 Provider Instructions for Making Automated Corrections Using the New MDS Correction Request Form." Please check this page often for timely RAI announcements, corrections, and updates.

Correction to RAI data may affect items that are used in the RUG-III grouper calculations, and could change the RUG-III group for which a beneficiary qualifies. An example of a valid correction would be a change to MDS v 2.0 item M1b, number of stage two ulcers. If the facility reported zero stage two ulcers when there were really three ulcers present, the item should be corrected using this process.

An adjustment request must be submitted if the RAI correction results in a RUG-III code that is different from that already billed and paid. The adjustment request is retroactive to the first date payment was made using the original (but incorrect) RUG-III code.

EXAMPLE 1

A Medicare 5-day assessment was completed timely and used to establish the RUG-III rate for days 1-14 of the Part A stay. The bill was paid before the SNF found the error. (The error on that 5-day assessment was identified on day 17 while staff was completing the Medicare 14-day assessment.) The facility corrects the 5-day assessment, and submits an adjustment request for days 1-14 of the Part A stay. Use SNF adjustment condition code D4 in this situation.

EXAMPLE 2

On day 39 of the Part A stay, the SNF identifies an error in a 30-day Medicare MDS. Five days of service had already been billed and paid based on the HIPPS code generated from that 30-day Medicare assessment. The SNF submits an MDS correction to the state that results in a change in the RUG-III group. The SNF submits an adjustment request to the intermediary for the five days of service using the corrected RUG-III group. Then, the corrected RUG-III code is used for billing any remaining covered days in the applicable payment period. An RAI correction is not a new assessment, and can never be used as a replacement for the next regular Medicare assessment.

The SNF must document the reason for an RAI correction and certify to the accuracy of the correction. This documentation must be kept in the medical record. Review of this documentation must be incorporated into the intermediary medical review process.

To meet the clinical RAI requirements, SNFs may be required to perform Significant Change in Status Assessments (SCSA) or Significant Correction of Prior Assessments (SCPA) in addition to completing the RAI correction. As long as the RUG-III group generated from the RAI correction and the SCSA or SCPA are the same, the SNF can use the corrected assessment to bill any remaining covered days in the applicable payment period (e.g., days 31-60 for the 30-day assessment). However, since the SCSAs and the SCPAs require a new observation period and new assessment reference dates, it is possible that the RUG-III group generated by the SCSA or SCPA assessment will be different. In this case, the corrected assessment would be used from the first day of the applicable payment period (e.g., days 31-60 for the 30-day assessment) until the assessment reference date of the SCSA or SCPA assessment. If the assessment reference date for the SCSA or SCPA is within the assessment window, the SCSA or SCPA must also be used as a replacement for the next regular assessment.

RAI corrections may also be processed to inactivate an RAI record. Some examples of records that should be inactivated include assessment data submitted under the Health Insurance Claim (HIC) number for a different beneficiary, or a record transmitted with the wrong reason for assessment. In most cases, the SNF will also have filed an accurate, timely RAI for the beneficiary, which can be used for billing purposes. If the SNF did

not realize the error until a request had been submitted and paid, the SNF would submit an adjustment request. However, this type of adjustment does not involve a correction of RAI clinical data, and is not subject to the clinical data correction procedures described above. This type of adjustment request would use the regular SNF adjustment condition code, D4. In those rare situations where an RAI is inactivated and there is no valid HIPPS code for that payment period, the SNF must submit an adjustment request at the default rate (AAA) for the applicable time period.

30.3.1 - Effective Date for Adjustment Requests

(Rev.)

Adjustment request 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. An edit is in place to limit the time for submitting this type of adjustment request to 120 days from the service "through" date.

The 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, such claims are identified in the FI's system by an indicator on the claim record. 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 Program Integrity Manual..

Billing errors for an incorrect HIPPS code prior to June 1, 2000, cannot be adjusted. However, the requirement that providers may not knowingly over bill the Medicare program remains in effect. SNFs that identify patterns of errors that result in overpayments must report them to the FI, and these overpayments must be recouped. A pattern of errors includes but is not limited to software errors in transmitting RAI files, misunderstandings of RAI instructions that result in consistent miscoding of one or more RAI items used in determining the RUG-III group, etc.

40 - Special Inpatient Billing Instructions

(Rev.)

SNF-517, SNF-561

SNFs bill upon the following:

- Discharge;
- Benefit exhaustion;
- A decrease in level of care to less than skilled care; or
- After 30 days (and if necessary, every 30 days thereafter).

Each bill must include all diagnoses and procedures applicable to the admission. However, SNFs do not include charges that were billed on an earlier bill. The "from" date must be the day after the "through" date on the earlier bill.

40.1 - Submit Bills in Sequence

(Rev.)

SNF-517.13, A3-3603.2

SNFs must submit bills in sequence for each beneficiary they service. The intermediary will return to the SNF a continuing stay bill if the prior bill has not been processed. When the intermediary receives an out-of-sequence claim for a continuous stay, it will search its history for the prior adjudicated claim. If the prior bill has not been finalized, the intermediary will return to the provider (RTP), the incoming bill, request that the prior bill be submitted first, and the returned bill only be submitted after the SNF receives notice of adjudication of the prior bill. A typical error message follows:

Bills for a continuous stay or admission must be submitted in the same sequence in which services are furnished. If the provider has not already done so, please submit the prior bill. Then, resubmit this bill after you receive the remittance advice for the prior bill.

If the prior bill was submitted, the SNF will hold the returned bill until it receives a remittance advice for the prior bill.

40.2 - Reprocessing Inpatient Bills in Sequence

(Rev.)

SNF-517.14, A3-3603.2

If a SNF, any beneficiary, or secondary insurer are disadvantaged by the Common Working File's (CWF's) first-in/first-out (FI/FO) processing, the SNF must notify the intermediary to arrange reprocessing of all affected claims. The intermediary will verify and cancel any bills posted out-of-sequence and request that any other intermediary involved also cancel any affected bills. The intermediaries will reprocess all bills in the benefit period in the sequence of the beneficiary's stays to properly allocate full and coinsurance days.

This is only an issue when the beneficiary experiences multiple admissions (to the same or different facilities) during the benefit period. This situation occurs most often when long-term care hospitals are involved.

This approach is only used when the beneficiary, other insurer, or provider have increased liability as a result of out-of-sequence processing. It is not used if the liability stays the same, e.g., if the deductible is applied on the second stay instead of the first, but there is no issue with regard to the effective date of supplementary coverage.

40.3 - Determining Part A Admission Date, Discharge Date, and Utilization Days

(Rev.)

SNF-515.4, SNF-517.6

40.3.1 - Date of Admission

(Rev.)

The beneficiary, entitled to Part A benefits, becomes a SNF resident for Part A PPS billing purposes when admitted to a Medicare certified bed. This could be a first time admission or a readmission following events described in §40.3.2. Services on and after this day are included in the PPS rate and cannot be billed by other providers and suppliers unless excluded as described in this chapter.

40.3.2 - Patient Readmitted Within 30 Days After Discharge

(Rev.)

SNF-517.5, A3-3630

A patient is deemed not to have been discharged if the time between SNF discharge and readmission to the same or another SNF is within 30 days. (See the Medicare Benefit

Policy Manual, Chapter 8, "Coverage of Extended Care Services (SNF) Under Hospital Insurance," §20.2.) However, if more than 30 days elapse after the patient's discharge from a participating SNF or after his/her transfer to a nonparticipating part of the institution, the patient must again meet the 3-day hospital stay requirement to become eligible for SNF benefits.

When a discharge bill has been sent and the patient is readmitted to the SNF within 30 days, the SNF must submit another bill, which shows the current admission date and the following additional data.

- The SNF must complete condition code "57" on the claim to indicate the patient previously received Medicare covered SNF care within 30 days of the current SNF admission.
- The SNF must complete occurrence span code "70" to indicate the qualifying stay dates for a hospital stay of at least 3 days which qualifies the patient for payment of the SNF level of care services billed on the claim.

If a discharge bill has not been sent at the time of readmission, the SNF must submit an interim bill with occurrence code "74" to show the from/through dates of the leave of absence, the period the patient was not in the facility, and the number of noncovered days.

40.3.3 - Same Day Transfer

(Rev.)

A3-3610.5, A3-3620, SNF-517.6

The day of admission counts as a utilization day except in the situation where the patient was admitted with the expectation that he remain overnight but was transferred to another participating provider before midnight of the same day. In this instance, the first provider completes the bill as follows:

- Indicate "1" in Covered Days;
- Insert condition code "40" to indicate the patient was transferred from one participating provider to another before midnight on the day of admission; and,
- Admission date, statement "from" and "through" dates are the same.

The provider to which the patient was transferred counts the admission day as a utilization day that includes the day of admission.

Both providers may bill for accommodation and ancillary charges.

This general rule applies to transfers between SNFs and between a hospital and an SNF. However, under these same circumstances, if the two providers represent an institution

composed of a participating hospital and a distinct part participating SNF, the first provider cannot bill for accommodations, but may bill for ancillary charges.

40.3.4 - Day of Discharge, Death or Leave of Absence

(Rev.)

SNF-517.6, SNF-515.4 (transmittal 368)

The beneficiary is considered discharged from the SNF when any of the following occur:

- The beneficiary is admitted as an inpatient to a Medicare participating hospital or critical access hospital or admitted as a resident to another SNF. Even if the beneficiary returns to the SNF by midnight of the same day, the beneficiary is considered discharged, and the admitting hospital or critical access hospital is responsible for billing. This is because these settings represent situations in which the admitting facility has assumed responsibility for the beneficiary's comprehensive health care needs.

The SNF should submit a discharge bill, and if the patient is readmitted to the SNF, the SNF should submit a new type of bill (TOB) 211.

Medicare systems are set up so that the SNF need not submit a discharge bill when the situation is that the beneficiary (who leaves the SNF and then returns by midnight of the same day) receives outpatient services from a Medicare participating hospital, CAH, or other appropriate provider during his/her absence. Edits allow hospitals and critical access hospitals to bill for these services for a SNF PPS inpatient. Receipt of outpatient services from another provider does not normally result in SNF discharge.

Bills for excluded services (identified in [§20.3](#) of this chapter) rendered by participating hospitals, CAHs, or other appropriate providers may be paid to the rendering provider in addition to the PPS payment made to the SNF. Other outpatient services furnished to a SNF PPS inpatient by another provider/supplier must be billed by the SNF. Home health or outpatient services provided during a leave of absence do not affect the leave and no discharge bill is required.

- Home health services are not payable unless the patient is confined to his home, and under Medicare regulations a SNF cannot qualify as a home. Where the beneficiary receives services from a home health agency, the home health agency is responsible for billing.
- The beneficiary is formally discharged or otherwise departs for reasons other than described in the bullets above. However, if the beneficiary is readmitted or returns by midnight of the same day, he is not considered discharged and the SNF is responsible for billing for services during the period of absence, unless such services are otherwise excluded from SNF PPS or are excluded from Medicare coverage. In this context, a patient "day" begins at 12:01 a.m. and ends the following midnight, so that the phrase "by midnight of the same day" refers to the

midnight that immediately follows the actual moment of departure from the SNF, rather than the midnight that immediately precedes it.

NOTE: This instruction only applies to Medicare fee-for-service beneficiaries in a participating SNF.

40.3.5 - Determine Utilization on Day of Discharge, Death, or Day Beginning a Leave of Absence

(Rev.)

SNF-517.6.B, A3-3103.4

Generally, the day of discharge, death, or a day on which a patient begins a leave of absence, is not counted as a utilization day. (See the Medicare Benefit Policy Manual, Chapter 3, "Duration of Covered Inpatient Services.") This is true even where one of these events occurs on a patient's first day of entitlement or the first day of a provider's participation in the Medicare program. In addition, a benefit period may begin with a stay in a hospital or SNF, on that day.

The exception to the general rule of not charging a utilization day for the day of discharge, death, or day beginning a leave of absence is where the patient is admitted with the expectation that he will remain overnight but is discharged, dies, or is transferred to a nonparticipating provider or a nonparticipating distinct part of the same provider before midnight of the same day. In these instances, such a day counts as a utilization day. This exception includes the situation where the beneficiary was admitted (with the expectation that he would remain overnight) on either the first day of his entitlement or the provider's first day of participation, and on the same day he was discharged, died, or transferred to a nonparticipating provider.

Payment is not made under PPS unless a covered day can be billed. Also, if no-payment is possible under PPS, billing is not allowed for ancillary services. Ancillary charges for these days have been included in the PPS rates for days that can be billed.

When a patient is discharged on the first day of a provider's participation or the first day of the patient's entitlement, complete the bill as follows:

- Admission date is the actual date of admission;
- From date of service is the date the patient became entitled or date the SNF began participation; and
- The number of noncovered days = 1.

40.3.5.1 - Day of Discharge or Death Is the Day Following the Close of the Accounting Year

(Rev.)

SNF-517.2

Where the day of discharge or death is the day following the close of the cost reporting period, the ancillary charges for services rendered on that day must be included in the bill submitted for services in the prior accounting year, which includes the covered days for the billing period in that year. In such cases, "Statement Covers Period", should show the date of discharge or death as the through date. The "Patient Status" should reflect the date of discharge or death, as appropriate. The SNF uses the same billing method when developing accrued non-Medicare charges. For cost settlement purposes, ancillary charges incurred in the new fiscal year, but billed under the prior fiscal year, are considered charges for the prior fiscal year.

PPS payment is for the number of covered days shown on the bill.

40.3.5.2 - Leave of Absence

SNF-517.4

(Rev.)

A leave of absence for the purposes of this instruction is the 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 leave of absence days are shown as zero on the bill, and the SNF cannot bill the beneficiary for them. Occurrence span code 74 is used to report the leave of absence from and through dates. The electronic data elements are shown in the following chart. Refer to the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-92 Data Set," for further information about billing, including UB-92 data elements and the corresponding fields in electronic billing records.

Data Element	UB-92 For Locator	ASC X12N 837 ver. 3051	ASC X12N 837 ver. 4010
Revenue code 018X	FL 42	2-395 SV201	2400 SV201
Revenue code units	FL 46	2-395 SV205	2400 SV205
Revenue code charges	FL 47	2-395 SV203	2400 SV203
Occurrence code 74	FL 32, FL 33, FL 34, and FL 35	2-225.C HI01-02 through HI12-02	2300 HI01-02 through HI12
Occurrence code Date	FL 32, FL 33, FL 34, and FL 35	2-225.C HI01-04 through HI07-04	2300 HI01-04 through HI12
Patient Status	FL22	2-140 CL103	2300 CL103

Where the patient does not return from a leave of absence, regardless of the reason, the SNF must submit a discharge bill showing the date of discharge as the date the individual actually left. If the patient status was reported as "30" (still patient) on an interim bill and the patient failed to return from a leave of absence within 30 days, including the day leave began, or has been admitted to another institution at any time during the leave of absence, the SNF must submit an adjustment request to correctly indicate the day the patient left as the date of discharge. (A beneficiary cannot be an inpatient in two institutions at the same time.) This closes the open admission on the patient's utilization record.

NOTE: Home health or outpatient services provided during a leave of absence do not affect the leave and no discharge bill is required.

EXAMPLE 1

The beneficiary goes on a leave of absence on January 3, expecting to return on January 10. On January 6, the SNF receives word that the patient died on January 5. The SNF submits a discharge bill showing January 3 as the date of discharge.

EXAMPLE 2

The beneficiary goes on a leave of absence on February 6, expecting to return on February 12. However, the beneficiary does not return on February 12 as expected, and

the SNF cannot determine whether the beneficiary will return. The SNF submits a discharge bill showing February 6 as the date of discharge as soon as practical, or after 30 days have elapsed from the day the leave began. If an interim bill had been submitted showing the beneficiary in "still patient" status (FL22), as of February 6 or later, the SNF submits an adjustment bill showing February 6 as the discharge date. The advantage of delaying the discharge bill for 30 days is that it will make unnecessary a new admission in the event the beneficiary returns before 30 days have elapsed.

EXAMPLE 3

The beneficiary goes on a leave of absence on March 4, and is expecting to return April 1 but does not. The SNF submits a discharge bill showing March 4 as the date of discharge since the beneficiary did not return within the 30-day period.

40.4 - Accommodation Charges Incurred in Different Accounting Years

(Rev.)

SNF-517.1

The SNF must not put accommodation charges incurred in different accounting years on the same bill. (See [§40.3.5.1](#) when billing for ancillary charges for services furnished on the day of discharge or death when it is also the day after the end of the accounting year.) At the end of the accounting year, the SNF must submit a bill that contains the charges for all services furnished to the patient since the last bill and through the end of that year. They show services furnished in the following accounting year on a separate bill.

40.5 - Billing Procedures for Periodic Interim Payment (PIP) Method of Payment

(Rev.)

SNF-517.7

SNFs using the PIP method of payment follow the regular billing instructions in Medicare Claim Processing Manual, Chapter 26, "Instructions for Completing UB-92 and Related ANSI 12 Formats."

See the Medicare Claims Processing Manual, Chapter 1, "General Billing Requirements," §80.4, for requirements SNFs must meet and intermediaries must monitor to continue PIP reimbursement. Refer to the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-92 Data Set," for further information about billing, as it contains UB-92 data elements and the corresponding fields in the electronic record.

40.6 - Total and Noncovered Charges

(Rev.)

SNF-517.9

For each cost center for which a separate charge is billed (type of accommodation or ancillary), a revenue code is assigned. The appropriate numeric revenue code is entered in FL 42 to explain each charge in FL 47.

Additionally, there is no fixed "Total" line in the charge area. Instead, revenue code "0001" is always entered last in FL 42. Thus, the adjacent charge entry, in FL 47, is the sum of charges billed. This is also the same line on which noncovered charges, if any, in FL 48, are summed.

The total charge for all services, covered and noncovered, will generally be shown. See [§40.6.1](#) below, for certain exceptions. In the "Noncovered Charges" column (FL48) enter the amount of any noncovered charge except where:

- The intermediary has notified the SNF that payment can be made under the limitation of liability provisions; and
- A payer primary to Medicare is involved. (See the Medicare Secondary Payer [MSP] Manual, Chapter 3, "MSP Provider Billing Requirements" and Chapter 4, "Contractor Prepayment Processing Requirements.")

Where a bill is submitted for a period including both covered and noncovered days (e.g., benefits exhausted during billing period), the SNF must list the charges for noncovered days under noncovered charges. See [§50](#) below for instructions on submitting bills for noncovered days. Refer to the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-92 Data Set," for further information about billing, as it contains UB-92 data elements and the corresponding fields in the electronic record.

40.6.1 - Services in Excess of Covered Services

(Rev.)

SNF-517.10

Where items and services are furnished which are more expensive or in excess of the services covered by the program, the SNF will make the following entries in the Total Charges and Noncovered fields on the bill:

- If the patient did not request such excess or more expensive services, the patient may not be charged for them, and only the services covered by the program are shown in total charges. No entry is made in noncovered charges in this situation. (However, where all patients are routinely billed for such excess or more

expensive items, total charges **may** reflect the excess items or services as discussed in Total and Noncovered Charges, above.);

- If the patient did request such excess or more expensive services, the SNF may charge the patient for them. In this case, the SNF will complete FL 47 to show the line item total charge (any customary charges covered by the program plus the excess charges). The excess charges that will be billed to the patient are shown in FL 48 (Noncovered charges.);
- In the same situation as above, except that the SNF will not bill the patient for the excess services, they show only the customary charges for covered services in FL 47 (Total Charges) and make no entry in FL 48 (Noncovered Charges).

40.6.2 - Showing Discounted Charges

(Rev.)

SNF-517.11

SNFs do not show credit or minus entries on the bill. Where the SNF gives a discount to some patients, they show charges in one of two ways:

1. SNFs show the charges as the full, undiscounted charge if full undiscounted charge data is accumulated for all patients for the purposes of the final cost report; or
2. They show the discounted charges as the only charges, if the SNF, for the purposes of the final cost report, accumulates charges for all patients at the discounted rate.

40.6.3 - Reporting Accommodations on the Claim

(Rev.)

SNF-517.12

See the Medicare Benefit Policy Manual, Chapter 1, "Inpatient Hospital Services" for an explanation of the rules when other than semi-private accommodations are furnished that apply to SNFs as well as hospitals. The type of accommodation furnished at the time of the SNF census-taking hour determines the applicable revenue code. Where a patient is admitted with the expectation that he will remain overnight, but on the same day is discharged, dies, or is transferred prior to the census, the revenue code is determined by the type of accommodation furnished at the time of the patient's discharge, death, or transfer.

Payment is based on the PPS rate, not on accommodation levels. See [§40.6.1](#) where the patient requests more expensive accommodations or patient convenience items.

The determination of charges does not affect the determination of inpatient utilization days or when a patient may be considered an inpatient for Medicare purposes as outlined in the Medicare Benefit Policy Manual, Chapter 8, "Coverage of Extended Care (SNF) Services Under Hospital Insurance," §50 and §60.2. Refer to the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-92 Data Set" for further information about billing, as it contains UB-92 data elements and the corresponding fields in the electronic record.

SNFs submit charges for accommodation for the entire period covered by the billing period in FL 47 (Total Charges) and charges for any noncovered days in FL 48 (Noncovered Charges.)

The accommodation days do not include the day of death or discharge, even where the discharge was late. However, where the SNF customarily makes an extra charge for a late discharge, they include this amount in FL 47 (Total Charge) opposite the appropriate accommodation revenue code. The day of discharge is not included in "FL 47 Covered Days" even though an extra charge is included in FL 47 (Total Charges) opposite the accommodation revenue code. Where the late discharge was for the patient's convenience and not for any medical necessity, SNFs enter the charge for late discharge in FL 48 (Noncovered) as a noncovered charge. Where the late discharge is for a medical reason, the charge is covered. (See the Medicare Benefit Policy Manual, Chapter 8, "Coverage of Extended Care (SNF) Services Under Hospital Insurance," §60.3.)

The charges for accommodations reflect only the total charges for general routine services as defined in §2202.6 and §2203.1 of the Provider Reimbursement Manual. All charges, which are charged to every patient for every patient day, are included in the routine accommodation charge.

SNFs bill ancillary charges for day of discharge, death or the day on which a leave of absence begins, under the proper revenue code.

Where the patient is discharged on his first day of entitlement or the first day of the SNF participation in the Medicare program, they submit a billing form with no accommodation charge, but with ancillary charges.

Where some of the days cannot be paid under Part A because benefits were exhausted before discharge, death, or the day on which a leave of absence began, SNFs show the charges for days after benefits were exhausted under noncovered charges, and enter the appropriate occurrence code, e.g. A3, and the date benefits are exhausted. See the Medicare Claims Processing Manual, Chapter 7, "SNF Part B Billing," §10, for billing under Part B in such circumstances.

40.6.4 - Bills with Covered and Noncovered Days

(Rev.)

SNF-525, A3-3620

Any combination of covered and noncovered days may be billed on the same bill. It is important to record a day or charge as covered or noncovered because of the following:

- Beneficiary utilization is recorded based upon days during which the patient received hospital or SNF accommodations, including days paid by Medicare and days for which the provider was held liable for reasons other than medical necessity or custodial care.
- The provider may claim credit on its cost report only for covered accommodations, days and charges for which actual payment is made. Provider liable days and charges are not included on the cost report. Data from the bill payment process are used in preparing the cost report.

SNFs show non-covered charges for denied or non-covered days, which will not be paid. The SNF submits the bill with occurrence span code 76 and the from/through dates to report periods where the beneficiary is liable. Occurrence span code 77 is used to report periods of non-covered care where the SNF is liable. Occurrence code A3 is used to indicate the last date for which benefits are available or the date benefits were exhausted.

The intermediary will use Occurrence span code 79 (a payer only code sent to CWF) to report periods of non-covered care due to lack of medical necessity or custodial care for which the provider is held liable. Periods of beneficiary liability and provider liability may be reported on one bill. Report all non-covered days.

Where the SNF stay begins as non-covered and ends as covered, only one bill is required. Since the bill will include a covered stay, SNFs complete it fully.

See the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-92 Data Set" for a complete description of Form CMS-1450, electronic formats UB-92, and X12N data elements. A crosswalk of the form data elements and related format data elements is found in that chapter. See the Medicare Claims Processing Manual, Chapter 30, "Limitation on Liability" for determining SNF liability.

The provider is always liable unless the appropriate "Notice of Non-Coverage" is issued to the beneficiary or appropriate family member or representative. If the SNF issues the appropriate "Notice of Non-Coverage," and the beneficiary agrees to make payment either personally or through a private insurer, the days will not be charged towards the 100-day benefit period.

40.6.5 - Notification of Limitation on Liability Decision

(Rev.)

SNF-517.8

Detailed instructions and application of limitation on Liability is found in The Medicare Claims Processing Manual Chapter 30 - Limitation on Liability. The limitation on liability decision is made by the intermediary when the medical evidence and admission notice, or the bill is submitted. When coverage is denied, notification will be by telephone, if possible, so written notice can be provided to the patient immediately. When it is determined during the course of a beneficiary's stay in an SNF that the care is not covered but both the beneficiary and the SNF are entitled to limitation on liability, the Medicare program may make payment for the noncovered services for a grace period of 1 day (24 hours) after the date of notice to you or to the beneficiary, whichever is earlier. If it is determined that more time is required in order to arrange post-discharge care, up to 1 additional "grace period" day may be paid for.

Limitation of liability may apply to Part A and Part B services furnished by the provider.

40.7 - Other Billing Situations

(Rev.)

SNF-517.3, SNF-526.3, SNF-527, A3-3624, HO-411, A3-3630.1, A3-3630.4, A3-3620, 526.3, SNF-527, SNF-527.1, A3-3624, HO-411, A3-3624.B

A - No Payment Bills

A hospital or SNF is required to submit a bill 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 are known as no-payment bills. A hospital or SNF must submit a no-payment bill every thirty days and also when there is a change in the level of care regardless of whether the no-payment days will be paid by Medicaid or a supplemental insurer. When a change in level of care occurs after exhaustion of a beneficiary's covered days of care, the provider must submit the no-payment bill in the next billing cycle.

See the Medicare Claims Processing Manual, Chapter 3, "Inpatient Hospital Billing," §40.4.1, for billing instructions and situations requiring a no-payment bill. See §40.4.2 of the same chapter for intermediary processing instructions.

Refer to the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-92 Data Set" for further information about billing, as it contains UB-92 data elements and the corresponding fields in the electronic record.

Where payment may be made for part of the services, one bill is prepared covering payable **and** nonpayable days and services.

A noncovered bill with condition code 21 indicates a request for a Medicare denial notice. The bill is submitted to obtain a denial notice for Medicaid or another insurer.

Do not send a no-payment discharge bill where the patient has Part B entitlement only.

B - Demand Bills

SNF-526, SNF-526.1, A3-3630.1, SNF-526.2, A3-3630.

Where the SNF believes that a covered level of care has ended but the beneficiary disagrees, they report occurrence code 21 (UR Notice Received) or 22 (active care ended) as applicable and condition code 20 indicating the beneficiary believes the services are covered beyond the occurrence date. The SNF reports the days and charges after the occurrence code 21 or 22 date as noncovered.

See the Medicare Claims Processing Manual, Chapter 1, "General Billing Requirements," §60, for additional instruction on advance beneficiary notices and demand bills.

Refer to the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-92 Data Set," for further information about billing, as it contains UB-92 data elements and the corresponding fields in the electronic record.

C - Request for Denial Notice for Other Insurer

SNFs complete a noncovered bill and enter condition code 21 to indicate a request for a Medicare denial notice. Refer to Chapter 25, "Completing and Processing the UB-92 Data Set," for further information about billing, as it contains UB-92 data elements and the corresponding fields in the electronic record.

D - Another Insurer is Primary to Medicare

See the Medicare Secondary Payer (MSP) Manual, Chapter 3, "MSP Provider Billing Requirements" and Chapter 5, "Contractor Prepayment Processing Requirements" for submitting claims for secondary benefits to Medicare. Refer to the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-92 Data Set," for further information about billing, as it contains UB-92 data elements and the corresponding fields in the electronic record.

50 - SNF Payment Bans Effect on Utilization Days and Benefit Period

(Rev.)

Under the Act at [§§1819\(h\)](#) and [1919\(h\)](#) and CMS' regulations at [42 CFR 488.417](#), CMS may impose a denial of payment for new admissions (DPNA) against a SNF when a facility is not in substantial compliance with requirements of participation. For policy

detail , see the Medicare Benefit Policy Manual, Chapter 8, "Coverage of Extended Care (SNF) Services Under Hospital Insurance," §§80.

Payment sanctions are applied to days that would otherwise be Part A-payable; i.e., the care is covered but no-payment will be made to the provider. Therefore, if the Medicare-participating SNF assumes responsibility for the beneficiary's costs during the sanction period, it will be considered the same as a program payment, and the days will count towards the 100-day benefit period.

A beneficiary's care in an SNF met the skilled level of care standards if a Medicare SNF claim for the services provided in the SNF was denied on grounds other than that the services were not at a skilled level of care. SNF days during the sanction period continue a spell of illness if the beneficiary received a skilled level of care.

The 30-day transfer requirement applies in the same manner as it would be for a beneficiary transferring between two SNFs that are not under sanction. A beneficiary may remain at a facility under sanction for a period of time and later transfer to a second SNF. Part A coverage will be available to the second SNF for all remaining days in the benefit period as long as the beneficiary meets the following conditions:

- Had a qualifying hospital stay;
- Was admitted to a Medicare-certified bed in the first (sanctioned) SNF within 30 days of the hospital discharge; and
- Is receiving a covered level of care at the time of transfer.

50.1 - Billing When Ban on Payment Is In Effect

(Rev.)

Facilities subject to a payment ban may continue to bill services for beneficiaries who are not in a Part A stay in the same way as any other SNF. However, services that would have been payable to the SNF as Part A benefits in the absence of a payment sanction must not be billed to either the FI or the carrier as Part B services.

60 - Billing Procedures for a Provider With Multiple Provider Numbers or a Change in Provider Number

(Rev.)

SNF-520, A3-3600.5

Where a hospital with sub-providers that meet provider-based criteria is assigned separate provider numbers for each sub-provider, the SNF is required to use the SNF number for all bills, beginning with the date the new number is effective.

Where there is a change of ownership (CHOW), and the new owner refuses assignment of the existing provider agreement, the old owner submits all claims for periods prior to the CHOW using the old provider number. The new owner submits claims for services rendered after the date of the CHOW using the new provider number.

Also with respect to CHOWs, the SNF submits a bill with the old provider number for the period before the change and another with the new provider number for the period after the change. The date of discharge on the first bill and the date of admission on the second bill are the same, which is the effective date of the new provider number. All subsequent billings are submitted under the new provider number.

70 - Billing for Services After Termination, Expiration, or Cancellation of Provider Agreement, or After Payment is Denied for New Admissions

(Rev.)

SNF-518

All agreements with SNFs are for a specified term of up to 12 full calendar months.

70.1 - General Rules

(Rev.)

A SNF whose provider agreement terminates, expires, or is cancelled, or is denied payment for new admissions as an option to termination for noncompliance with one or more conditions of participation, may only be paid for covered Part A inpatient services under the following conditions:

Termination (Voluntary or Involuntary)

- Payment can continue to be made for up to 30 days for covered Part A inpatient services furnished **on and after** the effective date of termination for beneficiaries who were admitted **prior** to the termination date.
 - EXAMPLE: Termination date: 9/30/86
 - Beneficiary admitted: before 9/30/86
 - Payment can be made: 9/30/86, up to and including 10/29/86

Expiration (Agreement Has Not Been Renewed)

- Payment can continue to be made for up to 30 days for covered Part A inpatient services furnished **after** the last day of the specified term of the agreement for beneficiaries who were admitted **on or before** the last day of the specified term.

EXAMPLE: Agreement expires: 9/30/86 (last date in effect)

- Beneficiary admitted: on or before 9/30/86
- Payment can be made: 10/1/86, up to and including 10/30/86

Cancellation (Cancellation Clause and SNF Has Been Formerly Notified by CMS)

- Payment can continue to be made for up to 30 days for covered Part A inpatient services furnished **after** the cancellation date for beneficiaries who were admitted **on or before** the cancellation date.

EXAMPLE: Cancellation date: 9/30/86 (last date in effect)

- Beneficiary admitted: on or before 9/30/86
- Payment can be made: 10/1/86, up to and including 10/30/86

Denial of Payments (For New Admissions)

- Payment can continue to be made for covered Part A inpatient services furnished **on or after** the effective date of denial of payments for beneficiaries who were admitted **before** the effective date of denial of payments.

EXAMPLE: Denial of payment date: 9/30/86

- Beneficiary admitted before: 9/30/86
- Payment can be made: Indefinitely

NOTE: An inpatient, who goes on leave from the SNF before or after the effective date of denial of payments for new admissions is not considered a new admission when returning from leave.

70.2 - Billing for Covered Services

(Rev.)

Upon cessation of a SNF's participation in the program, or in receiving payments for new admissions, the RO is supplied with the names and claim numbers of Medicare beneficiaries entitled to have payment made on their behalf for services in accordance with [§80.1](#).

SNFs no longer participating in the program, or in receiving payments for new admissions, continue to bill for covered services per §80.1. They continue to submit "no-payment" death, discharge and reduction from SNF level of care bills for Medicare beneficiaries admitted prior to the termination of their agreement, or prior to the denial of payments for new admissions.

70.3 - Part B Billing

(Rev.)

Following termination, expiration, or cancellation of its agreement, or **after** payment is denied for new admissions, a SNF is considered to be a "nonparticipating provider." An inpatient of such a SNF who has Part B coverage, but for whom Part A benefits have been exhausted or are otherwise not available, is entitled to payment only for those services that are covered in a nonparticipating institution. Do not bill such services furnished **on or after** the effective date of termination, or, **on or after** the effective date of denial of payments for new admissions or, in the case of expiration or cancellation of a SNF agreement, **on or after** the day following the close of such agreement, to the intermediary.

80 - Billing Related to Physician's Services

(Rev.)

SNF-502 updated with transmittal 368, SNF-275

Normally physicians are responsible for billing for their own services. However there are situations where

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 is 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 and facility based components of physician services delivered to SNF inpatients are bundled into the 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.

80.1 - Reassignment Limitations

(Rev.)

SNF-507

Assigned benefits for physician's services may not be paid to anyone other than the physician who furnished the services, except:

- To the employer of the physician who provided the service, if such physician is required as a condition of his employment to turn over his fee for the service to his employer. (See [§80.2](#) below.)
- To a facility in which the service is provided if there is a contractual arrangement between the facility and the physician furnishing the service under which only the facility can bill for the service. (See [§80.3](#) below.)
- To an organization, which furnishes health care through an organized health care delivery system (e.g., a freestanding physician clinic, or prepaid group practice prepayment plan) if there is a contractual arrangement between the organization and the physician furnishing the service under which only the organization can bill for the service.

80.2 - Payment to Employer of Physician

(Rev.)

SNF-508, SNF-510

Subject to the conditions and limitations described below, payment of Part B benefits due a physician under assignment for services furnished in a facility may be made to the facility if the facility and physician have an agreement under which only the facility may bill and receive fees or amounts charged for the services.

Form CMS-855R must be completed to describe the arrangement with the facility. This form and instructions for completing it can be downloaded from the [CMS Forms Web page](#). See the Medicare Program Integrity Manual for processing instructions after completion.

The contractual arrangement between the facility and a physician may apply to all services the physician furnishes in the facility, or merely to a particular category of services that is clearly distinguishable from other categories. The distinction between the categories must be consistent with proper determination of Part B reimbursement and may not be based on whether the patient has Medicare.

While the law permits physicians to reassign to a facility the Part B benefits for the patient care services they perform in the facility, this exception in favor of the facility is intended to apply to an arrangement in which the facility obtains a significant degree of

control or interest in the disposition of the benefits. Under the law, Medicare benefits cannot be paid to a facility under terms which make the facility a mere conduit for payment to another person or entity.

EXAMPLE

Under an agreement between a facility and a partnership of teaching physicians, the facility bills and receives payment in its name for the physician services but is required to turn over to the partnership all fees received, less a small deduction to defray billing expenses. The partnership distributes the monies received among its physician members in accordance with the partnership agreement. Since the SNF functions under the agreement as a mere conduit for payment to the partnership, the agreement is not an acceptable contractual arrangement for purposes of the exception to the prohibition on reassignment.

80.3 - Information Necessary to Permit Payment to a Facility

(Rev.)

SNF-510.1

A facility may ordinarily qualify to receive Part B payment for the services of physicians in the facility by submitting a Form CMS-855R to its intermediary, certifying that it will bill for their services only as called for by its written contractual arrangements.

For purposes of Medicare benefits payable for the services, this agreement may be terminated by either party upon written notice to the other, but such termination is not binding upon Medicare until two weeks after the contractor receives a revised Form CMS-855R notice of this termination.

80.4 - Services Furnished Within the SNF

(Rev.)

SNF-510.2

The term "facility" is limited for purposes of furnishing services to individuals as inpatients, e.g., hospitals, university medical centers that own and operate hospitals, SNFs, nursing homes, homes for the aged, or other institutions of a similar nature. Physician services furnished outside the physical premises of the facility are considered furnished in the SNF if furnished in connection with services received by patients in the SNF. For example, if SNF inpatients are taken to the private office of a neurologist for necessary tests such as an encephalograph, the services are considered performed in the SNF for billing and payment.

A provider may have others furnish certain covered items and services to their patients through arrangements under which receipt of payment by the provider for the services discharges the liability of the beneficiary or any other person to pay for the service. In

permitting providers to furnish services under arrangements, it is not intended that the provider merely serve as a billing mechanism for the other party. Accordingly, for services provided under arrangements to be covered, the provider must exercise professional responsibility over the arranged-for services. See the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, "Definitions," §10.3, for additional discussion on services furnished under arrangement.

80.5 - Billing Under Arrangements

(Rev.)

SNF-510.2

In some cases, SNFs may purchase services for their patients from a hospital "under arrangements." Such services may include a physician component. When the physician has entered into a valid contractual arrangement with the hospital in which his/her services are furnished for it to bill for the services, no additional written authorization is needed for SNFs to bill for his/her services. For example, where SNFs arrange to obtain an EKG interpretation from Hospital B, and Hospital B has a valid contractual arrangement with its cardiologist authorizing it to bill for his/her services, SNFs do not need written authorization from the cardiologist to bill Medicare for the cost of the services.

See the Medicare Benefit Policy Manual, Chapter 8, "Coverage of Extended Care (SNF) Services Under Hospital Insurance," §70.4, for additional information on services under arrangements.

80.6 - Indirect Contractual Arrangement

(Rev.)

SNF-510.3

The necessary contractual arrangement between physicians and the facility in which they perform their services may exist indirectly by reason of the terms of their relationship with an employer and the employer's contractual arrangement with the facility.

EXAMPLE

A professional corporation enters into a contractual arrangement with an SNF to provide physician services for it. Under this arrangement, the SNF alone bills and receives payment for the physician services and pays the corporation a percentage of the charges. The corporation, in turn, employs several physicians to provide the services, and under the terms of their employment, is entitled to any fees payable for the services (other than the portion of the fees retained by the SNF). The combination of the two arrangements - between the SNF and the corporation and the corporation and the physicians - constitutes an indirect contractual arrangement between the SNF and the physicians. For the SNF to

bill and receive payment for the physician services furnished in the SNF, the SNF must also enter into a direct contractual arrangement with the physicians for this purpose."

80.7 - Establishing That a SNF Qualifies to Receive Part B Payment on the Basis of Reassignment

(Rev.)

SNF-512

A SNF wishing to receive Part B payment as a reassignee of one or more physicians must furnish the carrier sufficient information to establish clearly that it qualifies or does not qualify to receive payment for their services. Where there is any doubt that a SNF qualifies as a reassignee, carriers will obtain additional evidence.

In some cases, a SNF may qualify to receive payment for the services of a physician both as the employer of the physician and as the facility in which the services are performed. As soon as it is determined that a SNF can qualify on either basis, no further development is undertaken with respect to that physician or to other physicians having the same status, and reassigned claims submitted by the SNF for services furnished by those physicians are honored. However, where other physicians have, or appear to have different status, further development is required. It is possible in some instances that a determination is made that Part B payment can be made only to the physician himself.

Where the SNF qualifies as a reassignee, it assumes the same liability for any overpayments that it may receive as a reassignee as the physician would have had if the payment had been made to him/her.

90 - SNF Billing to HMOs

(Rev.)

SNF-500, PM AB-01-132

For billing to HMOs, SNFs follow the requirements of the agreement they have with the HMO. In cases where the patient may have enrolled or disenrolled from an HMO plan during the billing period, the SNF will split the bill and send the HMO portion to it and the remaining portion to the intermediary. If the intermediary is responsible for processing both portions, split the bill and send both parts to the intermediary.

90.1 - Beneficiary Involuntarily Disenrolled from Terminated Medicare+Choice (M+C) Plans

(Rev.)

PM A-01-122, PM A-02-009

Medicare will cover SNF inpatient services for beneficiaries involuntarily disenrolling from Medicare+Choice (M+C) Plans as a result of an M+C plan termination when the beneficiary has not met the 3-day prior hospital stay requirement. Intermediaries will begin counting 100 days of SNF care with the SNF admission date regardless of whether the beneficiary met the skilled level of care requirements on that date. All other Medicare rules apply, such as the requirement that beneficiaries meet the skilled level of care requirement (for the period for which the original Medicare fee-for-service program is billed) and rules regarding cost sharing apply to these cases. That is, providers may only charge beneficiaries for SNF coinsurance amounts.

SNFs submit the first fee-for-service inpatient claim with condition code "58" to indicate a patient was involuntarily disenrolled from a M+C organization and the 3-day prior stay requirement was not met. Claims with condition code "58" will not require the 3-day prior inpatient hospital stay or that the SNF admission date is within 30 days of the inpatient discharge date identified in Occurrence Span code "70" "through" date. However, if the SNF admission and from date are the same, CWF will edit to ensure the patient was enrolled with an M+C plan within 30 days prior to admission.

The intermediary must use CWF files to validate the beneficiary was enrolled in an M+C organization upon admission to the SNF and that the M+C enrollment period ended prior to the "from" date on the claim. The intermediary does not need to verify that the M+C plan was the one that terminated.

100 - SNF PPS for Hospital Swing Bed Facilities

(Rev.)

PM A-02-016

Section 4432(a) of the Balanced Budget Act (BBA) of 1997 specifies that swing bed facilities must be incorporated into the SNF PPS by the end of the statutory transition period. Effective with cost reporting periods beginning on or after July 1, 2002, swing bed bills are not paid based on the cost-related method, but rather on the basis of the SNF PPS. These payment rates cover all payment for furnishing covered swing bed extended care services (routine, ancillary, and capital-related costs) other than approved educational activities as defined in [42 CFR 413.85](#).

The SNF PPS applies to short-term hospitals, long-term care hospitals, and rehabilitation hospitals that have Medicare swing bed agreements. Critical Access Hospitals (CAHs) with swing beds are exempt from the SNF PPS, and are not affected by these instructions.

The SNF PPS is phased in based on each swing bed hospital's fiscal year. The transition to SNF PPS is effective with the start of the provider's first cost reporting period that begins on or after July 1, 2002. Consequently, billing for all beneficiaries in a swing bed must be split at the end of the provider's current fiscal year. A new bill is created for beneficiaries remaining in the facility at the start of the new fiscal year. The bill must be prepared under the SNF PPS claim guidelines described in this chapter and in Chapter 1, "General Billing Requirements." Payment is made according to the instructions for SNFs under PPS.

Providers of swing bed services submit Part A inpatient claims using type of bill (TOB) 18X.

The swing bed program does not include an inpatient Part B benefit. For beneficiaries who continue to receive extended care services after the end of a Part A stay (e.g., benefits exhausted, not receiving a skilled level of care, etc.), ancillary services may be billed under the hospital as inpatient Part B services.

If the beneficiary remains a resident in the swing bed facility after the end of the Part A stay, the hospital may submit a claim to the intermediary for those inpatient services covered by Part B using TOB 12X. The beneficiary would be eligible for the same benefits available to a hospital inpatient in a Part B stay. The hospital provider of SNF level swing bed services must also file a Part A nonpayment bill monthly using the appropriate nonpayment code.

For SNF PPS purposes, intermediaries assign swing bed hospitals to provider type 38 on their Provider-Specific File. Swing bed providers will be paid at 100 percent of the Federal rate. Swing bed claims will be paid using the actual MSA code (based on county codes), and the related rural or urban rate tables. Intermediaries must set the Federal PPS Blend Indicator in the Provider-Specific file to "4." The CMI ADJ CPD field should be blank.

Unless exceptions are noted, instructions applicable to SNFs are also applicable to swing bed providers e.g., demand bills, spell of illness, covered and noncovered days, nonpayment bills, and adjustment bills.

100.1 - Swing Bed Services Not Included in the Part A PPS Rate

(Rev.)

Providers of swing bed services are eligible for additional payment for services that are excluded from the SNF Part A consolidated billing requirements. These consolidated billing exclusions are not subject to the hospital bundling requirements specified in [§1862 \(a\)\(14\)](#) of the Act and in [42 CFR 411.15\(m\)](#). All services not specifically excluded from the SNF PPS consolidated billing requirements must be included in the Part A swing bed bill (TOB 18x).

If a swing bed hospital furnishes a service or supply to a beneficiary receiving SNF-level services, which is excluded from the SNF PPS rate, the swing bed hospital may submit a separate bill to the FI for the SNF PPS-excluded service. This bill must use TOB 13x with all appropriate revenue codes, HCPCS codes, and line item date of service billing information. A list of services that are excluded from the SNF PPS rate is found in [§§20.3](#) above.

Bills for these SNF PPS consolidated billing "exclusions" must be filed as outpatient Part B services (TOB13X) and will be paid as inpatient Part B services under the Outpatient Prospective Payment System (OPPS). Services included under the SNF PPS may not be billed separately. Swing bed hospitals may bill Part B ancillary services furnished to