CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2399	**Date: January 26, 2012**
	Change Request 7717

SUBJECT: Clarification for Skilled Nursing Facility (SNF) and Swing Bed (SB) Part A Billing - Updating System Requirements for Assessment Date Reporting and Removal of the Occurrence Code 16 Reporting Requirement

I. SUMMARY OF CHANGES: This transmittal discontinues the SNF and SB provider reporting requirement for reporting Occurrence Code 16 and updates instructions for assessment date reporting.

EFFECTIVE DATE: October 1, 2011
IMPLEMENTATION DATE: July 2, 2012

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	6/30/Billing SNF PPS Services

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2399	Date: January 26, 2012	Change Request: 7717

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EFFECTIVE DATE: **October 1, 2011**

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I. GENERAL INFORMATION

A. Background: This instruction updates current system edits and manual sections to add the following assessment indicators (AIs) that only require one Occurrence Code 50 (Assessment date reporting) for an assessment that produces two Health Insurance Prospective Payment System (HIPPS) codes required on the claim: 0A, 0B, 0C, 1A, 1B, 1C, 2A, 2B, 2C, 3A, 3B, 3C, 4A, 4B, 4C, 5A, 5B and 5C

In addition, the requirement for SNF and SB providers to report Occurrence Code 16 to indicate the last day of therapy services is discontinued. Upon release of this instruction, SNF and SB providers no longer need to report this. Chapter 6, Section 30, SNF Inpatient Part A Billing, is updated to remove this requirement in the Claims Processing Manual.

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

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7717.1	Medicare contractors shall update existing editing to allow only one occurrence code 50 be reported for 2 HIPPS code lines that both end in the same 2 digits for the following new applicable HIPPS: xxx0A, xxx0B, xxx0C, xxx1A, xxx1B, xxx1C, xxx2A, xxx2B, xxx 2C, xxx3A, xxx3B, xxx3C, xxx4A, xxx4B, xxx4C, xxx5A, xxx5B, xxx5C where 'xxx' is varying alpha-numeric characters.						X				
7717.2	Medicare contractors shall allow two occurrence code 50's on a claim with the same date of service.						X				
7717.3	Medicare contractors shall make providers aware of the clarifications provided in the updated manual sections	X		X							

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

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7717.4	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X							

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Jason Kerr, Jason.Kerr@cms.hhs.gov or Cindy Pitts, Cindy.Pitts@cms.hhs.gov

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

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

30 - Billing SNF PPS Services

(Rev.2399, Issued: 01-26-12, Effective: 10-01-11, Implementation:07-02-12)

SNFs and hospital swing bed providers are required to report inpatient Part A PPS billing data as follows. Refer to the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-04 (CMS-1450) Data Set," for further information about billing, as it contains UB-04 data elements and the corresponding fields in the electronic record:

- In addition to the required fields identified in the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-04 (CMS-1450) Data Set," SNFs must also report occurrence span code "70" to indicate the dates of a qualifying hospital stay of at least three consecutive days which qualifies the beneficiary for SNF services.

- Separate bills are required for each Federal fiscal year for admissions that span the annual update effective date (October 1.)

- Use Type of Bill 21X for SNF inpatient services or 18X for hospital swing bed services.

- Revenue Code 0022. This code indicates that this claim is being paid under the SNF PPS. This revenue code can appear on a claim as often as necessary to indicate different HIPPS Rate Code(s) and assessment periods.

- Effective for claims with dates of service on or after January, 1 2011, there must be an occurrence code 50 (assessment date) for each assessment period represented on the claim with revenue code 0022. The date of service reported with occurrence code 50 must contain the ARD. An occurrence code 50 is not required with default HIPPS code AAAxx (where 'xx' equals varying digits). In addition, for OMRA related AIs 05, 06, *0A, 0B, 0C,* 12, 13, 14, 15, 16, 17, *1A, 1B, 1C,* 24, 25, 26, *2A, 2B, 2C,* 34, 35, 36, *3A, 3B, 3C,* 44, 45, 46, *4A, 4B, 4C,* 54, 55, 56, *5A, 5B, 5C* where 2 HIPPS may be produced by one assessment, providers need only report one occurrence code 50 to cover both HIPPS codes.

- HCPCS/Rates field must contain a 5-digit "HIPPS Code". The first three positions of the code contain the RUG group and the last two positions of the code contain a 2-digit assessment indicator (AI) code. *See Chapter 6 of the MDS RAI manual* for valid RUG codes and AI codes.

- SNF and SB PPS providers must bill the HIPPS codes on the claim form in the order in which the beneficiary received that level of care.

- Service Units must contain the number of covered days for each HIPPS rate code.

  NOTE: Fiscal Intermediary Shared System (FISS) requirement:

  The sum of all covered units reported on all revenue code 0022 lines should be equal to the covered days field less the number of days reported in an OSC 77.

(Note: The covered units field is utilized in FISS and has no mapping to the 837 or paper claim).

- Total Charges should be zero for revenue code 0022.

- When a HIPPS rate code of RUAxx, RUBxx , RUCxx, RULxx and/or RUXxx is present, a minimum of two rehabilitation therapy ancillary codes are required (revenue code 042x and/or, 043x and/or, 044x). When a HIPPS rate code of RHAxx, RHBxx, RHCxx, RHLxx, RHXxx, RLAxx, RLBxx, RLXxx, RMAxx, RMBxx, RMCxx, RMLxx, RMXxx, RVAxx, RVBxx, RVCxx, RVLxx, and/or RVXxx is present, a minimum of one rehabilitation therapy ancillary revenue code is required (revenue code 042x, 043x, or 044x. Bills that are missing required rehabilitation therapy ancillary revenue codes are to be returned to the SNF for resubmission.

- The accommodation revenue code 018x, leave of absence is reported when the beneficiary is on a leave of absence and is not present at the midnight census taking time.

- Principal Diagnosis Code - SNFs enter the ICD-CM code for the principal diagnosis in the appropriate form locator. The code must be reported according to Official ICD-CM Guidelines for Coding and Reporting, as required by the Health Insurance Portability and Accountability Act (HIPAA), including any applicable guidelines regarding the use of V codes. The code must be the full ICD-CM diagnosis code, including all five digits where applicable.

- Other Diagnosis Codes Required – The SNF enters the full ICD-CM codes for up to eight additional conditions in the appropriate form locator. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in the ICD-CM guidelines.

NOTE: Information regarding the form locator numbers that correspond to these data element names and a table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25.