CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3230	**Date: April 3, 2015**
	Change Request 8997

Transmittal 3216, dated March 13, 2015, is being rescinded and replaced by Transmittal 3230 to delete sections 30.5.1, 30.6 and 30.7 in Chapter 6 as this information has been reorganized to sections 30.3, 30.4 and 30.5, respectively. All other information remains the same.

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

I. SUMMARY OF CHANGES: This instruction updates various sections of the internet-only manual chapters in regards to SNF policy and billing.

EFFECTIVE DATE: June 15, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 15, 2015

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/Table of Contents
R	6/20.1.1.2/Hospital's "Facility Charge" in Connection with Clinic Services of a Physician
R	6/20.1.2/Other Excluded Services Beyond the Scope of a SNF Part A Benefit
R	6/20.4/Screening and Preventive Services
R	6/20.6/SNF CB Annual Update Process for Part A MACs
R	6/30.1/Health Insurance Prospective Payment System (HIPPS) Rate Code
R	6/30.2/Coding PPS Bills for Ancillary Services
R	6/30.3/Adjustment Requests
R	6/30.4/SNF PPS Pricer Software
N	6/30.4.1/Input/Output Record Layout

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N	6/30.4.2/SNF PPS Rate Components
N	6/30.4.3/Decision Logic Used by the Pricer on Claims
R	6/30.5/Annual Updates to the SNF Pricer
D	6/30.5.1/Adjustments Requests
D	6/30.6/SNF PPS Pricer Software
D	6/30.6.1/Input/Output Record Layout
D	6/30.6.2/SNF PPS Rate Components
D	6/30.6.3/Decision Logic Used by the Pricer on Claims
D	6/30.7/Annual Updates to the SNF Pricer
R	6/40.3.5.2/Leave of Absence
R	13/Table of Contents
R	13/90.5/Transportation of Equipment Billed by a SNF to a MAC

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

IV. ATTACHMENTS:
Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3230	Date: April 3, 2015	Change Request: 8997

Transmittal 3216, dated March 13, 2015, is being rescinded and replaced by Transmittal 3230 to delete sections 30.5.1, 30.6 and 30.7 in Chapter 6 as this information has been reorganized to sections 30.3, 30.4 and 30.5, respectively. All other information remains the same.

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

EFFECTIVE DATE: June 15, 2015

**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 15, 2015

I. GENERAL INFORMATION

A. Background: This Change Request (CR) updates chapters 6 and 13 of Pub 100-04, the Medicare Claims Processing Manual.

B. Policy: N/A

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8997 - 04.1	Medicare contractors shall be aware of the revisions to Pub 100-04, Chapters 6 and 13.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8997 - 04.2	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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 sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's 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				

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

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

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

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

immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 6 - SNF Inpatient Part A Billing and SNF Consolidated Billing

Table of Contents

(Rev. 3230, Issued: 04-03-15)

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

(Rev. 3230, Issued: 04-03-15, Effective: 06-15-15, Implementation: 06-15-15)

As noted above in section 20.1.1, physician services are excluded from Part A PPS payment and the requirement for consolidated billing. When a beneficiary receives clinic services from a hospital-based physician, the physician in this situation would bill his or her own professional services directly to the Part B *MAC* and would be reimbursed at the facility rate of the Medicare physician fee schedule--which does not include overhead expenses. The hospital historically has submitted a separate Part B "facility charge" for the associated overhead expenses to its *Part A MAC*. The hospital's facility charge does not involve a separate service (such as a diagnostic test) furnished in addition to the physician's professional service; rather, it represents solely the overhead expenses associated with furnishing the professional service itself. Accordingly, hospitals bill for "facility charges" under the physician evaluation and management (E&M) codes in the range of 99201-99245 *and G0463 (for hospitals paid under the Outpatient Prospective Payment System).*

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

NOTE: Unless otherwise excluded in one of the Five Major Categories for billing services to FIs, physician services codes are to be billed to the carrier by the physician. Facility charges associated with the physician's clinic visit must be reported as explained above.

20.1.2 - Other Excluded Services Beyond the Scope of a SNF Part A Benefit

(Rev. 3230, Issued: 04-03-15, Effective: 06-15-15, Implementation: 06-15-15)

The following services are not included in Part A PPS payment when furnished in a Medicare participating hospital or CAH and may be paid to the provider rendering them.

This exception does not apply if the service is furnished in an ambulatory surgical center (ASC) or other independent (non-hospital) facility, because it specifically addresses those services that are so far beyond the normal scope of SNF care as to require the intensity of the hospital setting in order to be furnished safely and effectively. In transmittals for *Part A and B institutional* billing providing the annual update list of HCPCS codes affected by SNF consolidated billing, such services are referred to as " Major Category I" of SNF consolidated billing editing. Note that of the types of services listed, only ambulatory surgeries are listed as inclusions, rather than exclusions, to consolidated billing.

- 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 or comparable hospital facilities (i.e., the use of a gastrointestinal (GI) suite or endoscopy suite for the insertion of a percutaneous esophageal gastrostomy (PEG) tube); For Part A inpatients, the professional portion of these services is billed by the rendering practitioner to the carrier. Any hospital outpatient charges are billed to the FI.
- Certain radiation therapies;

- Certain angiographies, and lymphatic and venous procedures;
- Emergency services; and
- Ambulance services when related to an excluded service within this list (see §20.3 of this chapter for ambulance transportation related to dialysis services).

These relatively costly services are beyond the general scope of care in SNFs, and their receipt has the effect of temporarily suspending a beneficiary's status as an SNF "resident" for CB purposes with respect to such services. 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 excluded 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 FI for the services. Excluded services provided to Medicare beneficiaries in swing beds subject to SNF PPS are to be billed on TOB 13x by the swing bed hospital.

Services directly related to these services, defined as services billed for the same place of service and with the same line item date of service as the services listed below, are also excluded from SNF CB, with exceptions as listed below.

- Note that anesthesia, drugs incident to radiology and supplies (revenue codes 037x, 0255, 027x and 062x) will be bypassed by enforcement edits when billed with CT Scans, Cardiac Catheterizations, MRIs, Radiation Therapies, or Angiographies or surgeries.

In general, bypasses also allow CT Scans, Cardiac Catheterization, MRI, Radiation Therapy, Angiography, and Outpatient Surgery HCPCS codes 0001T – 0021T, 0024T – 0026T, or 10021 - 69990 (*except those HCPCS codes listed in Major Category I. F.*) to process and pay. This includes all other revenue code lines on the incoming claim that have the same line item date of service (LIDOS).

20.4 - Screening and Preventive Services

(Rev. 3230, Issued: 04-03-15, Effective: 06-15-15, Implementation: 06-15-15)

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. Accordingly, this benefit does not encompass screening services (which serve to check a member of an at-risk population for the possible presence of a specific latent condition, before it manifests any overt symptoms to diagnose or treat) or preventive services (which are aimed at warding off the occurrence of a particular condition altogether rather than diagnosing or treating it once it occurs). Coverage of screening and preventive services (e.g., screening mammographies, pneumococcal pneumonia vaccine, influenza vaccine, hepatitis *B* vaccine) is a separate Part B inpatient benefit when rendered to beneficiaries in a covered Part A stay and is paid outside of the Part A payment rate. For this reason, screening and preventive services must not be included on the global Part A bill. However, screening and preventive services 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 submits a separate Part B inpatient bill for them rather than including them on its global Part A bill. Screening and preventive services must be billed with a 22X type of bill. Swing Bed providers must use TOB 12x for eligible beneficiaries in a Part A SNF level of care. **NOTE:** For beneficiaries residing in the Medicare non-certified area of the facility, these services should be billed on a 23x type of bill. In transmittals for FI billing providing the annual update list of HCPCS codes affected by SNF consolidated billing, such services are referred to as "Major Category IV". See §10.1 above for the link to where transmittals providing current lists of HCPCS codes used for Major Category IV can be found.

There are certain limited circumstances in which a vaccine would no longer be considered preventive in nature, and this can affect how the vaccine is covered. For example, while a booster shot of tetanus vaccine would be considered preventive if administered routinely in accordance with a recommended schedule, it would not be considered preventive when administered in response to an actual exposure to the disease (such as an animal bite, or a scratch on a rusty nail). In the latter situation, such a vaccine furnished to an SNF's Part A resident would be considered therapeutic rather than preventive in nature, as its use is reasonable and necessary for treating an existing condition.

In terms of billing for an SNF's Part A resident, a vaccine that is administered for therapeutic rather than preventive purposes would be included on the SNF's global Part A bill for the resident's covered stay. Alternatively, if a vaccine is preventive in nature and is one of the three types of vaccines (i.e., pneumococcal pneumonia, hepatitis B, or influenza virus) for which a Part B benefit category exists (see §50.4.4.2 of the Medicare Benefit Policy Manual, Chapter 15), then the SNF would submit a separate Part B bill for the vaccine. (Under section 1888(e)(9) of the Social Security Act (the Act) and the implementing regulations at 42 CFR 413.1(g)(2)(ii), payment for an SNF's Part B services generally is made in accordance with the applicable fee schedule for the type of service being billed (see the Medicare Claims Processing Manual, Chapter 7, §10.5). However, when these three types of vaccines are furnished in the SNF setting, Part B makes payment in accordance with the applicable instructions contained in the Medicare Claims Processing Manual, Chapter 7, §80.1, and Chapter 18, §10.2.2.1.)

If the resident receives a type of vaccine that is preventive in nature but for which no Part B benefit category exists (e.g., diphtheria), then the vaccine would not be covered under either Parts A or B and, as a consequence, would become coverable under the Part D drug benefit. This is because priority of payment between the various parts of the Medicare law basically proceeds in alphabetical order: Part A is primary to Part B (see section 1833(d) of the Act), and both Parts A and B are primary to Part D (see section 1860D-2(e)(2)(B) of the Act).

Further, it is worth noting that unlike preventive services covered under Part B, those preventive vaccines covered under Part D are not subject to SNF CB, even when furnished to an SNF's Part A resident. This is because section 1862(a)(18) of the Act specifies that SNF CB applies to ". . . covered skilled nursing facility services described in section 1888(e)(2)(A)(i) . . . ." Section 1888(e)(2)(A)(i) of the Act, in turn, defines "covered skilled nursing facility services" specifically in terms of (I) Part A SNF services, along with (II) those non-excluded services that (if not for the enactment of SNF CB) would be types of services ". . . for which payment may be made under Part B . . ." (emphasis added).

Formerly, bone mass measurement (screening) was listed as a preventive service excluded from SNF consolidated billing. This was incorrect. Such services are diagnostic, not screening, procedures, and therefore are bundled into SNF PPS payment and subject to consolidated billing.

20.6 - SNF CB Annual Update Process for *Part A MACs*

(Rev. 3230, Issued: 04-03-15, Effective: 06-15-15, Implementation: 06-15-15)

Barring any delay in the Medicare Physician Fee Schedule, CMS will provide the new Annual Update code file to CWF by November 1. Should this date change, CWF will be notified through the appropriate mechanism. All future updates will be submitted via a Recurring Update Notification form. These Recurring Update Notifications also describe how the changes will be implemented.

The CWF contractor shall compare the new code list for Major Categories I through V to the codes in the current edits. Codes that appear on the new list, but not in the current edit, shall be added to the edit.

CMS will make a determination as to which codes should be deleted from which edits. This mechanism will allow for any changes in professional component/technical component designations to be correctly coded for

edits and for deleted codes and codes no longer valid for Medicare purposes as of the end of the calendar year, to continue to pay correctly for prior dates of service.

CMS will respond to the list provided by the CWF contractor and provide the determination on the codes to the CWF contractor.

The CWF contractor will delete codes from the edits per the CMS determination.

Part A MACs, *a term used to indicate both Part A and Part B institutional services*, shall continue to respond to rejects and unsolicited responses received from CWF per current methodology. *Part A* MACs shall reopen and reprocess any claims brought to their attention for services that prior to this update were mistakenly considered to be subject to consolidated billing and therefore, not separately payable. *Part A* MACs need not search claims history to identify these claims. Prior to January 1 of each year, a new code file will be posted to the CMS Web site at: http://www.cms.hhs.gov/SNFConsolidatedBilling/. Should this date change, *A* MACs will be notified through the appropriate mechanism.

Coding changes throughout the year may also be made as necessary through a quarterly update process.

As soon as the new code file is posted to the CMS Web site, through their Web sites and list serves, *Part A* MACs shall notify providers of the availability of the new file.

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

(Rev. 3230, Issued: 04-03-15, Effective: 06-15-15, Implementation: 06-15-15)

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

SNFs must use the version of the Grouper software program identified by CMS for national PPS as described in the Federal Register for that year. The Grouper translates the data in the Long Term Care Resident Instrument into a case-mix group and assigns the correct RUG code. Effective for dates of service on or after October 1, 2010, the Grouper will automatically assign the 2-digit AI.

Providers may access the following link for HIPPS code information:
http://www.cms.hhs.gov/ProspMedicareFeeSvcPmtGen/02_HIPPSCodes.asp#TopOfPage

The above link includes documents that contain the complete list of RUG codes and AIs billed for Part A SNF stays. Definitions and usage of each code are included. In addition, a master file of all valid/termed HIPPS codes is provided.

The HIPPS rate code that appears on the claim must match the assessment that has been transmitted and accepted by the State in which the facility operates. The SNF may bill the program only after:

- An assessment has been completed and submitted to the State RAI Database;
- A Final Validation Report indicating that the assessment has been accepted by the state; and
- The covered day has actually been used.

SNFs that submit claims that have not completed this process will not be paid. It is important to remember that the record will be accepted into the State RAI database, even if the calculated RUG code differs from the submitted values. The error will be flagged on the final validation report by issuing a warning message and listing the correct RUG code. When such discrepancies occur, the RUG code reported on the Final Validation Report shall be used for billing purposes.

30.2 - *Coding PPS Bills for Ancillary Services*

(Rev. 3230, Issued: 04-03-15, Effective: 06-15-15, Implementation: 06-15-15)

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.*
- *For therapy services, that is revenue codes 042x, 043x, and 044x, units represent the number of calendar days of therapy provided. For example, if the beneficiary received physical therapy, occupational therapy or speech-language pathology on May 1, that would be considered one calendar day and would be billed as one unit.*
- *SNFs are required to report the actual charge for each line item, in Total Charges.*

30.3 - Adjustment Requests

(Rev. 3230, Issued: 04-03-15, Effective: 06-15-15, Implementation: 06-15-15)

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

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 FISS 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 Medicare Program Integrity Manual.

30.4 – *SNF PPS Pricer Software*

(Rev. 3230, Issued: 04-03-15, Effective: 06-15-15, Implementation: 06-15-15)

The Balanced Budget Act (BBA) of 1997 (Public Law 105-33) mandated the implementation of a per diem prospective payment system (PPS) for skilled nursing facilities (SNFs), covering all costs (routine, ancillary, and capital) of covered SNF services furnished to beneficiaries under Part A of the Medicare program.

Effective for cost reporting periods beginning on or after July 1, 1998, all skilled nursing services billed on TOB 21x will be paid based on calculations made by the SNF Pricer. The SNF Pricer operates as a module within CMS' claims processing systems. The SNF Pricer makes all payment calculations applicable under SNF PPS. Medicare claims processing systems must send an input record for each HIPPS code reported on the claim to Pricer and Pricer will return an output record to the shared systems. The Pricer is available electronically to the shared systems and is updated at least annually. A PC version of the SNF Pricer Program can be found at: http://www.cms.hhs.gov/providers/pricer/default.asp?

The following describes the elements of SNF PPS claims that are used in the SNF PPS Pricer and the logic that is used to make payment determinations. No part of the Pricer logic is required to be incorporated into a SNF's billing system in order to bill Medicare. The following is presented for FIs and as information for the SNFs, in order to help SNFs understand their SNF PPS payments and how they are determined.

30.4.1 - Input/Output Record Layout

(Rev. 3230, Issued: 04-03-15, Effective: 06-15-15, Implementation: 06-15-15)

The SNF Pricer input/output file will be 250 bytes in length. The required data and format are shown below.

File Position	***Format***	***Title***	***Description***
1-4	*X(4)*	*MSA*	*Input item: The metropolitan statistical area (MSA) code. Medicare claims processing systems pull this code from field 13 of the provider specific file.*
5-9	*X(5)*	*CBSA*	*Input item: Core-Based Statistical Area*
10	*X*	*SPEC-WI-IND*	*Input item (if applicable) :Special Wage Index Indicator Valid Values: **Y** (yes) or **N** (no)*
11-16	*X(6)*	*SPEC-WI*	*Input item (if applicable): Special Wage Index*
17-21	*X(5)*	*HIPPS-CODE*	*Input Item: Health Insurance Prospective Payment System Code – Medicare claims processing systems must copy the HIPPS code reported by the provider on each 0022 revenue code line*
22-29	*9(8)*	*FROM-DATE*	*Input item: The statement covers period "from" date, copied from the claim form. Date format must be CCYYMMDD.*
30-37	*9(8)*	*THRU-DATE*	*Input item: The statement covers period "through" date, copied from the claim form. Date format must be CCYYMMDD.*
38	*X*	*SNF-FED-BLEND*	*Input item: Code for the blend ratio between federal and facility rates. For SNFs on PPS effective for cost reporting periods beginning on or*

			after 7/1/98. Medicare claims processing systems pull this code from field 19 of the provider specific file. ***Transition Codes:*** *Faci1ity % Federal %* ***1*** *75 25 (1st year)* ***2*** *50 50 (2nd year)* ***3*** *25 75 (3rd year)* ***4*** *0 100 (full fed rate)* ***NOTE****: All facilities have been paid at the full federal rate since FY 2002.*
39-45	*9(05)V9(02)*	*SNF-FACILITY RATE*	*Input item: Rate based on each SNF's historical costs (from intermediary audited cost reports) including exception payments.* ***NOTE****: All facilities have been paid at the full federal rate since FY 2002.*
46-52	*X(7)*	*SNF-PRIN-DIAG-CODE*	*Input item: The principle diagnosis code, copied from the claim form. Must be three to seven positions left justified with no decimal points.*
53-59	*X(7)*	*SNF-OTHER-DIAG-CODE2*	*Input item: Additional Diagnosis Code, copied from the claim form, if present, must be three to seven positions left justified with no decimal points.*
60-221	*Defined above*	*Additional Diagnosis data*	*Input item: Up to twenty-three additional diagnosis codes accepted from claim. Copied from the claim form. Must be three to seven positions left justified with no decimal points.*
222-229	*9(06)V9(02)*	*SNF-PAYMENT RATE*	*Output item: Calculated per diem amount received by the SNF that includes a base payment amount adjusted for local wages and the clinical characteristics of individual patients.*
230-231	*9(2)*	*SNF-RTC*	*Output item: A return code set by Pricer to define the payment circumstances of the claim or an error in input data.* ***Payment return code:*** *00 RUG III group rate returned* ***Error return codes:*** *20 Bad RUG code* *30 Bad MSA code* *40 Thru date < July 1,1998 or Invalid* *50 Invalid federal blend for that Year*

			60 Invalid federal blend *61 Federal blend = 0 and SNF Thru date < January 1, 2000*
232-250	*X(19)*	*FILLER*	*Blank*

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

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

30.4.2 – SNF PPS Rate Components

(Rev. 3230, Issued: 04-03-15, Effective: 06-15-15, Implementation: 06-15-15)

The SNF PPS rate for each RUG group consists of 3 components: a nursing component, a therapy component and a non-case-mix adjusted component. The following describes the rate components used for SNF PPS:

--The nursing per diem amount is a standard amount which includes direct nursing care and the cost of non-therapy ancillary services required by Medicare beneficiaries.

--The nursing index is based on the amount of staff time, weighted by salary levels, associated with each RUG group. This index represents the amount of nursing time associated with caring for beneficiaries who qualify for the group.

The nursing per diem amount is case-mix adjusted by applying the nursing index. The result is the nursing component for that RUG group.

--The therapy per diem amount is a standard amount which includes physical, occupational, and speech-language therapy services provided to beneficiaries in a Part A stay. Payment varies based on the actual therapy resource minutes received by the beneficiary and reported on the MDS;

--The therapy index is based on the amount of staff time, weighted by salary levels, associated with each RUG group. This index represents the amount of rehabilitation treatment time associated with caring for beneficiaries who qualify for the group.

If the RUG group is in the Rehabilitation plus Extensive Services or Rehabilitation category, the therapy per diem amount is case-mix adjusted by applying the therapy index. The result is the therapy component for that Rehabilitation RUG group.

--The non-case-mix therapy component is a standard amount to cover the cost of therapy assessments of beneficiaries who were determined not to need continued therapy services.

If the RUG group is not in the Rehabilitation plus Extensive Services or Rehabilitation category, this payment is added to the rate as therapy component for that RUG group.

--The non-case-mix component is also a standard amount added to the rate for each RUG group to cover administrative and capital-related costs.

This standard amount is added to all RUG groups.

30.4.3 - Decision Logic Used by the Pricer on Claims

(Rev. 3230, Issued: 04-03-15, Effective: 06-15-15, Implementation: 06-15-15)

The SNF Pricer shall calculate the rate for each line item with revenue code 0022 on a SNF claim. The SNF Pricer shall determine the rate using the following information:

- "HIPPS-CODE" on line item 0022;
-"CBSA"
- Per diem amounts defined within the Pricers as types of rate based on the statement covers "THRU-DATE":
Inpatient rate = Nursing case mix component
General service rate = Non-case-mix component
Therapy rate = Therapy non-case mix component
Rehabilitation rate = Therapy case-mix component
- Labor and non labor percentages based on the statement covers "THRU-DATE";
- Wage index, "SNF-FED BLEND" year, and "SNF-FACILITY RATE" based on the statement covers "THRU_DATE"
- Rate adjustments applicable to the specific RUG code;
- Nursing index based on the RUG code;
- Therapy index based on the rehabilitation RUG code;

On input records with TOB 21x (that is, all provider submitted claims and provider or FI initiated adjustments), Pricer will perform the following calculations in numbered order for each RUG code:

(1) Multiply the applicable urban or rural inpatient rate depending on CBSA by the nursing index;

(2) Multiply the applicable urban or rural rehab rate by the therapy index, add to (1);

(3) For the top 23 RUG categories, add the general service rate to the sum of (1) and (2) for the (non-wage-adjusted) total PPS rate and proceed to step (4); ***OR*** *for the lower 43 RUG categories, add the general service rate to the therapy rate to the sum of (1) and (2) for the (non-wage- adjusted) total PPS rate and proceed to step (4);*

(4) Multiply the sum of (3) by the labor percentage then multiply the product by the applicable wage index and round;

(5) Multiply the sum of (3) by the non- labor percentage and round;

(6) Add the product of (5) to the non-labor product in (4) for the (wage-adjusted) total PPS rate.

Conditional Steps completed if applicable after (6):

(6a) If diagnosis code 042 is present, multiply (6) by 2.28 and proceed to (7)– Effective October 1, 2004, for the FY 2005 Pricer, this represents the 128% AIDS adjustment implemented with Section 511 of the MMA.

30.5 *– Annual Updates to the SNF Pricer*

(Rev. 3230, Issued: 04-03-15, Effective: 06-15-15, Implementation: 06-15-15)

*Rate and weight information used by the SNF Pricer is updated periodically, usually annually. Updates occur each October, to reflect the fact that SNF PPS rates are effective for a Federal fiscal year. Updates may also occur at other points in the year when required by legislation. The following update items, when changed, are published in the "**Federal Register**:"*

- *Four components of the unadjusted Federal rates for both Rural and Urban areas. Components include the nursing case-mix, non-case mix, therapy case-mix, and therapy non-case-mix amounts.*
- *A table of nursing and therapy indices to be used for each RUG;*
- *The factors to be applied in making the area wage adjustment;*
- *Changes, if any, to the labor and non-labor percentages.*

Whenever these update items change, Medicare also publishes a Recurring Update Notification to inform providers and contractors about the changes. These Recurring Update Notifications also describe how the changes will be implemented through the SNF Pricer.

40.3.5.2 - Leave of Absence

(Rev. 3230, Issued: 04-03-15, Effective: 06-15-15, Implementation: 06-15-15)

A leave of absence for the purposes of this instruction is a 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 LOA days are shown as zero on the bill, and the SNF cannot bill the beneficiary for them except as specified in Chapter 1 of this manual at §30.1.1.1. Occurrence span code 74 is used to report the LOA from and through dates. *Providers should review the RAI manual to clarify situations where an LOA is not appropriate, for example observation stays in a hospital lasting greater than 24 hours.*

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90.5 - Transportation of Equipment Billed by a SNF to a *MAC*

(Rev. 3230, Issued: 04-03-15, Effective: 06-15-15, Implementation: 06-15-15)

When a SNF bills for portable x-ray equipment transported to a site by van or other vehicle, the SNF should bill for the transportation costs using one of the following HCPCS codes along with the appropriate revenue code:

R0070	Transportation of Portable x-ray Equipment and Personnel to Home or Nursing Home, Per Trip to Facility or Location, One Patient Seen.
R0075	Transportation of Portable x-ray Equipment and Personnel to Home or Nursing Home, Per Trip to Facility or Location, More than One Patient Seen, Per Patient.

These HCPCS codes are subject to the fee schedule.

Effective April 1, 2006, SNFs are required to report the appropriate modifiers to identify the number of patients served when billing for R0075. See section 90.3, of this chapter for the list of modifiers used to identify on the claim the number of patients served.

MACs shall ensure that payment for R0075 is consistent with the definition of the modifiers.

NOTE: *When a SNF resident receives a portable x-ray service during the course of a Medicare-covered stay in the SNF, only the service's professional component (representing the physician's interpretation of the test results) is a separately billable physician service under Part B (see §20.1 of this chapter and §20.1.1 of Chapter 6). By contrast, the technical component representing the procedure itself, including any associated transportation and setup costs, would be subject to consolidated billing (the SNF "bundling" requirement for services furnished to the SNF's Part A residents), and must be included on the SNF's Part A bill for the resident's covered stay (Bill Type 21x) rather than being billed separately under Part B (see §20.2.1of this chapter).*