

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10880	Date: August 6, 2021
	Change Request 12009

SUBJECT: Internet Only Manual Updates to Pub. 100-01, 100-02, and 100-04 to Implement Consolidated Appropriations Act Changes and Correct Errors and Omissions (SNF)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the Medicare manuals to correct various minor technical errors and omissions and to reflect provisions of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260).

EFFECTIVE DATE: November 8, 2021

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

IMPLEMENTATION DATE: November 8, 2021

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	6/10.4.1/"Under Arrangements" Relationships
R	6/20.3/Other Services Excluded from SNF PPS and Consolidated Billing
R	6/20.3.1/Ambulance Services
R	6/30/Billing SNF PPS Services
R	6/30.1/Health Insurance Prospective Payment System (HIPPS) Rate Code
R	6/30.4.2/SNF PPS Rate Components
R	6/30.5/Annual Updates to the SNF Pricer
R	6/40.9/Other Billing Situations
R	6/50.4/Conducting Resident Assessments
R	6/120.2/Interrupted Stay Policy
R	7/10/Billing for Medical and Other Health Services
R	25/75.5/Form Locators 43-65

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: 10880	Date: August 6, 2021	Change Request: 12009
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SUBJECT: Internet Only Manual Updates to Pub. 100-01, 100-02, and 100-04 to Implement Consolidated Appropriations Act Changes and Correct Errors and Omissions (SNF)

EFFECTIVE DATE: November 8, 2021

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IMPLEMENTATION DATE: November 8, 2021

I. GENERAL INFORMATION

A. Background: This CR updates the Medicare manuals with regard to SNF policy to clarify the existing content. These changes are being made to correct various omissions and minor technical errors.

This CR also updates the Medicare manuals in response to the Consolidated Appropriations Act, 2021 (Pub. L. 116-260), specifically, to note the exclusion from consolidated billing, as of October 1, 2021, of certain blood clotting factors indicated for the treatment of hemophilia and other bleeding disorders.

Pub 100-04, Chapter 6, §10.4.1:

The first paragraph of this section is revised to clarify the language on arrangements.

Pub 100-04, Chapter 6, §20.3:

This section is revised to reflect the exclusion from consolidated billing, as of October 1, 2021, of certain blood clotting factors indicated for the treatment of hemophilia and other bleeding disorders, as enacted in §134 in Division CC of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260).

Pub 100-04, Chapter 6, §20.3.1:

This section is revised by adding a subheading and clarifying the language.

Pub 100-04, Chapter 6, §30:

This section is revised by adding cross-references as appropriate to the instructions on the SNF PPS's Payment Driven Payment Model (PDPM) that appear at the end of the chapter.

Pub 100-04, Chapter 6, §30.1:

This section is revised by adding a cross-reference to the PDPM instructions that appear at the end of the chapter.

Pub 100-04, Chapter 6, §30.4.2:

This section is revised by adding a cross-reference to the PDPM instructions that appear at the end of the chapter, and replacing dashes with bullet points for consistency.

Pub 100-04, Chapter 6, §30.5:

This section is updated to reflect the SNF PPS's changeover, as of October 1, 2019, from its previous Resource Utilization Group (RUG) case-mix model to the PDPM.

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E D I C A N S	C O N T R A C T O R S
		A	B	H H H		
12009 - 04.2	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X	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): Anthony Hodge, Anthony.Hodge@cms.hhs.gov, Bill Ullman, 410-786-5667 or william.ullman@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

10.4.1 - “Under Arrangements” Relationships

(Rev. 10880, Issued: 08-06-21, Effective: 11-08-21, Implementation: 11-08-21)

Under an arrangement as defined in §1861(w) of the Act, Medicare’s payment to the SNF represents payment in full for the arranged-for service, and the supplier must look to the SNF (rather than to A/B MAC (B)) for its payment. Further, in entering into such an arrangement, the SNF cannot function as a mere billing conduit, but must actually exercise professional responsibility over the arranged-for service (see the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, §10.3, and the Medicare Benefit Policy Manual, Chapter 8, §70.4, for additional information on services furnished under arrangements).

Medicare does not prescribe the actual terms of the SNF’s relationship with its suppliers (such as the specific amount or timing of payment by the SNF), which are to be arrived at through direct negotiation between the parties to the agreement. However, in order for a valid “arrangement” to exist, the SNF must reach a mutual understanding with its supplier as to how the supplier is to be paid for its services. Documenting the terms of the arrangement confers the added benefit of providing both parties with a ready means of resolution in the event that a dispute arises over a particular service. This type of arrangement has proven to be effective in situations where suppliers regularly provide services to facility residents on an ongoing basis; e.g., laboratory and x-ray suppliers, DME supplies, etc. Sample model agreements involving arrangements between SNFs and their suppliers are available for review on CMS’s “Best Practices Guidelines” website, at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/BestPractices.html>.

If a SNF elects to utilize an outside supplier to furnish medically appropriate services that are subject to consolidated billing, but then refuses to reimburse that supplier for the services, then there is no valid arrangement as contemplated under §1862(a)(18) of the Act. Not only would this potentially result in Medicare’s noncoverage of the particular services at issue, but a SNF demonstrating a pattern of nonpayment would also risk being found in violation of the terms of its provider agreement. Under §1866(a)(1)(H)(ii) of the Act (and 42 CFR 489.20(s)), the SNF’s provider agreement includes a specific commitment to comply with the requirements of the consolidated billing provision. Further, §1866(g) of the Act imposes a civil money penalty on any person who knowingly and willfully presents (or causes to be presented) a bill or request for payment inconsistent with an arrangement or in violation of the requirement for such an arrangement.

20.3 - Other Services Excluded from SNF PPS and Consolidated Billing

(Rev. 10880, Issued: 08-06-21, Effective: 11-08-21, Implementation: 11-08-21)

The following services may be billed separately under Part B by the rendering provider, supplier, or practitioner (other than the SNF that receives the Part A PPS payment) and paid to the entity that furnished the service. These services may be provided by any Medicare provider licensed to provide them, other than the SNF that receives the Part A PPS payment, and are excluded from Part A PPS payment and the requirement for consolidated billing, and are referred to as “Major Category III” for consolidated billing edits applied to claims submitted to A/B MACs (A).

- A medically necessary ambulance trip (other than a transfer to another SNF) that transports a beneficiary to the SNF for the initial admission or from the SNF following a final discharge, or that occurs pursuant to the offsite provision of Part B dialysis services (see section 20.3.1 for additional situations involving ambulance transportation);

- Certain chemotherapy (that is, anti-cancer) drugs. The chemotherapy exclusion applies solely to the particular chemotherapy codes designated under Major Category III.A of the SNF website’s A/B MAC (A) Annual Update. These same codes also appear on the list of exclusions in File 1 of the SNF website’s A/B MAC (B) Annual Update (though not displayed as a separate subcategory). The excluded chemotherapy codes serve to identify those high-intensity chemotherapy drugs that are not typically administered in a SNF, are exceptionally expensive, or require special staff expertise to administer. By contrast, chemotherapy drugs that are relatively inexpensive and are administered routinely in SNFs do not qualify for this exclusion and, thus, remain subject to SNF CB. Further, this exclusion would not encompass any related items that, while commonly furnished in conjunction with chemotherapy, are not themselves inherently chemotherapeutic in nature (that is, they specifically address the side effects of the chemotherapy rather than actively fighting the cancer itself). Examples of such chemotherapy-related drugs would include anti-emetics (anti-nausea drugs), as well as drugs that function as an adjunct to an anti-emetic, such as an anti-anxiety drug that helps to relieve anticipatory nausea. Even when furnished in conjunction with a chemotherapy drug that is itself excluded (and, thus, separately payable under Part B), these related drugs would remain subject to SNF CB. Similarly, if a drug designated by one of the excluded chemotherapy codes is prescribed for a use that is not actually associated with fighting cancer, it would no longer be considered an excluded “chemotherapy” drug in such an instance, because it is not being used for a chemotherapeutic purpose within the meaning of this exclusion.
- Certain chemotherapy administration services. The chemotherapy administration 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;
- Certain customized prosthetic devices (see §10);
- *Effective for items and services furnished on or after October 1, 2021, certain blood clotting factors indicated for the treatment of hemophilia and other bleeding disorders;*
- The transportation costs of electrocardiogram equipment (HCPCS code R0076), but only with respect to those for electrocardiogram test services furnished during 1998; 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 (as noted previously in §10, consolidated billing applies only to Medicare fee-for-service beneficiaries).

The HCPCS code ranges for chemotherapy, chemotherapy administration, radioisotopes, customized prosthetic devices, *and blood clotting factors* are set in statute. The statute also gives the Secretary authority to make modifications in the particular codes that are designated for exclusion within each of these service categories. See §10.1 above for the link to where transmittals providing current lists of HCPCS codes used for Major Category III SNF consolidated billing editing for A/B MACs (A) can be found.

20.3.1 - Ambulance Services

(Rev. 10880, Issued: 08-06-21, Effective: 11-08-21, Implementation: 11-08-21)

The following ambulance transportation and related ambulance services for residents in a Part A stay are not included in the Part A PPS payment. Except for specific exclusions, consolidated billing includes those medically necessary ambulance trips that are furnished during the course of a covered Part A stay. A/B MACs (A), (B), (HHH), and DME MACs are responsible for assuring that payment is made only for ambulance services that meet established coverage criteria.

In most cases, ambulance trips are excluded from consolidated billing when resident status has ended. The ambulance company then must bill the A/B MAC (A), (B), or (HHH), or DME MAC (as appropriate) directly for payment. Listed below are a number of specific circumstances under which a beneficiary may receive ambulance services that are covered by Medicare, but excluded from consolidated billing.

The following ambulance services may be billed as Part B services by the supplier in the following situations only.

- 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 after discharge, to the beneficiary's home (the first character (origin) of any HCPCS ambulance modifier is N (SNF), the second character (destination) of the HCPCS ambulance modifier is R (Residence), and date of ambulance service is the same date as the SNF through date). Note: this includes beneficiaries discharged home to receive services from a Medicare-participating home health agency under a plan of care;
- The ambulance trip is to or from a hospital based or nonhospital based ESRD facility (the first or second character (origin or destination) of the HCPCS ambulance modifier is N (SNF), and the other character of the HCPCS ambulance modifier is G (Hospital-based dialysis facility) or J (Non-hospital based dialysis facility)) for the purpose of receiving dialysis and related services excluded from consolidated billing.
- The ambulance trip is from the SNF to a Medicare-participating hospital or a CAH for an inpatient admission (the first character (origin) of the HCPCS ambulance modifier is N (SNF), and the second character (destination) of the HCPCS modifier is H).
- The ambulance trip follows a formal discharge or other departure from the SNF to any destination other than another SNF, and the beneficiary does not return to that or any other SNF before the following midnight; and
- An ambulance trip that conveys a beneficiary to a hospital or CAH and back to the SNF, for the specific purpose of receiving emergency or other excluded services (see section 20.1.2 above for list of other excluded services). As discussed in section 20.1.2, the receipt of these exceptionally intensive outpatient hospital services has the effect of temporarily suspending the beneficiary's status as an SNF "resident" for CB purposes with respect to those services; moreover, once suspended in this manner, the beneficiary's "resident" status would not resume until he or she actually arrives back at the SNF. Accordingly, the **entire** related ambulance roundtrip, both the outbound (SNF-to-hospital) portion and the return (hospital-to-SNF) portion, would be excluded from SNF CB and billed separately under Part B.

The following ambulance services are included in SNF CB and may **not** be billed as Part B services to the A/B MAC (A), (B), or (HHH) when the beneficiary is in a Part A stay:

- *Transfers Between Two SNFs:* Under the regulations at 42 CFR 411.15(p)(3)(iv), the day of departure from SNF 1 is a covered Part A day (to which consolidated billing would apply) only if the beneficiary's admission to SNF 2 occurs before the following midnight (the first and second character of the ambulance modifier is N). Patient Status is 03. An ambulance trip that is medically

necessary to effect this type of SNF-to-SNF transfer would be bundled back to SNF 1, as in this specific situation the beneficiary would continue to be considered a “resident” of SNF 1 for CB purposes up until the actual point of admission to SNF 2. However, it should be noted that in addition to the “medical necessity” criterion in the regulations at 42 CFR 409.27(c) pertaining specifically to ambulance transports under the SNF benefit (i.e., the patient’s medical condition is such that transportation by any means other than ambulance would be contraindicated), coverage in this context also involves the underlying requirement of being reasonable and necessary for diagnosing or treating the patient’s condition. For example, a SNF-to-SNF transfer would be considered reasonable and necessary in a situation where needed care is unavailable at the originating SNF, thus necessitating a transfer to the receiving SNF in order to obtain that care. By contrast, a SNF-to-SNF transfer that is prompted by non-medical considerations (such as *the* patient’s preference to be placed in the receiving SNF) is not considered reasonable and necessary for diagnosing or treating the patient’s condition and, thus, would not be bundled back to the originating SNF.

- Ambulance transports to or from a diagnostic or therapeutic site other than a hospital or renal dialysis facility (e.g., an independent diagnostic testing facility (IDTF), cancer treatment center, radiation therapy center, wound care center, etc.). The ambulance transport is included in the SNF PPS rate if the first or second character (origin or destination) of any HCPCS code ambulance modifier is “D” (diagnostic or therapeutic site other than “P” or “H”), and the other modifier (origin or destination) is “N” (SNF). The first SNF is responsible for billing the services to the A/B MAC (A).
- An SNF resident’s ambulance roundtrip to a physician’s office (first or second character (origin or destination) of any HCPCS code ambulance modifier is “P” (physician’s office), and the other modifier (origin or destination) is “N” (SNF)) is subject to SNF CB and would remain the responsibility of the SNF, because even though the physician’s services are themselves excluded from SNF CB, this exclusion does not affect the beneficiary’s overall status as an SNF “resident” for CB purposes. Further, while a physician’s office is not normally a covered destination under the **separate Part B** ambulance benefit, the SNF benefit’s Part A coverage of ambulance transportation under the regulations at 42 CFR 409.27(c) incorporates **only** the Part B ambulance benefit’s general medical necessity requirement at 42 CFR 410.40(e)(1), and not any of the latter benefit’s more detailed coverage restrictions regarding destinations.

See chapter 15 for additional information on Part B coverage of Ambulance Services.

In contrast to the ambulance coverage described above, Medicare simply does not provide any coverage at all under Part A **or** Part B for any **non-ambulance** forms of transportation, such as ambulette, wheelchair van, or litter van. Further, as noted previously, in order for the Part A SNF benefit to cover transportation via ambulance, the regulations at 42 CFR 409.27(c) specify that the ambulance transportation must be **medically necessary**, that is, the patient’s condition is such that transportation by any means other than ambulance would be medically contraindicated.

This means that in a situation where it is medically feasible to transport an SNF resident by some means other than an ambulance, for example, via wheelchair van, the wheelchair van would not be covered (because Medicare does not cover any non-ambulance forms of transportation), and an ambulance **also** would not be covered (because the use of an ambulance in such a situation would not be medically necessary). With respect to noncovered services for which a resident may be financially liable, the SNF is required under the regulations at 42 CFR 483.10(g)(18) to “. . . inform each resident before, or at the time of admission, and periodically during the resident’s stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/Medicaid or by the facility’s per diem rate.”

30 - Billing SNF PPS Services

(Rev. 10880, Issued: 08-06-21, Effective: 11-08-21, Implementation: 11-08-21)

SNFs and hospital swing bed providers are required to report inpatient Part A PPS billing data as follows. Refer to the Medicare Claims Processing Manual, Chapter 25, “Completing and Processing the Form CMS-1450 Data Set,” for a description of claim data elements.

- In addition to the required fields identified in Chapter 25, SNFs must also report occurrence span code “70” to indicate the dates of a qualifying hospital stay of at least three consecutive days which qualifies the beneficiary for SNF services.
- Separate bills are required for each Federal fiscal year for admissions that span the annual update effective date (October 1).
- Use Type of Bill 21X for SNF inpatient services or 18X for hospital swing bed services.
- Revenue Code 0022. This code indicates that this claim is being paid under the SNF PPS. This revenue code can appear on a claim as often as necessary to indicate different HIPPS Rate Code(s) and assessment periods.
- Effective for claims with dates of service on or after January, 1 2011, there must be an occurrence code 50 (assessment date) for each assessment period represented on the claim with revenue code 0022. The date of service reported with occurrence code 50 must contain the ARD. An occurrence code 50 is not required with default HIPPS code AAaxx (where ‘xx’ equals varying digits) or ZZZZZ October 1, 2019 and after. 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. As of October 1, 2019, SNF PDPM changes are effective (*see §§120ff.*).
- 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. As of October 1, 2019, SNF PDPM changes are effective (*see §§120ff.*).
- 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. As of October 1, 2019, SNF PDPM changes are effective (*see §§120ff.*).

- The accommodation revenue code 018x, leave of absence is reported when the beneficiary is on a leave of absence and is not present at the midnight census taking time.
- Principal Diagnosis Code - SNFs enter the ICD-CM code for the principal diagnosis in the appropriate form locator. The code must be reported according to Official ICD-CM Guidelines for Coding and Reporting, as required by the Health Insurance Portability and Accountability Act (HIPAA), including any applicable guidelines regarding the use of V codes for ICD-9. The code must be the full ICD-CM diagnosis code, including all five digits (for ICD-9) or all seven digits (for ICD-10) where applicable.
 - Other Diagnosis Codes Required - The SNF enters the full ICD-CM codes for up to eight additional conditions in the appropriate form locator. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in the ICD-CM guidelines.

30.1 - Health Insurance Prospective Payment System (HIPPS) Rate Code *(Rev. 10880, Issued: 08-06-21, Effective: 11-08-21, Implementation: 11-08-21)*

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. *As of October 1, 2019, SNF PDPM changes are effective (see §§120ff.).*

30.4.2 – SNF PPS Rate Components

(Rev. 10880, Issued: 08-06-21, Effective: 11-08-21, Implementation: 11-08-21)

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.

As of October 1, 2019, SNF PDPM changes are effective (see §§120ff.).

30.5 - Annual Updates to the SNF Pricer

(Rev. 10880, Issued: 08-06-21, Effective: 11-08-21, Implementation: 11-08-21)

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:**”

- *The following* components of the unadjusted Federal rates for both Rural and Urban areas:

- *physical therapy,*
 - *occupational therapy,*
 - *speech-language pathology,*
 - *nursing,*
 - *non-therapy ancillary, and*
 - *non-case-mix.*
- *The case-mix indexes* to be used for each *case-mix group*.
 - 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 A/B MACs (A) about the changes. These Recurring Update Notifications also describe how the changes will be implemented through the SNF Pricer.

40.9 - Other Billing Situations

(Rev. 10880, Issued: 08-06-21, Effective: 11-08-21, Implementation: 11-08-21)

A. Demand Bills

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 (date active care ended) as applicable and condition code 20 indicating the beneficiary believes the services are covered beyond the occurrence date.

See the Medicare Claims Processing Manual, Chapter 1, “General Billing Requirements,” §60.3, for instructions on advance beneficiary notices and demand bills.

Refer to the Medicare Claims Processing Manual, Chapter 25 for further information about billing.

B. Request for Denial Notice for Other Insurer

The SNFs complete a noncovered bill and enter condition code 21 to indicate a request for a Medicare denial notice. Refer to Chapter 25 further information about billing.

C. 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 for further information about billing.

D. Special MSN Messages

The Medicare Prescription Drug Improvement and Modernization Act of 2003 requires that Medicare Summary Notices (including SNF claims for post-hospital extended care services provided under Part A) report the number of covered days remaining in the given spell of illness. This requirement became effective July 6, 2004.

E. Interrupted Stay

Refer to the Medicare Claims Processing Manual, Chapter 6, “Interrupted Stay Policy,” §120.2, for information about billing when a patient returns to a covered level of care after an interrupted stay.

50.4 - Conducting Resident Assessments

(Rev. 10880, Issued: 08-06-21, Effective: 11-08-21, Implementation: 11-08-21)

The imposition of sanctions does not waive the SNF's responsibility to perform assessments in accordance with the clinical schedule defined in the SOM. Comprehensive admission assessments are still due within 14 days of admission to the SNF. Facility staff must also maintain the schedule for quarterly and annual assessments, and perform SCSAs and SCPAs when clinically appropriate.

Medicare-required assessments are also necessary for all beneficiaries in the SNF whose stays are not subject to the payment ban. If, during the sanction period, staff do not perform Medicare-required assessments for beneficiaries in covered Part A stays, no payment is made and the SNF must submit a claim using the HIPPS default rate code and an occurrence code 77 indicating provider liability, in order to ensure that the beneficiary's spell of illness (benefit period) is updated.

Part A benefits are NOT available for beneficiaries admitted after the effective date of the payment ban. Therefore, the facility is not required to perform Medicare PPS assessments. Medicare payments can begin no earlier than the date the sanction is lifted. For Medicare PPS assessment scheduling purposes, the date the sanction is lifted should be considered day 1. In this case, if the sanctions are lifted effective June 15, the assessment reference date for the Medicare 5-day assessment must be set between June 15 and June 22 (i.e., the eighth day of the covered stay).

An SNF may choose to perform the Medicare-required assessments during the sanction period, but is not required to do so. Generally, a facility should continue to do the Medicare PPS assessments if SNF staff believe the sanction was in error and may be lifted retroactively. In this case, the SNF would be able to bill Medicare at the correct rate.

When the SNF does not receive timely notification that a payment ban has been lifted, and staff is unaware of the need to start the Medicare-Required schedule (the beneficiary meets all applicable eligibility and coverage requirements), the SNF shall bill the Medicare 5-day and 14-day assessment using the HIPPS code generated by the 14-day OBRA required assessment. If the SNF did not perform any assessments with an assessment reference date during the assessment window for the Medicare-Required 5-day or 14-day assessment, the SNF shall bill the default rate for those covered days associated with the assessment. Where the SNF did not perform an assessment with an ARD that fell in the applicable Medicare-Required Assessment window for the 30, 60 and 90-day Medicare-Required Assessments it shall bill the default rate. If the SNF did perform an assessment, including a SCSA, where the ARD fell in the window of a 30, 60 or 90-day Medicare-Required Assessment (including grace days), the SNF shall bill using the HIPPS code generated from the assessment in accordance with the payment policies found in Chapter 28 of the Provider Reimbursement Manual. The date the sanction is lifted is Day 1 for purposes of the Medicare assessment schedule.

NOTE: In order to bill with the default code the beneficiary must at least meet the requirements for SNF coverage.

EXAMPLE 1: The SNF is notified on June 15th that its payment ban was lifted effective June 1. The beneficiary was admitted on June 1. The SNF did not perform any of the Medicare-Required Assessments. However, the SNF did perform the initial OBRA assessment. The initial OBRA assessment shall be used to bill the 5-day Medicare-Required Assessment for up to 14 days. Day 15 is day 1 for purposes of starting the Medicare-required assessment schedule and a 5-day Medicare required assessment shall be performed.

EXAMPLE 2: The SNF is notified on August 15 that its payment ban was lifted on June 1. The beneficiary was admitted on June 1. The SNF did not perform any of the Medicare-Required Assessments. However, the SNF did perform the initial OBRA Assessment.

The initial OBRA assessment shall be used to bill the 5-day Medicare required assessment and the 14-day Medicare required assessment. The 30-day assessment shall be billed through day 44 at the default rate. Day 45 is day 1 for purposes of starting the Medicare- required assessment schedule and a 5-day Medicare required assessment shall be performed.

See §120.1 for the revised Medicare-required assessment schedule under the SNF PDPM effective October 1, 2019.

120.2 - Interrupted Stay Policy

(Rev. 10880, Issued: 08-06-21, Effective: 11-08-21, Implementation: 11-08-21)

PDPM includes an interrupted stay policy, which would combine multiple SNF stays into a single stay in cases where the patient's discharge and readmission occurs within a prescribed window (i.e., interruption window), similar to that which exists currently in many other Medicare inpatient facilities. Specifically, if a patient in a covered Part A SNF stay is discharged from the SNF but returns to the SNF no later than **11:59pm** of the third consecutive calendar day after having left Part A coverage, then this would be considered a continuation of the same SNF stay. In such cases, no new patient assessments are required and the variable per diem adjustment is not reset. If the patient returns to the same SNF outside the interruption window, or returns to a different SNF, then this would be considered a new stay.

The interruption window begins on the first non-covered day following a Part A-covered SNF stay and ends at **11:59pm** on the third consecutive non-covered day. The first non-covered day *in this context* may be different depending on *whether* the patient *actually* leaves the facility or simply leaves Part A coverage. *Specifically, if the patient physically leaves the SNF, the first day of the interruption window would be the day of departure itself, whereas if the patient simply discontinues Part A coverage but remains in the SNF, the first day of the interruption window would be the day following the final day of Part A coverage.*

Specifying the endpoint of the interruption window's third day as occurring at 11:59 pm rather than at midnight is consistent with the regulations at 42 CFR 411.15(p)(3)(iv), which define a beneficiary's SNF "resident" status for consolidated billing purposes as ending whenever he or she is formally discharged (or otherwise departs) from the SNF, unless he or she is readmitted (or returns) to that or another SNF "... before the following midnight" (emphasis added). See §10.1 of this chapter, and also see §20.1 in the Medicare Benefit Policy Manual, Chapter 3, which specifies that in counting inpatient days, "... a day begins at midnight and ends 24 hours later." However, unlike similar interrupted stay policies under some of the other prospective payment systems, the SNF interrupted stay policy is not used in determining whether bundling would apply to services furnished during the interruption. That determination would instead continue to follow the longstanding set of rules under 42 CFR 411.15(p)(3) regarding SNF "resident" status for consolidated billing purposes (see §§10ff.).

The day of discharge (*as noted above, this* date could be different if the patient leaves the facility or simply leaves Part A coverage) is the FROM date and the last day the patient is not in the SNF at midnight is the THROUGH date. Occurrence span code 74 should be reported for each interruption of more *than* ONE day.

The interrupted stay would be recorded on the claim in the same manner as is done for the IRF PPS, and as further discussed in the examples below.

Examples:

1) Patient is admitted to SNF on 11/07/19 and is in a covered Part A stay. Patient is discharged from the SNF and admitted to the hospital on 11/20/19. Patient is readmitted to the same SNF on 11/25/19 and is in a covered Part A stay. The readmission is a new stay because more than 3 days have passed from the date the patient was discharged from the SNF and the date the patient was readmitted to the same SNF.

New stay

Assessment Schedule: Reset; stay begins with new 5-day assessment.

Variable Per Diem (VPD): Reset: stay begins on Day 1 of VPD Schedule.

2) Patient is admitted to SNF on 11/07/19 and in a covered Part A stay. The patient is discharged from Part A on 11/20/19 but remains in the facility. The patient returns to a covered Part A stay on 11/22/19. This is a continuation of a previous stay because the patient returned to a covered Part A stay within 3 days of being discharged from a covered Part A stay.

Continuation of previous stay

Assessment Schedule: No PPS assessments required, IPA optional

VPD: Continues from Day 14 (Day of Part A Discharge).

Billing Example: Patient is admitted to SNF on 10/1/2019 and discharged to home on 12/25/2019, with an interrupted stay to an IPPS on 10/20/2019-10/22/2019. This was an admission to an IPPS on 10/20/2019-10/22/2019.

10/1/2019 – 10/31/2019 first interim claim,

Claim must be billed with occurrence span code 74 and occurrence span dates 10/20 – 10/21/2019 to represent the interrupted stay,

11/1/2019 – 11/30/2019 second interim claim,

12/1/2019 – 12/25/2019 final interim claim,

(Occurrence span code 74 only appears on the claim in which its dates fall within the statement covers period – in this example only on October claim).

- Accommodation revenue code 018x is reported during the interrupted stay and is when the beneficiary is not present at the midnight census taking time.
- Occurrence span code 74 and date range for the interruption.

Days for the interruption shall be reported as non-covered, not to exceed 3 days or it will be considered a new admission.

On the SNF Medicare bill, the presence of occurrence span code 74 indicates an interrupted stay has occurred. Report occurrence span code 74 with the *FROM* and *THROUGH* dates of the interruption in the stay. The day of discharge from the SNF is the FROM date and the last day the patient is not in the SNF at midnight is the THROUGH date. Report accommodation revenue code 18X (leave of absence) and the quantity of leave days. Occurrence span code 74 should be reported for each interruption of more than 1 day along with the dates of each interruption. Revenue code 018X should reflect the total number of days for all occurrence span code 74 entries. In other words, revenue code 018X should be listed on one line, with all interrupted days included in the units column. No charges should be added to this charge line.

Medicare Claims Processing Manual

Chapter 7 - SNF Part B Billing (Including Inpatient Part B and Outpatient Fee Schedule)

10 - Billing for Medical and Other Health Services

(Rev. 10880, Issued: 08-06-21, Effective: 11-08-21, Implementation: 11-08-21)

See Business Requirements at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R20CP.pdf>.

There are three situations in which a SNF may submit a claim for Part B services. These are identified in subsections A through C below.

No bill is required when:

- The patient is not enrolled under Part B;
- Payment was made or will be made by the Public Health Service, VA, or other governmental entity;
- Workers' compensation has paid or will pay the bill; or
- Payment was made by liability, no-fault insurance, group health plan, or a large group health plan.

A - Beneficiaries in a Part B Inpatient Stay (Part B Residents)

A Part B inpatient stay includes services furnished to inpatients whose benefit days are exhausted, or who are not entitled to have payment made for services under Part A. A more detailed description of services covered for beneficiaries in a Part B stay is *found* at §10.1 – Billing for Inpatient Services Paid Under Part B.

B - Outpatient Services

Covered Part B services rendered to beneficiaries who are not inpatients of a SNF are considered SNF outpatient services. They include the services listed in §10.1 below as well as additional services described in the Medicare Benefit Policy Manual, Chapter 8, "Coverage of Extended Care (SNF) Services Under Hospital Insurance," §§80 and Medicare Benefit Policy Manual, Chapter 6, "Hospital Services Covered Under Part B." Detailed instructions for billing are located in §10.2 – Billing for Outpatient SNF Services.

C - Beneficiaries in a Part A Covered Stay

SNFs are required to consolidate billing to their intermediary for their covered Medicare inpatient services. However, certain services rendered to SNF inpatients are excluded from the SNF Prospective Payment System (PPS) reimbursement and are also excluded from consolidated billing by the SNF. Those services must be billed to Part B by the rendering provider and not by the SNF (except screening and preventive services as described in the next paragraph.) A list of services excluded from consolidated billing is found in the Medicare Claims Processing Manual, Chapter 6, "SNF Inpatient Part A Billing," §§20 – 20.4.

Screening and preventive services are not included in the SNF PPS amount but may be paid separately under Part B for Part A patients who also have Part B coverage. Screening and preventive services are covered only under Part B. Only the SNF may bill for screening and preventive services under Part B for its covered Part A inpatients. Bill type 22X is used *in billing screening and preventive services* for beneficiaries in a covered Part A stay and for beneficiaries that are Part B residents. TOB 23x is used for SNF outpatients or for beneficiaries not in the SNF or DPU. The SNF must provide the service or obtain it under arrangements.

Coverage, billing and payment guidelines are found in the Medicare Claims Processing Manual, Chapter 18, "Preventive and Screening Services;" Chapter 17, "Drugs and Biologicals;" and the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §50.4.4.2.

There are certain medical and other health services for which payment may not be made to a SNF. Most of these are professional services performed by physicians and other practitioners. These services are always billed to the Medicare Part B *MAC*. Others are services that have been determined to require a hospital setting to assure beneficiary safety. *Part A MAC* shared systems receive an annual file listing these non-payable HCPCS in November, and, if necessary, a quarterly update via a one-time-only notification.

Physicians, non-physician practitioners, and suppliers billing the *Part B MAC*, and providers billing the *Part A MAC* should consult the CMS Web site at <http://www.cms.hhs.gov/SNFConsolidatedBilling/> for lists of separately billable services.

Medicare Claims Processing Manual

Chapter 25 - Completing and Processing the Form

CMS-1450 Data Set

75.5 - Form Locators 43-65

(Rev. 10880, Issued: 08-06-21, Effective: 11-08-21, Implementation: 11-08-21)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

FL 43 - Revenue Description/IDE Number/Medicaid Drug Rebate

Not Required. The provider enters a narrative description or standard abbreviation for each revenue code shown in FL 42 on the adjacent line in FL 43. The information assists clerical bill review. Descriptions or abbreviations correspond to the revenue codes. "Other" code categories are locally defined and individually described on each bill.

The investigational device exemption (IDE) or procedure identifies a specific device used only for billing under the specific revenue code 0624. The IDE will appear on the paper format of Form CMS-1450 as follows: FDA IDE # A123456 (17 spaces).

HHAs identify the specific piece of durable medical equipment (DME) or non-routine supplies for which they are billing in this area on the line adjacent to the related revenue code. This description must be shown in Healthcare Common Procedure Coding System (HCPCS) coding.

When required to submit drug rebate data for Medicaid rebates, submit N4 followed by the 11-digit National Drug Code (NDC) in positions 01-13 (e.g., N499999999999). Report the NDC quantity qualifier followed by the quantity beginning in position 14. The Description Field on Form CMS-1450 is 24 characters in length. An example of the methodology is illustrated below.

N	4	1	2	3	4	5	6	7	8	9	0	1	U	N	1	2	3	4	.	5	6	7	
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	--

FL 44 - HCPCS/Rates/HIPPS Rate Codes

Required. When coding HCPCS for outpatient services, the provider enters the HCPCS code describing the procedure here. On inpatient hospital bills the accommodation rate is shown here.

HCPCS used for Medicare claims are available from Medicare contractors.

Health Insurance Prospective Payment System (HIPPS) Rate Codes

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. 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. The AIs were developed by CMS.

The Grouper will not automatically assign the 2-digit AI, except in the case of a swing bed MDS that is will result in a special payment situation AI (see below). The HIPPS rate codes that appear on the claim must match the assessment that has been transmitted and accepted by the State in which the facility operates. The SNF cannot put a HIPPS rate code on the claim that does not match the assessment.

HIPPS Rate Codes used for Medicare claims are available from Medicare contractors. *As of October 1, 2019, SNF PDPM changes are effective (see §§120ff. in Chapter 6 of this manual).*

HIPPS Modifiers/Assessment Type Indicators

The assessment indicators (AI) were developed by CMS to identify on the claim, which of the scheduled Medicare assessments or off-cycle assessments is associated with the assessment reference date and the RUG that is included on the claim for payment of Medicare SNF services. In addition, the AIs identify the Effective Date for the beginning of the covered period and aid in ensuring that the number of days billed for each scheduled Medicare assessment or off cycle assessment accurately reflect the changes in the beneficiary's status over time. The indicators were developed by utilizing codes for the reason for assessment contained in section AA8 of the current version of the Resident Assessment Instrument, Minimum Data Set in order to ease the reporting of such information. Follow the CMS manual instructions for appropriate assignment of the assessment codes.

HIPPS Modifiers/Assessment Type Indicators used for Medicare claims are available from Medicare contractors. *As of October 1, 2019, SNF PDPM changes are effective (see §§120ff. in Chapter 6 of this manual).*

HCPCS Modifiers (Level I and Level II)

Form CMS-1450 accommodates up to four modifiers, two characters each. See AMA publication CPT 20xx (xx= to current year) Current Procedural Terminology Appendix A - HCPCS Modifiers Section: "Modifiers Approved for Ambulatory Surgery Center (ASC) Hospital Outpatient Use". Various CPT (Level I HCPCS) and Level II HCPCS codes may require the use of modifiers to improve the accuracy of coding. Consequently, reimbursement, coding consistency, editing and proper payment will benefit from the reporting of modifiers. Hospitals should not report a separate HCPCS (five-digit code) instead of the modifier. When appropriate, report a modifier based on the list indicated in the above section of the AMA publication.

HCPCS modifiers used for Medicare claims are available from Medicare contractors.

FL 45 - Service Date

Required Outpatient. CMHCs and hospitals (with the exception of CAHs, Indian Health Service hospitals and hospitals located in American Samoa, Guam and Saipan) report line item dates of service on all bills containing revenue codes, procedure codes or drug codes. This includes claims where the "from" and "through" dates are equal. This change is due to a HIPAA requirement.

There must be a single line item date of service (LIDOS) for every iteration of every revenue code on all outpatient bills (TOBs 013X, 014X, 023X, 024X, 032X, 033X, 034X, 071X, 072X, 073X, 074X, 075X, 076X, 077X (effective April 1, 2010), 081X, 082X, 083X, and 085X and on inpatient Part B bills (TOBs 012x and 022x). If a particular service is rendered 5 times during the billing period, the revenue code and HCPCS code must be entered 5 times, once for each service date.

FL 46 - Units of Service

Required. Generally, the entries in this column quantify services by revenue code category, e.g., number of days in a particular type of accommodation, pints of blood. However, when HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was performed.

The provider enters up to seven numeric digits. It shows charges for noncovered services as noncovered, or omits them. **NOTE:** Hospital outpatient departments report the number of visits/sessions when billing under the partial hospitalization program.

FL 47 - Total Charges - Not Applicable for Electronic Billers

Required. This is the FL in which the provider sums the total charges for the billing period for each revenue code (FL 42); or, if the services require, in addition to the revenue center code, a HCPCS procedure code, where the provider sums the total charges for the billing period for each HCPCS code. The last revenue code entered in FL 42 is “0001” which represents the grand total of all charges billed. The amount for this code, as for all others is entered in FL 47. Each line for FL 47 allows up to nine numeric digits (0000000.00). The CMS policy is for providers to bill Medicare on the same basis that they bill other payers. This policy provides consistency of bill data with the cost report so that bill data may be used to substantiate the cost report. Medicare and non-Medicare charges for the same department must be reported consistently on the cost report. This means that the professional component is included on, or excluded from, the cost report for Medicare and non-Medicare charges. Where billing for the professional components is not consistent for all payers, i.e., where some payers require net billing and others require gross, the provider must adjust either net charges up to gross or gross charges down to net for cost report preparation. In such cases, it must adjust its provider statistical and reimbursement (PS&R) reports that it derives from the bill. Laboratory tests (revenue codes 0300-0319) are billed as net for outpatient or nonpatient bills because payment is based on the lower of charges for the hospital component or the fee schedule. The A/B MAC (A or HHH) determines, in consultation with the provider, whether the provider must bill net or gross for each revenue center other than laboratory. Where “gross” billing is used, the A/B MAC (A or HHH) adjusts interim payment rates to exclude payment for hospital-based physician services. The physician component must be billed to the *Part B MAC* to obtain payment. All revenue codes requiring HCPCS codes and paid under a fee schedule are billed as net.

FL 48 - Noncovered Charges

Required. The total non-covered charges pertaining to the related revenue code in FL 42 are entered here.

FL 49 - (Untitled)

Not used. Data entered will be ignored.

Note: the “PAGE ____ OF ____” and CREATION DATE on line 23 should be reported on all pages of the UB-04.

FL 50A (Required), B (Situational), and C (Situational) - Payer Identification

If Medicare is the primary payer, the provider must enter “Medicare” on line A. Entering Medicare indicates that the provider has developed for other insurance and determined that Medicare is the primary payer. All additional entries across line A (FLs 51-55) supply information needed by the payer named in FL 50A. If Medicare is the secondary or tertiary payer, the provider identifies the primary payer on line A and enters Medicare information on line B or C as appropriate.

FL 51A (Required), B (Situational), and C (Situational) – Health Plan ID

Report the national health plan identifier when one is established; otherwise report the “number” Medicare has assigned.

FLs 52A, B, and C - Release of Information Certification Indicator

Required. A “Y” code indicates that the provider has on file a signed statement permitting it to release data to other organizations in order to adjudicate the claim. Required when state or federal laws do not supersede the HIPAA Privacy Rule by requiring that a signature be collected. An “I” code indicates Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes. Required when the provider has not collected a signature and state or federal laws do not supersede the HIPAA Privacy Rule by requiring a signature be collected.

NOTE: The back of Form CMS-1450 contains a certification that all necessary release statements are on file.

FL 53A, B, and C - Assignment of Benefits Certification Indicator

Not used. Data entered will be ignored.

FLs 54A, B, and C - Prior Payments

Situational. Required when the indicated payer has paid an amount to the provider towards this bill.

FL 55A, B, and C - Estimated Amount Due From Patient

Not required.

FL 56 – Billing Provider National Provider ID (NPI)

Required on or after May 23, 2008.

FL 57 – Other Provider ID (primary, secondary, and/or tertiary)

Not used. Data entered will be ignored.

FLs 58A, B, and C - Insured’s Name

Required. The name of the individual under whose name the insurance benefit is carried.

FL 59A, B, and C - Patient’s Relationship to Insured

Required. If the provider is claiming payment under any of the circumstances described under FLs 58 A, B, or C, it must enter the code indicating the relationship of the patient to the identified insured, if this information is readily available.

Codes used for Medicare claims are available from Medicare contractors. Codes are also available from the NUBC (www.nubc.org) via the NUBC’s Official UB-04 Data Specifications Manual.

FLs 60A (Required), B (Situational), and C (Situational) – Insured’s Unique ID (Certificate/Social Security Number/*Medicare beneficiary identifier*)

The unique number assigned by the health plan to the insured.

FL 61A, B, and C - Insurance Group Name

Situational (required if known). Where the provider is claiming payment under the circumstances described in FLs 58A, B, or C and a Worker’s Compensation (WC) or an Employer Group Health Plan (EGHP) is involved, it enters the name of the group or plan through which that insurance is provided.

FL 62A, B, and C - Insurance Group Number

Situational (required if known). Where the provider is claiming payment under the circumstances described in FLs 58A, B, or C and a WC or an EGHP is involved, it enters the identification number, control number or code assigned by that health insurance carrier to identify the group under which the insured individual is covered.

FL 63 - Treatment Authorization Code

Situational. Required when an authorization or referral number is assigned by the payer and then the services on this claim AND either the services on this claim were preauthorized or a referral is involved. Whenever Quality Improvement Organization (QIO) review is performed for outpatient preadmission, pre-procedure, or Home IV therapy services, the authorization number is required for all approved admissions or services.

FL 64 – Document Control Number (DCN)

Situational. The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control.

FL 65 - Employer Name (of the Insured)

Situational. Where the provider is claiming payment under the circumstances described in the second paragraph of FLs 58A, B, or C and there is WC involvement or an EGHP, it enters the name of the employer that provides health care coverage for the individual identified on the same line in FL 58.