Program Memorandum Intermediaries

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUEST 1666

SUBJECT: Conversion of Hospital Swing Bed Facilities to the Skilled Nursing Facility Prospective Payment System (SNF PPS) Effective for Cost Reporting Periods Starting July 1, 2002

This Program Memorandum (PM) describes billing and payment for hospitals providing SNF level swing bed services under the SNF PPS as required under §888 (e)(7) of the Act and §203 of the Benefits Improvement and Protection Act (BIPA), and explained in our Final Regulation that was issued July 31, 2001.

This PM provides general information and specific instructions related to the implementation of the Medicare prospective payment system (PPS) for swing bed facilities and fiscal intermediaries (FIs). The PM is divided into three sections. The first section deals with coverage of swing bed extended care services under SNF PPS, the second with payment provisions under SNF PPS, and the third with billing by providers and claims processing under SNF PPS.

Section 4432(a) of the Balanced Budget Act (BBA) of 1997 specifies that swing bed facilities must be incorporated into the SNF PPS by the end of the statutory transition period. Effective with cost reporting periods beginning on or after July 1, 2002, swing bed bills will no longer be paid based on the current cost-related method, but rather on the basis of the SNF PPS. These payment rates will cover all costs of furnishing covered swing bed extended care services (routine, ancillary, and capital-related costs) other than costs associated with operating approved educational activities as defined in 42 CFR 413.85.

The SNF PPS will be phased in based on each swing bed hospital's fiscal year. This transition period will start on the first day of the provider's next cost report year that begins on or after July 1, 2002. Consequently billing for all beneficiaries in a swing bed must be split at the end of the provider's current fiscal year. A new bill must be created for beneficiaries remaining in the facility at the start of the new fiscal year. The bill must be prepared under the SNF PPS claim guidelines described below.

The SNF PPS will apply to short term hospitals, long term hospitals, and rehabilitation hospitals certified as swing bed hospitals. **Critical Access Hospitals (CAHs) with swing beds are exempt from the SNF PPS, and are not affected by the instructions in this PM.**

MEDICARE SNF COVERAGE GUIDELINES UNDER PPS

Posthospital extended care services furnished in a swing bed hospital are covered under Part A of Medicare. Beneficiaries with hospital insurance coverage are entitled to have payment made on their behalf for covered extended care services furnished by the provider, by others under arrangement with the provider, or by a hospital with which the provider has a transfer agreement.

Under SNF PPS, beneficiaries must continue to meet the established eligibility requirements for an SNF-level stay; i.e., the beneficiary must have received acute care as a hospital inpatient for a medically necessary stay of at least 3 consecutive calendar days. In addition, the beneficiary must have started receiving extended care services in the swing bed hospital within 30 days after discharge as an acute care patient from the swing bed facility or other hospital, unless the exception in §3131.3b of the Medicare Intermediary Manual (MIM) applies. To be covered, the extended care services must be needed for a condition which was treated during the beneficiary's qualifying hospital stay, or for a condition which arose while receiving extended care services for a condition for which the beneficiary was previously treated during the acute care stay.

Under the SNF PPS, coverage determinations (i.e., level of care determinations) have been significantly simplified by adopting the system for classifying residents based on resource utilization known as resource utilization groups, version 3 (RUG-III). Swing bed providers will assess the clinical condition of beneficiaries by preparing a Minimum Data Set (MDS) for Swing Bed Hospitals for each Medicare beneficiary receiving SNF level care. The MDS must be completed in compliance with the Medicare PPS schedule shown in Chart 1 below. Each MDS record must then be encoded and electronically transmitted. Swing bed providers must complete the MDS assessment within 14 days of the Assessment Reference Date. An MDS is considered complete on the day that the registered nurse (RN) coordinating the assessment signs and dates the assessment. The MDS records must be transmitted electronically to CMS, and will be considered timely if transmitted and accepted into the data base within 14 days of completion. We will utilize information from the MDS to classify residents into the RUG-III groups for purposes of Medicare reimbursement.

Chart 1
MEDICARE ASSESSMENT SCHEDULE FOR SWING BED FACILITIES

Medicare MDS Assessment Type	Reason for Assessment (MDS Item 11b code)	Assessment Reference Date * (based on start of Part A stay)	Assessment Reference Date Grace Days	Number of Days Authorized for Coverage and Payment	Applicable Medicare Payment Days
5-day	1	1 - 5**	6 - 8**	14	1 - 14
14-day	7	11 - 14	15 - 19	16	15 - 30
30-day	2	21 - 29	30 - 34	30	31 - 60
60-day	3	50 - 59	60 - 64	30	61 - 90
90-day	4	80 - 89	90 - 92	10	91 - 100

*The assessment reference date is the last date of the observation period for the clinical assessment. The timeliness requirements are calculated using the first day of the Medicare Part A-covered stay as "day 1".

** If a beneficiary expires or transfers to another facility before day 8, the facility will still need to prepare an MDS as completely as possible for the RUG-III classification and Medicare payment purposes. Otherwise the days will be paid at the default rate. The assessment reference date may also need to be adjusted to no later than the date of discharge.

SNF PPS is linked to the beneficiary acuity level as identified by classification into one of the 44 RUG-III groups. Medicare beneficiaries typically group into one of the upper 26 RUG-III groups, classification groups that indicate the need for skilled services. We have established an administrative presumption of Medicare Part A coverage for beneficiaries correctly assigned to one of the upper 26 RUG-III groups (i.e., the rehabilitation, extensive care, special care and clinically complex categories) under the initial 5-day, Medicare-required assessment and the 5-day Medicare-required readmission/return assessment. In these cases, the level of care requirement is considered met from the date the beneficiary is "admitted" for extended care services (even though the beneficiary may remain in the same hospital or even the same bed) up to and including the assessment reference date for that 5-day assessment. Although this presumption does not apply in connection with any of the subsequent assessments, the coverage that arises from the presumption remains in effect for as long thereafter as it continues to be supported by the actual facts of the beneficiary's condition and care needs. See Attachment 1 for a detailed discussion of the presumptive coverage criteria.

A beneficiary who is assigned to any of the lower 18 of the 44 RUG-III groups is not automatically classified as meeting or not meeting the SNF level of care definition. Instead, the beneficiary must receive an individual level of care determination using existing administrative criteria and procedures. See Attachment 2 for a list of the administrative criteria used to establish coverage.

Any beneficiary who is in a covered SNF Part A stay on the date the facility comes under the SNF PPS will not have his or her coverage terminated on the basis of the change in the method of making level of care determinations under the PPS for the duration of that covered stay. Therefore, if the beneficiary was determined to be "skilled" using the level of care criteria in place prior to the transition to the SNF PPS, the beneficiary continues to be considered skilled through the earlier of the:

- last day of the Part A benefit period,
- date of discharge from the swing bed, or
- date the condition/service that required skilled care is resolved/eliminated.

CMS is developing a customized swing bed MDS software program that will permit hospitals to data enter, store, and transmit their swing bed MDS assessments. This software will be available to providers, at no charge, in the late Spring of 2002. Detailed information on the RUG-III classification methodology can be obtained by accessing CMS's Internet web site at http://www.hcfa.gov/medicaid/mds20. We expect that similar software products will be available from commercial vendors later this year.

PAYMENT PROVISIONS UNDER SNF PPS

SNF PPS - Payment Provisions - Federal Rate

Swing bed services reimbursed under the SNF PPS will be paid at the full Federal rate. The Federal payment rates were developed by CMS using allowable costs from hospital-based and freestanding SNF cost reports from reporting periods beginning in fiscal year 1995. The data used in developing the Federal rates also incorporated an estimate of the amount payable under Part B for covered SNF-level services furnished during fiscal year 1995 to individuals who were residents of the facility and receiving Part A covered services.

In accordance with the formula prescribed in the Balanced Budget Act (BBA), the Federal rates were set at a level equal to the weighted mean of freestanding costs plus 50 percent of the difference between the freestanding mean and the mean of all SNF costs (hospital-based and freestanding) combined. In addition, the portion of the Federal rate attributable to wage-related costs is adjusted by an appropriate wage index. Payment rates are computed and applied separately for facilities located in urban and rural areas. All swing bed hospitals are classified as rural providers, and will be paid at the rural rate for their geographic locations.

The Federal rate incorporates adjustments to account for facility case mix from the RUG-III patient classification system used under the national PPS. RUG-III, is a 44-group patient classification system that provides the basis for the case-mix payment indices (or relative payment weights) used to standardize the Federal rates and subsequently to establish case-mix adjustments to the rates for patients with different service use. Information from the MDS is used to classify residents into one of 44 RUG-III groups. A customized 2-page MDS has been developed for use by swing bed hospitals. A draft of the MDS for Swing Bed Hospitals is available on our CMS website at http://www.hcfa.gov/medicare/snfpps.htm. Like other providers subject to the SNF PPS, swing bed providers must complete these assessments according to an assessment schedule specifically designed for Medicare payment; i.e., on the 5th, 14th, 30th, 60th, and 90th days after admission. (See Chart 1)

For Medicare billing purposes, there is a Health Insurance PPS (HIPPS) rate code associated with each of the 44 RUG-III groups, and each assessment applies to specific days within a resident's swing bed stay. (See Tables 1 and 2 below.) When assessments are performed late, the swing bed facility will be paid at a default rate equal to the payment made for the lowest RUG III group. The default rate will remain in effect for as long as the provider is not in compliance with this MDS schedule.

Under the SNF PPS, covered swing bed services will include posthospital services for which benefits are provided under Part A (the hospital insurance program). In addition, the SNF PPS rate includes all items and services for which, prior to July 1, 1998, payment had been made under Part B (the supplementary medical insurance program) but furnished to SNF residents during a Part A covered stay.

Services that are not reimbursed through the SNF PPS per diem rate include physician services, physician assistant services, nurse practitioner and clinical nurse specialist services, certified mid-wife services, qualified psychologist services, certified registered nurse anesthetist services and

anesthesiologist assistant services. Services of nurses and physician assistants are not separately billable when they are employees of the swing bed facility. When employed by independent physicians, these services may be billed to the carrier on Form CMS-1500. In addition, certain legislative and administrative exclusions specified in PM A- 01-135 are also excluded from the services included under the SNF PPS rate. See Attachment 3 for more detailed information on services that are separately billable for a beneficiary in a Part A stay.

PART A BILLING REQUIREMENTS UNDER SNF PPS

Billing SNF PPS Services

Providers of swing bed services reimbursed under the SNF PPS will be required to bill room and board charges using a SNF PPS revenue code (0022) and a Health Insurance PPS (HIPPS) code on Form CMS-1450 (or electronic equivalent) for all Part A inpatient claims (Type of Bill (TOB) 18X). The Medicare A 837 Health Care Claim version 3051 implementations 3A.01 and 1A.C1, along with the UB-92 version 6.0 are at http://www.CMS.gov/medicare/edi/edi3.htm. These formats are effective through the implementation date of the HIPAA requirements. The X12N 837 version 4010 (HIPAA) to UB-92 version 6.0 mapping is at http://www.CMS.gov/medicare/edi/hipaadoc.htm. The 837 version 4010 can be downloaded at http://www.wpc-edi.com. Revenue code 0022 will be used in conjunction with the HIPPS code to identify the beneficiary's RUG-III group as of the assessment reference date. These claims must be submitted on TOB 18x.

- The Revenue Code, ANSI X-12 837-Institutional (SV201), Record Type (RT) 60 (field 5), or Form Locator (FL) 42, must contain revenue code 0022. This code indicates that this claim is being paid under the SNF PPS. This revenue code can appear on a claim as often as necessary to indicate different HIPPS Code(s) or assessment periods.

- The HCPCS/Rates, ANSI X-12 837-Institutional (SV202-2), RT60 (field 6), or FL 44, must contain a five digit HIPPS code (AAA00-SSC79). The first three positions of the code contain the MDS RUG-III group and the last two positions of the code contain a two-digit assessment indicator that identifies the type of assessment for payment purposes. See **Tables 1 and 2** for valid group codes and assessment indicators.

- The Service Date, ANSI X-12 837-Institutional (2400 loop DTP03), RT60 (field 13), or FL 45, must contain an assessment reference date when FL 42 contains revenue code 0022 unless FL 44 contains HIPPS code AAA00.

- Service Units, ANSI X-12 837-Institutional (SV205), RT60 (field 9), or FL46, must contain the number of covered days for each HIPPS code and, if applicable, the number of modalities/treatments for each rehabilitation therapy code.

- Total Charges, ANSI X-12 837-Institutional (SV203), RT60 (field 10), FL 47, should contain zero total charges when the revenue code is 0022. For accommodation revenue codes (010x-021x), total charges must equal the rate times the units. The SNF PRICER will calculate and return the rate for each line item with revenue code 0022, and place it in

the claims record. The standard system will then sum the 0022 revenue code lines for TOB 18x and 21x, and make the appropriate payment. Payments will not be made based on the total charges shown in Revenue Code 0001 on the incoming claim. The actual PPS payment amount for each iteration of revenue code 0022 will be shown on the remittance advice and will be stored in the ANSI X-12 837-Institutional (SV203), RT 60 (field 10), or FL 47 on the claim in CWF.

TABLE 1

RUG-III GROUP CODES

AAA (the default code)
BA1, BA2, BB1, BB2
CA1, CA2, CB1, CB2, CC1, CC2
IA1, IA2, IB1, IB2
PA1, PA2, PB1, PB2, PC1, PC2, PD1, PD2, PE1, PE2
RHA, RHB, RHC, RLA, RLB, RMA, RMB, RMC, RUA, RUB, RUC, RVA, RVB, RVC
SE1, SE2, SE3, SSA, SSB, SSC

TABLE 2

HIPPS MODIFIERS/ASSESSMENT TYPE INDICATORS

Basic Assessments
01 5-day Medicare-required assessment
02 30-day Medicare-required assessment
03 60-day Medicare-required assessment
04 90-day Medicare-required assessment
05 Readmission/Return Medicare-required assessment
07 14-day Medicare-required assessment
08 Off-cycle other Medicare-required assessment (OMRA)
30 Off-cycle swing bed change in clinical status (outside assessment window)

Replacement Assessments - OMRAs
18 OMRA replacing 5-day Medicare-required assessment or 5-day Readmission/Return Assessment
28 OMRA replacing 30-day Medicare-required assessment
38 OMRA replacing 60-day Medicare-required assessment
48 OMRA replacing 90-day Medicare-required assessment
78 OMRA replacing 14-day Medicare-required assessment

Replacement Assessments -Change in Clinical Status
32 Swing bed change in clinical status replaces 30-day Medicare-required assessment
33 Swing bed change in clinical status replaces 60-day Medicare-required assessment
34 Swing bed change in clinical status replaces 90-day Medicare-required assessment
35 Swing bed change in clinical status replaces a readmission/return Medicare-required assessment
37 Swing bed change in clinical status replaces 14-day Medicare-required assessment

NOTE: We have not provided a code for a change in clinical status replacing the initial 5-day Medicare-required assessment. If the change in clinical status occurs after the initial 5-day assessment has been completed (i.e., between days 1-8), and before the assessment window for the 14-day assessment, it will be considered an off-cycle change in clinical status, and the HIPPS code will be coded as 30.

Replacement Assessments: Combined OMRA and Change in Clinical Status

When billing for swing bed services, there is no need to differentiate between an OMRA and an OMRA that is also a change in clinical status. For any assessment that meets both the OMRA and clinical change criteria, use the appropriate OMRA assessment indicator.

18 OMRA and change in clinical status replaces 5-day assessment
28 OMRA and change in clinical status replaces 30-day assessment
38 OMRA and change in clinical status replaces 60-day assessment
48 OMRA and change in clinical status replaces 90-day assessment
78 OMRA and change in clinical status replaces 14-day assessment

Special Payment Situations -**New Assessment Indicator Codes Effective July 1, 2002**

In some situations, beneficiaries may change payor source after admission to the swing bed, but fail to notify the provider in a timely manner; e.g., disenrollment from an HMO, disenrollment from a hospice, change in Medicare payor status from secondary to primary, etc. In those situations, the provider may not have completed the MDS assessments needed for Medicare billing. New assessment indicator codes have been established for these special payment situations. Claims processing instructions are being developed and will be issued separately.

19 Special payment situation 5-day assessment
29 Special payment situation 30-day assessment
39 Special payment situation 60-day assessment
49 Special payment situation 90-day assessment
79 Special payment situation 14-day assessment

Default Code - No Assessment Completed
00 Default code (No assessment completed)

When a HIPPS code of RUAxx, RUBxx and/or RUCxx is present, a minimum of two rehabilitation therapy ancillary revenue codes are required (042x and/or, 043x and/or, 044x). When a HIPPS code of RHAxx, RHBxx, RHCxx, RLAxx, RLBxx, RMAxx, RMBxx, RMCxx, RVAxx, RVBxx and/or RVCxx is present, a minimum of one rehabilitation therapy ancillary revenue code is required (042x, 043x or 044x). Generally, it is assumed that facilities will perform an OMRA assessment within 10 days from the date of the last therapy session. The OMRA assessment would be used to establish a new RUG-III group that would not be in the rehabilitation category.

Therefore, allowing the 10-day grace period will allow the processing of bills that span more than one month with the therapy billed entirely on the prior month's bill. Bills that are missing the required rehabilitation therapy ancillary revenue codes for a period greater than 10 days are to be returned to the provider of swing bed services for resubmission. Current policy does not require that another assessment be performed when therapy services are reduced. Therefore, when one therapy service is discontinued at the end of the month, and the RUG-III code being used on the subsequent month's bill is edited by the provider (i.e., verifies the presence of two therapy ancillaries during the observation period for the MDS being used to support the billing), the facility may utilize a "workaround." Use 1 unit of the discontinued therapy at a charge of $0.01. Medical records must reflect that the beneficiary continued treatment in at least one therapy discipline until the next assessment was required.

Edits

The edits described in this PM are currently in place for SNFs and must be expanded to included swing bed hospital (TOB 18x) claims by July 1, 2002. Additional edits are being developed that will apply to both SNFs and swing bed providers that are reimbursed under the SNF PPS. Until the expanded edits are in place, swing bed bills will be edited as described below.

Standard system edits should be installed to ensure that swing bed claims will process correctly under the SNF PPS billing requirements: These edits should be incorporated into the front end acceptance process since all the necessary data elements are on the claim.

- Providers of swing bed services reimbursed under the SNF PPS must report revenue code 0022 on TOB 18x. The customary room and board revenue codes (010x-021x) and charges must also be included on the bill.

- A valid HIPPS code is always present on revenue code 0022.

- All revenue code 0022 lines have total units greater than 0. Charges cannot be associated with the 0022 revenue code, and the charge field should be left blank.

- The assessment reference date of the MDS used to support the bill must be entered into the service date field for all HIPPS codes except AA000. The AA000 default code indicates that no assessment was performed so the date field will be blank.

- Revenue code total charges line 0001 must equal the sum of the individual total charges lines;

- The length of stay in the statement covers period and in the from and through dates equals the total days for accommodations revenue codes 010x - 021x, including revenue code 018x (leave of absence).

- The sum of revenue codes 010x - 021x units minus revenue code 018x, leave of absence units, is equal to the sum of PPS revenue code 0022 covered units.

Billing Ancillary Services Under SNF PPS

When coding PPS bills for ancillary services associated with a Part A swing bed stay, continue to show the traditional revenue codes in FL 42 (e.g., 0250 - Pharmacy, 042x - Physical Therapy) in conjunction with the appropriate entries in Service Units, FL 46 and Total Charges, FL 47.

- Providers of swing bed services are required to report the number of units in FL 46 based on the procedure or service.

- Providers of swing bed services are required to report the actual charge for each line item (except for revenue code 0022), in Total Charges, FL 47.

- The accommodation revenue code 018x, leave of absence, ANSI X-12 837-Institutional (SV201) RT 50 (field 5), or FL 42, will continue to be used in the current manner including the appropriate UB92 occurrence span code, 74, non-covered days or leave of absence, ANSI X-12 837-Institutional (2300 loop HI code BI), RT 40 (fields 28-33), or FL 36, and the date range of the non-covered care.

Billing Ancillary Services under Medicare Part B

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

Swing bed providers must utilize line item, date of service HCPCS coding for Part B inpatient billing.

Demand Bills

Demand bills, identified by the presence of condition code 20, (ANSI X-12 837-Institutional (2300 loop HI code BG) RT 41 (fields 4 - 13), or FLs 24 - 30)) may be submitted at the request of a beneficiary or family member. All required billing information must be present, including the HIPPS codes (reflecting either the RUG-III group generated by processing the MDS through the RUG-III grouper program or the default code, AAA) and the 0022 revenue code.

Spell of Illness

To code a claim properly for a resident whose Medicare Part A coverage is ending due to a change in the skilled level of care (or benefits exhausted) when the beneficiary continues to reside in the facility, the patient status ANSI X-12 837-Institutional (CL103), RT 20 (field 21), or FL 22 must equal 30 (still patient). For the purpose of breaking a spell of illness, those residents who have changed to a non-skilled level of care must have their Part A claim coded with an occurrence code 22 ANSI X-12 837-Institutional (2300 loop HI code BH), RT 40 (fields 8 - 21), or FL 32 - 35 and must enter the date of the last medically covered day. A benefits exhausted situation does not automatically break a spell for a Medicare beneficiary; therefore, occurrence code 22 should not be coded in a benefits exhausted situation unless there is medical justification for doing so.

For a beneficiary who changes to a non-skilled level of care after Part A reimbursement ends, occurrence code 22 and the date of the last medically covered day should be coded on a claim, showing the from and through dates of the non-covered period and indicating beneficiary or provider liability (76 or 77) as ANSI X-12 837-Institutional (2300 loop HI code RH), RT 40 (fields 22 - 27), or FL 36. When using code 76 to show beneficiary liability, the provider must also use occurrence code 31 and value code 31 as is currently required for hospital inpatient claims.

When properly applied, occurrence code 22 (and the date) will set an indicator on common working file (CWF) to track the days of utilization properly for spell of illness. In addition to the SNF PPS revenue code, providers of swing bed services will also be required to bill the customary room and board revenue codes (01x - 021x) and charges on inpatient claims (TOB 18X).

If a beneficiary's Part A benefits are exhausted, TOB 18x should be coded with occurrence code A3, B3 or C3 (payer status indicators), as appropriate, ANSI X-12 837-Institutional (2300 loop HI code BH), RT 40 (fields 8-21), or FL 32 - 35.

If the beneficiary remains a resident in the swing bed facility after the end of the Part A stay, the hospital may submit a claim to the FI for those services covered under inpatient Part B using TOB 12x. The beneficiary would be eligible for the same benefits available to a hospital inpatient in a Part B stay. The hospital provider of SNF level swing bed services must also file a Part A non-payment bill either monthly or at discharge using the appropriate non-payment code. (See MIM §3624.)

If a beneficiary is admitted to another hospital as an inpatient for services not available at the swing bed facility, the beneficiary should be discharged. If that beneficiary subsequently returns to the swing bed facility, the beneficiary should be readmitted.

Late Charges

Bills for late charges will not be processed. Providers must file adjustments if they determine the original bill inadvertently omitted charges for services/supplies furnished to the beneficiary.

SNF PRICER SOFTWARE

The SNF PRICER will be used for swing bed providers. The current procedures for updating the PRICER will be maintained. This SNF PRICER program calculates the daily Medicare SNF PPS rate for each facility. PRICER uses the facility's provider-specific rate, the provider's Metropolitan Statistical Area, the Statement Covers Through Date on the claim and the HIPPS code to calculate the SNF PPS rates. The SNF PRICER will calculate and return the rate for each line item with revenue code 0022, and place it in the claims record. The standard system will then sum the 0022 revenue code lines for TOB 18x and 21x, and make the appropriate payment. Payments will not be made based on the total charges shown in revenue code 0001. The actual PPS payment amount for line item 0022 will be shown on the remittance advice and will be stored on the claim in CWF.

For every revenue code 0022 on the SNF bill, the standard system multiplies the payment rate by the number of days (units) associated with that revenue code. The standard system then sums the amount payable for each PPS HIPPS code and determines the proper payment amount.

Provider-Specific File

For SNF PPS purposes, swing bed hospitals should be assigned to provider type 38. Swing bed providers will be paid at 100 percent of the Federal rate. Swing bed hospitals are rural facilities, and should be designated as such by their MSA codes. Swing bed facilities will be paid at the SNF PPS rural rate.

FIs must set the Federal PPS Blend Indicator in the Provider-Specific file to "4". The CMI ADJ CPD field should be blank.

Remittance Advice

Use existing remittance advice notices for SNF PPS on a swing bed Part A inpatient stay.

Medicare Summary Notices

Use existing notices for SNF PPS coverage on a swing bed stay.

SPECIAL BILLING REQUIREMENTS UNDER SNF PPS

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

If a swing bed hospital furnishes a service or supply to a beneficiary receiving SNF-level services that is excluded from the SNF PPS rate; the swing bed hospital may submit a separate bill to the FI for the SNF PPS-excluded service. This bill must use TOB 12x with all appropriate revenue codes, HCPCS codes, and line item date of service billing information. A list of services that are excluded from the SNF PPS rate is included in Attachment 3. For more detailed information on services that are separately billable under the SNF PPS, see PM A-01-135.

Bills for these SNF PPS consolidated billing "exclusions" must be filed as inpatient Part B services and will be paid as inpatient Part B services under the Outpatient Prospective Payment System (OPPS). See PM A-01-142 for a list of billable inpatient Part B services that are covered through the OPPS. Note that services included under the SNF PPS may not be billed separately.

Similarly, as explained above, swing bed hospitals may file bills with the FIs for Part B ancillary services furnished to Medicare beneficiaries who are not in a Part A swing bed stay. These claims will also be billed as inpatient Part B services, and payable under the OPPS.

These instructions should be implemented within your current operating budget.

The effective date of this PM is for cost reporting periods starting July 1, 2002.

The implementation date of this PM is July 1, 2002.

This PM may be discarded January 1, 2003.

If you have any questions regarding this PM, you may contact your regional office.

ATTACHMENT 1

CLARIFICATION OF THE PRESUMPTION OF COVERAGE

The following scenarios further clarify that a beneficiary's classification to one of the upper 26 RUG-III groups triggers the coverage presumption under the initial 5-day, Medicare-required assessment only when that assessment occurs directly following the beneficiary's hospital discharge.

1. Routine Swing Bed Admission Directly from Qualifying Hospital Stay

If the beneficiary is admitted for SNF-level care immediately following a 3-day qualifying hospital stay (regardless of whether the acute care hospital stay was in the swing bed facility or not), there is a presumption that he or she meets the Medicare level of care criteria. The presumption lasts through the assessment reference date of the 5-day assessment, which must occur no later than the eighth day of the stay.

2. **Admission for SNF-level Care Does Not Immediately Follow Discharge from the Qualifying Hospital Stay, but Occurs Within 30 Days (as required under the "30 day transfer" rule)**

If the beneficiary is discharged from the hospital to a setting other than the SNF-level services provided in the swing bed facility, the presumption of coverage does not apply, even if the beneficiary's return to the swing bed facility for SNF-level services occurs within 30 days of discharge from the qualifying hospital stay. Accordingly, coverage would be determined based on a review of the medical evidence in file.

3. **Resident is Re-hospitalized and then Returns**

If a beneficiary who has been in a covered Part A stay requires readmission to a hospital (either the swing bed hospital or another hospital), and is transferred directly back to the swing bed to receive SNF-level services, there is a presumption that he or she meets the level of care criteria upon readmission. A new Medicare 5-day assessment is required and the presumption of coverage lasts through the assessment reference date, which must occur no later than the eighth day of the stay.

4. Routine Swing Bed Admission Directly from Qualifying Hospital Stay, but Initial Portion of Swing Bed Stay Covered by Another Insurer (Medicare as Secondary Payer)

When a beneficiary goes directly from a qualifying hospital stay to the swing bed for SNF-level care, but the initial portion of the post acute stay is covered by another insurer that is primary to Medicare, Medicare coverage would not start until coverage by the insurer ends. The Medicare required schedule of assessments would not begin until the first day of Medicare coverage. If Medicare begins within the first 8 days of the stay, the presumption lasts through the assessment reference date of the 5-day assessment or, if earlier, the eighth day of the stay.

Thus, if the other insurer's coverage lasts through the eighth day of the stay, there is no presumption.

5. Beneficiary Receives a Notice of Non-Coverage upon Admission and Requests a Demand Bill

In this situation, a Medicare 5-day assessment was not performed because the SNF's clinical staff determined upon admission that the beneficiary did not meet the level of care criteria for coverage. Since no 5-day assessment was performed, the medical review would be based on the coverage criteria described in Attachment 2. If the medical review indicated that the services should have been covered, the days would be paid at the default rate since no 5-day assessment was actually performed.

6. Readmission for Post - Acute Swing Bed Care within 30 Days after Discharge from Initial Swing Bed Stay—No Intervening Hospitalization

As noted in scenario 1, if a beneficiary is initially admitted to the swing bed directly following a covered Part A acute care stay, the presumption for that stay is applicable. However, if that beneficiary is discharged (NOT to an acute care facility) and then subsequently readmitted, there is no presumption applicable to the second swing bed admission. (If the beneficiary is transferred to a hospital, and returns directly to the swing bed, see scenario 3 above.)

***7.* Initial, Non-Medicare Swing Bed Stay Followed by Qualifying Hospitalization and Readmission to a Swing Bed Facility for a Medicare-Covered Extended Care Stay**

Dually eligible (Medicare/Medicaid) beneficiaries whose initial post acute swing bed stay is either Medicaid-covered or private pay, are eligible for the Medicare presumption of coverage when readmitted to the swing bed for SNF-level services following a qualifying hospitalization.

8. **Transfer from One Extended Care (i.e., SNF-level) Facility to Another**

There is no presumption of coverage in cases involving transfer of a beneficiary from one SNF-level provider to another. The presumption applies only to the SNF-level stay that immediately follows the qualifying hospital stay. Similarly, in cases involving transfer of a beneficiary from a swing-bed hospital to a SNF, the presumption applies only when the beneficiary stopped receiving inpatient acute care services and initiated the extended care portion of the stay in the swing bed hospital. The swing bed services payable under the SNF PPS are eligible for the presumption. However, the presumption does not apply to beneficiaries transferring to a SNF after receiving extended care services in a swing bed hospital.

Bear in mind that the presumption was deliberately designed to create a very high probability of identifying those situations that involve a need for skilled care. Accordingly, we do not anticipate that there will be a significant number of cases in which a beneficiary qualifies for the presumption and yet does not actually require any skilled care. However, as indicated in the July 30, 1999 final rule (64 FR 41668-69), if it becomes apparent in actual practice that this is not the case with regard to certain specific criteria under the RUG-III classification system (e.g., the 14-day "look-back" provision), CMS reserves the right to reassess the validity of the presumption's use of those criteria.

Attachment 2

COMPARISON & RATIONALE FOR ELIGIBILITY AND COVERAGE CHANGES

TECHNICAL ELIGIBILITY

Prior to SNF PPS	**Changes Under SNF PPS**
3-Day Qualifying Stay	SAME
Transferred Within 30 Days Of Hospital Stay Of 3 Consecutive days	SAME
Physician Certification Need Skilled Care (*Admission/by Day 14 and every 30 days thereafter*)	Physician, Nurse Practitioner or Clinical Nurse Specialist ***may initially*** Certify to the Need for Skilled Care ***or*** Correctness of the RUG III ***Re-certifications*** are for the ongoing need of skilled services
Medical Predictability(Continuation Rx is inappropriate from a Medical perspective)	SAME
Treated for a condition which was treated during qualified stay, ***or*** which arose while in a SNF for a treatment of condition for which the beneficiary previously was treated in a hospital	SAME

Attachment 2 (cont'd)

COMPARISON & RATIONALE FOR ELIGIBILITY AND COVERAGE CHANGES

Prior to SNF PPS	Changes with SNF PPS Final Rule
Skilled nursing or skilled rehabilitation on a daily basis	**Remains the Same**
Performed by or under direct MD supervision	**Remains the Same**
Management/evaluation of the Plan of Care	**Remains the Same**
Observation and assessment of the Plan of Care	**Remains the Same**
Teaching and Training Activities: *To teach self maintenance; Examples:* • Self Injection • Newly Diagnosed Diabetic Insulin INJ/Diet/Observation Foot Care Precautions • Gait Training & Prosthesis Care • Recent colostomy/ileostomy care • Self Catherization & Self GT feedings Care & Maintenance CVP's/Hickman Catheters • Care of Braces, Splints, Orthotics Associated Skin Care • Specialized dressings or skin treatment	**Requires Skills of a Technical/Professional For the teaching of a Self maintenance program**

Attachment 2 (cont'd)

COMPARISON & RATIONALE FOR ELIGIBILITY AND COVERAGE CHANGES

Prior to SNF PPS	Changes with SNF PPS Final Rule
DIRECT SKILLED SERVICES	
• IV, IM, SC Injections	**IV , IM Injections Only**
• Hypodermoclycis, IV feedings	**IV Feedings Only**
• NG tube, Gastrostomy, Jejunostomy • Naso-Pharyngeal Tracheotomy aspiration	**MODIFIED TO:** **Feedings 26 percent of QD calories And a Minimum of 501 ml fluid per day**
• Insertion, sterile irrigation, replacement catheters/care of suprapubic catheter and insertion/ care of catheter adjunct to active rx of a disease	**Suprapubic Catheters Only**
• Application of Dressings with Prescription Meds and Aseptic Techniques	**Remains the Same**
• Treatment of decubitus ulcers. Severity of grade 3 or worse or widespread skin disorder	**Remains the Same**
• Heat RX's ordered by MD requiring skilled observation	**Remains the Same**
• Rehabilitation Nursing procedures includes related teaching adaptive aspects of nursing and part of active treatment necessitating skilled nursing; e.g., institution of bowel and bladder training programs	**Remains the Same**
• Initial regimen involving administration of medical gases such as bronchodilator therapy	**Remains the Same**
• Care of a colostomy/early post-op phase with associated complications	**Remains the Same**

Attachment 2 (cont'd)

COMPARISON & RATIONALE FOR ELIGIBILITY AND COVERAGE CHANGES

Prior to SNF PPS	**Changes with SNF PPS Final Rule**
SKILLED PHYSICAL THERAPY • Directly related written plan of treatment • Requires knowledge/skills/ judgment of qualified professional • Services must be considered under acceptable standards of clinical practice • Expectation of improvement of restorative potential in a reasonable & predictable period of time, or.... • Establishment of a safe and effective maintenance program* **Applications** • Hot Packs Hydrocollator infra red, Paraffin Baths only in the presence of complicating condition; e.g., open wounds • Gait training • Ultrasound, short-wave, diathermy • ROM tests • Therapeutic exercises	***Skilled Rehabilitation Services are captured within the RUG III Rehabilitation groups***

Attachment 2 (cont'd)

COMPARISON & RATIONALE FOR ELIGIBILITY AND COVERAGE CHANGES

Prior to SNF PPS	**Changes with SNF PPS Final Rule**
SKILLED OCCUPATIONAL THERAPY • Ordered by a physician to improve or restore function **Applications** • Eval/ Re-Eval of Function • Teaching task oriented therapeutic activities • Plan/implement/supervise individualized • therapeutic activities and sensory integration functions • Testing of compensatory techniques • Design/fabrication and fitting orthotic or self help devices • Vocational/pre-vocational	**Skilled Rehabilitation Services are captured within the RUG III Rehabilitation groups**
SPEECH THERAPY • Directly related written plan of treatment • Requires knowledge/skills/ judgment of qualified professional • Services must be considered under acceptable standards clinical practice • Expectation of improvement; i.e. restorative potential in a reasonable & predictable period of time Or • Establishment of a safe and effective maintenance program Services necessary for diagnosis and treatment of speech and language disorders **Applications** • Restoration therapy • Establishment of a maintenance program* • Diagnostic & evaluation services • Therapeutic services • Services for the treatment of dysphagia	**Skilled Rehabilitation Services are captured within the RUG III Rehabilitation groups**
*The actual provision of maintenance therapy does not generally require the skills of a licensed therapy professional.	

ATTACHMENT 3

SWING BED RESPONSIBILITY FOR BILLING ANCILLARY SERVICES

A -- Medicare SNF Consolidated Billing Responsibility

SERVICES	***BUNDLED BACK TO SWING BED PROVIDER***	***SEPARATELY BILLABLE BY SWING BED PROVIDER***
Services Provided After Discharge From the SNF-Level Extended Care Bed		
• To home (no return by midnight)		**X**
• To home (return by midnight)	**X**	
• To home for home health services under a plan of care		**X**
• To hospital or CAH for inpatient admission		**Billed by hospital or CAH**
Services Within the General Scope of Swing Bed Care (All services except those specifically excluded by legislation and/or by CMS)	**X**	
Services Excluded by the BBA • Physician services • Physician assistant services performed under supervision • Nurse practitioners and clinical nurse specialists working in collaboration with a physician • Certified nurse midwife • Qualified psychologist • Certified registered nurse anesthetist • Home dialysis supplies and equipment, self care dialysis support services, and institutional dialysis services and supplies • Erythropoietin (EPO) for certain dialysis patients • Hospice care related to a beneficiary's terminal illness • Ambulance - initial admission /final discharge		**X**

ATTACHMENT 3 (cont'd)

SWING BED RESPONSIBILITY FOR BILLING ANCILLARY SERVICES

Services Excluded by CMS from SNF PPS Financial Responsibility Under Consolidated Billing[1] (as identified by codes in CMS PM No. A-00-88, 11/22/2000)		**X**
• **Outpatient Hospital Emergency Services[2]**		**X**
• Magnetic resonance imaging (MRI)		**X**
• Computerized axial tomography (CT) scans		**X**
• Ambulatory surgery involving the use of an operating room - (1999 PPS Final Rule provides that PEG tube procedures performed in a GI suite or an endoscopy suite are also excluded from consolidated billing.)		**X**
• Cardiac catheterization		**X**
• Hospital outpatient radiation therapy		**X**
• Hospital outpatient angiography		**X**
• Lymphatic and venous procedures		**X**
Services excluded by the BBRA[3]		
• Certain Chemotherapy items and administrative services,		**X**
• Certain Radioisotope services,		**X**
• Certain Customized prosthetic devices		
Ambulance Trips	**See chart B**	**See chart B**

[1] Services must be obtained at an outpatient hospital department. Services obtained at a freestanding clinic are not exempt.

[2] Outpatient hospital emergency services are defined in 42 CFR Section 424.101 as services that are necessary to prevent death or serious impairment of health and, because of the danger to life or health, require use of the most accessible hospital available and equipped to furnish those services.

[3] Services do not have to be obtained at an outpatient hospital department. The Part B suppliers of these services will be able to bill Medicare Part B directly, i.e., the specified chemotherapy and radioisotope services can be provided and billed by hospital outpatient departments, physicians' offices, or other appropriate suppliers, and prosthetics suppliers will be able to bill for the specified customized prosthetic devices indicated by the codes in the legislation.

Attachment 3 (cont'd)

SWING BED RESPONSIBILITY FOR BILLING ANCILLARY SERVICES

B -- Current Responsibility for Ambulance Services to Medicare Beneficiaries Receiving SNF-Level Services in a Swing Bed Hospital

TYPE OF TRIP	*AMBULANCE BILLS CARRIER*	*AMBULANCE BILLS Swing Bed Facility*
Initial Admission to SNF-Level Care at Swing Bed Facility[4]	**X**	
Final Discharge From SNF		
• To home (no return by midnight)	**X**	
• To home (return by midnight)		**X**
• To home for home health services under a plan of care	**X**	
• To another hospital for acute care services	**X**	
• To another SNF (medical necessity)[5]		**X**
Round-Trip to Obtain Dialysis Services (BBRA) in another facility	**X**	
Round-Trip to Another Hospital for Emergency Services	**X**	
Round-Trip to Another Hospital for Services Within the General Scope of Swing Bed Care (All services except those specifically excluded by CMS)		**X**
Round-Trip to Another Hospital for Services Excluded by CMS from SNF PPS Financial Responsibility Under Consolidated Billing[6]	**X**	
• Magnetic resonance imaging (MRI)	**X**	
• Computerized axial tomography (CT) scans	**X**	
• Ambulatory surgery involving the use of an operating room -- (1999 PPS Final Rule provides that PEG tube procedures performed in a GI suite or an endoscopy suite are also excluded from consolidated billing.)	**X**	
• Cardiac catheterization	**X**	
• Hospital outpatient radiation therapy	**X**	

[4] Applicable to swing bed providers only when the patient is being transferred from another acute care hospital to receive extended care services at a swing bed facility.

[5] Ambulance bills transferring facility.

[6] Services must be obtained at an outpatient hospital department. Ambulance payment is available only if the services required by the beneficiary are not available at the swing bed hospital. Services obtained at a freestanding clinic are not exempt.

Attachment 3 (cont'd)

SWING BED RESPONSIBILITY FOR BILLING ANCILLARY SERVICES

• Hospital outpatient angiography	**X**	
• Lymphatic and venous procedures	**X**	
Round-Trip to Provider of Services Excluded by BBA from SNF PPS Financial Responsibility Under Consolidated Billing, e. g., a round-trip to a physician's office		**X**
Round-Trip to Provider of Services Excluded by BBRA from SNF PPS Financial Responsibility Under Consolidated Billing[7] -- Certain chemotherapy items and administrative services, radioisotope services, and customized prosthetic devices		**X**

[7] It is expected that swing bed providers perform these services within the facility. However, if the services are not available in the swing bed facility, the swing bed provider may use an independent supplier. The Part B suppliers of these services will be able to bill Medicare Part B directly, e.g., radioisotope services performed in a free-standing center, ambulance transportation to a dialysis center.