How to Bill for Nursing Facility Add-On Code S0315 (Also known as "Weekend Admission Add-On")

Nursing Facilities Billing for Add-On Services Provided in a Nursing Facility

Beginning *December 1, 2021*, a nursing facility will be eligible for a Medicaid add-on of $200 per member per day for up to 2 days of a Fee-for-Service (FFS) member's nursing facility stay, if the FFS member meets all the following criteria:

(a) MassHealth is the FFS member's primary payer for nursing facility services at the time of admission. This includes members enrolled in the Primary Care Clinician (PCC) Plan or enrolled in a Primary Care Accountable Care Organization (PCACO).
(b) The FFS member was transferred to the nursing facility directly from an inpatient hospital in Massachusetts between 12:00 a.m. on Saturday and 11:59 p.m. on Sunday on or after December 1, 2021.
(c) The FFS member is not returning to the nursing facility from a medical leave of absence.

Nursing facilities will need to submit one claim for the member to be reimbursed for add-on services. Claims should be submitted directly to MassHealth as indicated below.

BILL NURSING FACILITY ADD-ON RATE USING AN INSTITUTIONAL 837I OUTPATIENT CLAIM

These are the values that are different than what a Nursing Facility normally bills for.

On the 837I transaction enter a Type of Bill TOB: **231**

From and through dates of claim: **Should be inclusive of the entire admitting weekend and cannot exceed 2 days. Claims may span multiple months.**

Use a Revenue Code: **0220 Special Charges General Classification**

With a HCPCS Code: **S0315 DISEASE MANAGEMENT PROGRAM**

Image from page 145 of the 837I Guide, annotated to instruct billers to use Type of Bill Code 231

REQUIRED CLM05 C023 **HEALTH CARE SERVICE LOCATION INFORMATION** O 1

To provide information that identifies the place of service or the type of bill related to the location at which a health care service was rendered

REQUIRED CLM05 - 1 1331 **Facility Code Value** M AN 1/2

Code identifying where services were, or may be, performed; the first and second positions of the Uniform Bill Type Code for Institutional Services or the Place of Service Codes for Professional or Dental Services.

IMPLEMENTATION NAME: **Facility Type Code**

REQUIRED CLM05 - 2 1332 **Facility Code Qualifier** O ID 1/2

Code identifying the type of facility referenced

SEMANTIC:
C023-02 qualifies C023-01 and C023-03.

CODE	DEFINITION
A	**Uniform Billing Claim Form Bill Type**

CODE SOURCE 236: Uniform Billing Claim Form Bill Type

REQUIRED CLM05 - 3 1325 **Claim Frequency Type Code** O ID 1/1

Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type

USE TOB 231

IMPLEMENTATION NAME: **Claim Frequency Code**

CODE SOURCE 235: Claim Frequency Type Code

Image from page 284 of the 837I Guide to instruct billers on the use of Value Code 24

ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	HI01	C022	**HEALTH CARE CODE INFORMATION**	M 1

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

REQUIRED HI01 - 1 1270 **Code List Qualifier Code** M ID 1/3

Code identifying a specific industry code list

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

CODE	DEFINITION
BE	**Value**

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED HI01 - 2 1271 **Industry Code** M AN 1/30

Code indicating a code from a specific industry code list

ENTER VALUE CODE 24

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

IMPLEMENTATION NAME: **Value Code**

Image from pages 424, 425, and 426 of the 837I Guide, annotated to instruct billers on the use of Revenue Code 220 and corresponding HCPCS code

ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	SV201	234	**Product/Service ID** Identifying number for a product or service SYNTAX: R0102 SEMANTIC: SV201 is the revenue code. IMPLEMENTATION NAME: **Service Line Revenue Code** **See Code Source 132: National Uniform Billing Committee (NUBC) Codes.**	X 1 AN 1/48
REQUIRED	SV202 - 1	235	**Product/Service ID Qualifier** Code identifying the type/source of the descriptive number used in Product/Service ID (234) SEMANTIC: C003-01 qualifies C003-02 and C003-08. IMPLEMENTATION NAME: **Product or Service ID Qualifier** HC **Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes** **Because the AMA's CPT codes are also level 1 HCPCS codes, they are reported under HC.** CODE SOURCE 130: Healthcare Common Procedural Coding System	M ID 2/2
REQUIRED	SV202 - 2	234	**Product/Service ID** Identifying number for a product or service SEMANTIC: If C003-08 is used, then C003-02 represents the beginning value in the range in which the code occurs. IMPLEMENTATION NAME: **Procedure Code**	M AN 1/48
REQUIRED	SV203	782	**Monetary Amount** Monetary amount SEMANTIC: SV203 is the submitted service line item amount. IMPLEMENTATION NAME: Line Item Charge Amount **This is the total charge amount for this service line. The amount is inclusive of the provider's base charge and any applicable tax amounts reported within this line's AMT segments.**	O 1 R 1/18

USE REVENUE CODE 0220

ENTER HC

ENTER HCPCS CODE S0315

ENTER CHARGES

Image from page 428 of the 837I Guide, annotated to instruct Billers on inputting of required Days

REQUIRED	SV204	355	**Unit or Basis for Measurement Code** Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken	X 1	ID	2/2

ENTER DA

SYNTAX: P0405

CODE	DEFINITION
DA	Days
UN	Unit

REQUIRED	SV205	380	**Quantity** Numeric value of quantity	X 1	R	1/15

ENTER # OF DAYS

SYNTAX: P0405

IMPLEMENTATION NAME: **Service Unit Count**

The maximum length for this field is 8 digits excluding the decimal. When a decimal is used, the maximum number of digits allowed to the right of the decimal is three.

Image from pages 319-321 of the 837I Guide on the NPI requirements for Billers

SEGMENT DETAIL

NM1 - ATTENDING PROVIDER NAME

ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	M 1 ID 2/3
			CODE: 71 — DEFINITION: Attending Physician **When used, the term physician is any type of provider filling this role.**	
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE: 1 — DEFINITION: Person	M 1 ID 1/1
REQUIRED	NM103	1035	**Name Last or Organization Name** Individual last name or organizational name SYNTAX: C1203 IMPLEMENTATION NAME: Attending Provider Last Name	X 1 AN 1/60
SITUATIONAL	NM104	1036	**Name First** Individual first name SITUATIONAL RULE: *Required when the person has a first name. If not required by this implementation guide, do not send.* IMPLEMENTATION NAME: Attending Provider First Name	O 1 AN 1/35
SITUATIONAL	NM105	1037	**Name Middle** Individual middle name or initial SITUATIONAL RULE: *Required when the middle name or initial of the person is needed to identify the individual. If not required by this implementation guide, do not send.* IMPLEMENTATION NAME: Attending Provider Middle Name or Initial	O 1 AN 1/25
NOT USED	NM106	1038	**Name Prefix**	O 1 AN 1/10
SITUATIONAL	NM107	1039	**Name Suffix** Suffix to individual name SITUATIONAL RULE: *Required when the name suffix is needed to identify the individual. If not required by this implementation guide, do not send.* IMPLEMENTATION NAME: Attending Provider Name Suffix	O 1 AN 1/10

SITUATIONAL **NM108** **66** **Identification Code Qualifier** **X 1 ID 1/2**

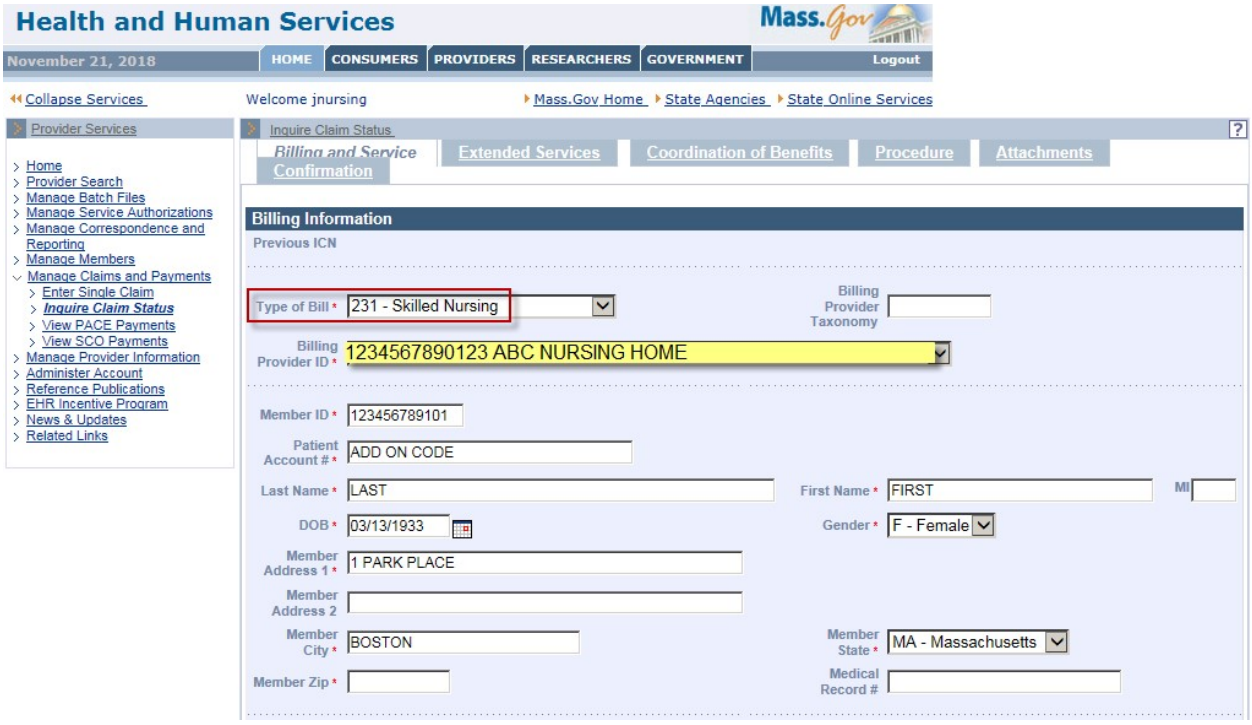
Code designating the system/method of code structure used for Identification Code (67)

SYNTAX: P0809

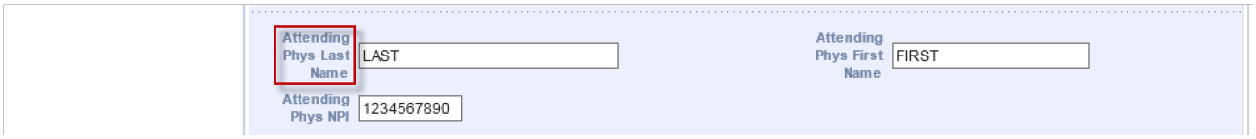
SITUATIONAL RULE: ***Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI.***
OR
Required for providers not in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider has received an NPI.
OR
Required for providers prior to the mandated NPI implementation date when the provider has received an NPI and the submitter has the capability to send it.
If not required by this implementation guide, do not send.

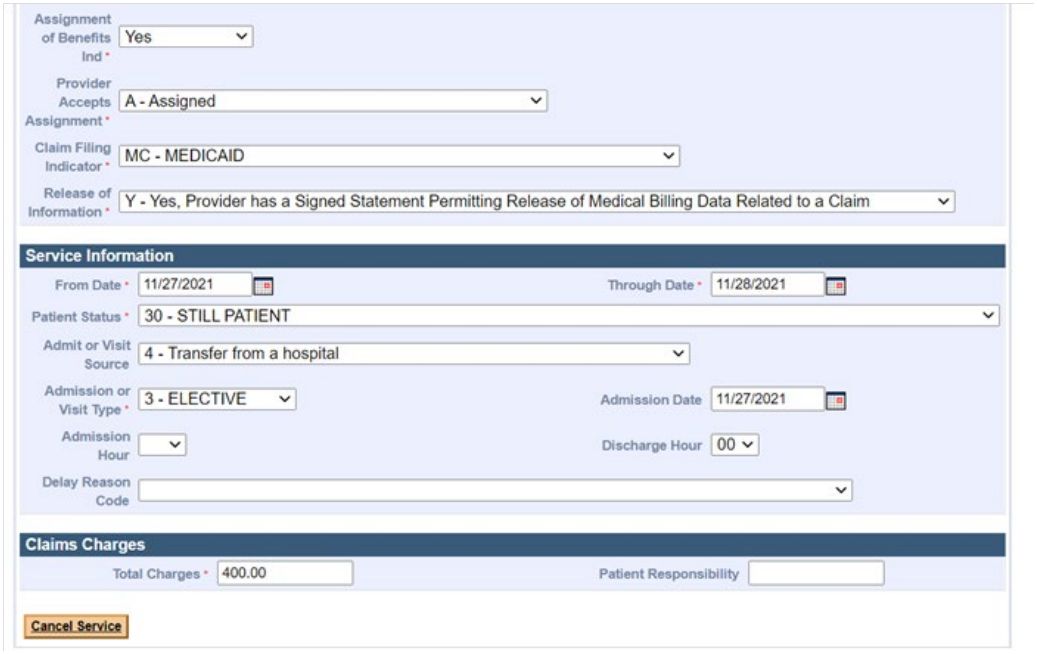
CODE	DEFINITION
XX	**Centers for Medicare and Medicaid Services National Provider Identifier** CODE SOURCE 537: Centers for Medicare and Medicaid Services National Provider Identifier

POSC SCREEN SHOTS IF MANUALLY BILLING VIA DIRECT DATA ENTRY (DDE)-



MUST INDICATE ATTENDING PROVIDER





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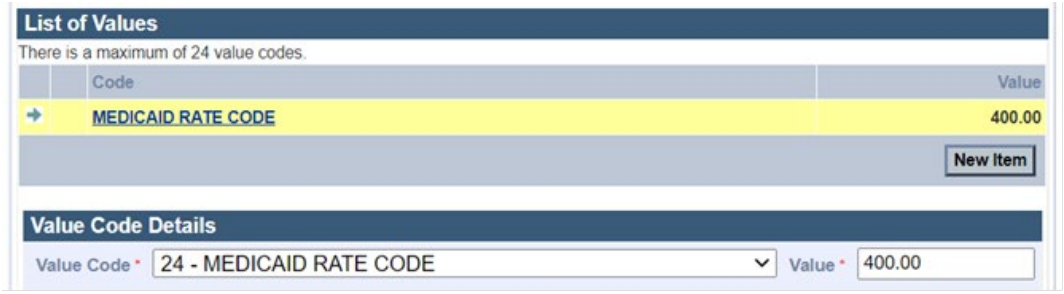
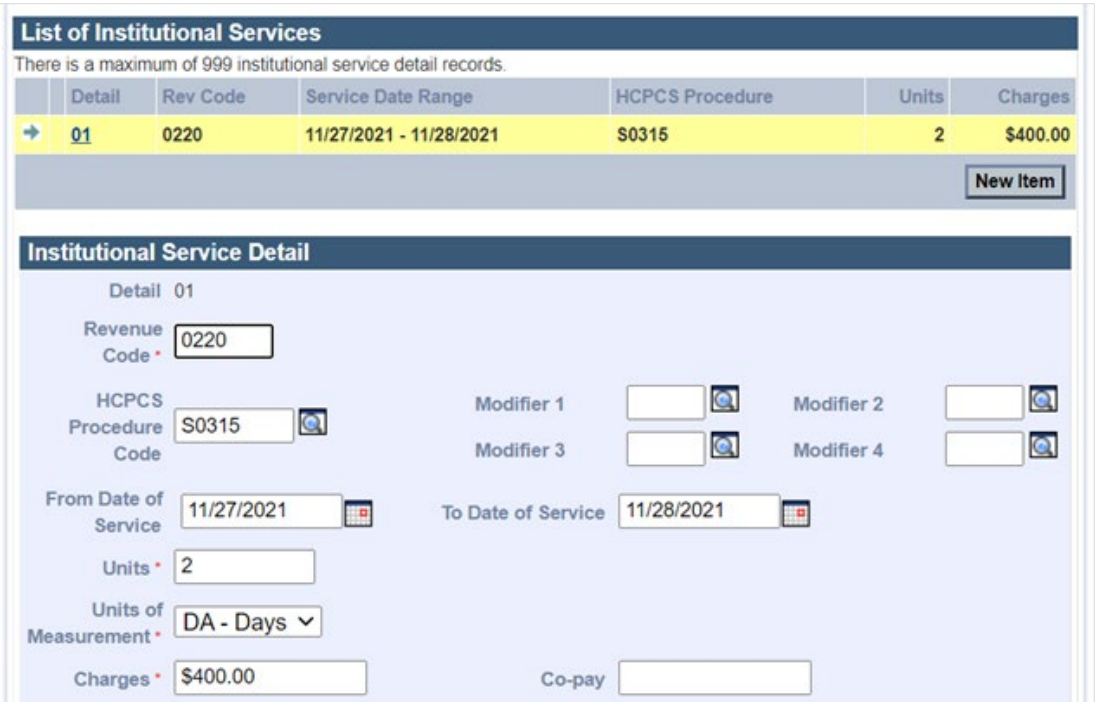
* Patient Account Number field: type in the Patient Account Number


List of Values
There is a maximum of 24 value codes.
Code
Value
MEDICAID RATE CODE
400.00
New Item
Value Code Details
Value Code *
24 - MEDICAID RATE CODE
Value *
400.00


List of Institutional Services
There is a maximum of 999 institutional service detail records.
Detail
Rev Code
Service Date Range
HCPCS Procedure
Units
Charges
01
0220
11/27/2021 - 11/28/2021
S0315
2
$400.00
New Item
Institutional Service Detail
Detail 01
Revenue Code *
0220
HCPCS Procedure Code
S0315
Modifier 1
Modifier 2
Modifier 3
Modifier 4
From Date of Service
11/27/2021
To Date of Service
11/28/2021
Units *
2
Units of Measurement *
DA - Days
Charges *
$400.00
Co-pay