How to Bill for Nursing Facility Add-On Code S0317 (Also knows as "Medicaid Transitional Add-On")

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

Beginning *January 25, 2021*, a nursing facility will be eligible for a Medicaid Transitional add-on of $130 per member per day for the first 30 days of the FFS member's nursing facility stay, not including any leaves of absence, if the FFS member meets all of the following criteria:
(a) MassHealth is the FFS member's primary payer for nursing facility services at the time of admission;
(b) The FFS member was transferred to the nursing facility directly from an acute inpatient hospital on or after January 25, 2021; and
(c) The FFS member is not returning to the nursing facility from a medical leave of absence.

Nursing facilities should submit claims for the add-on services 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**

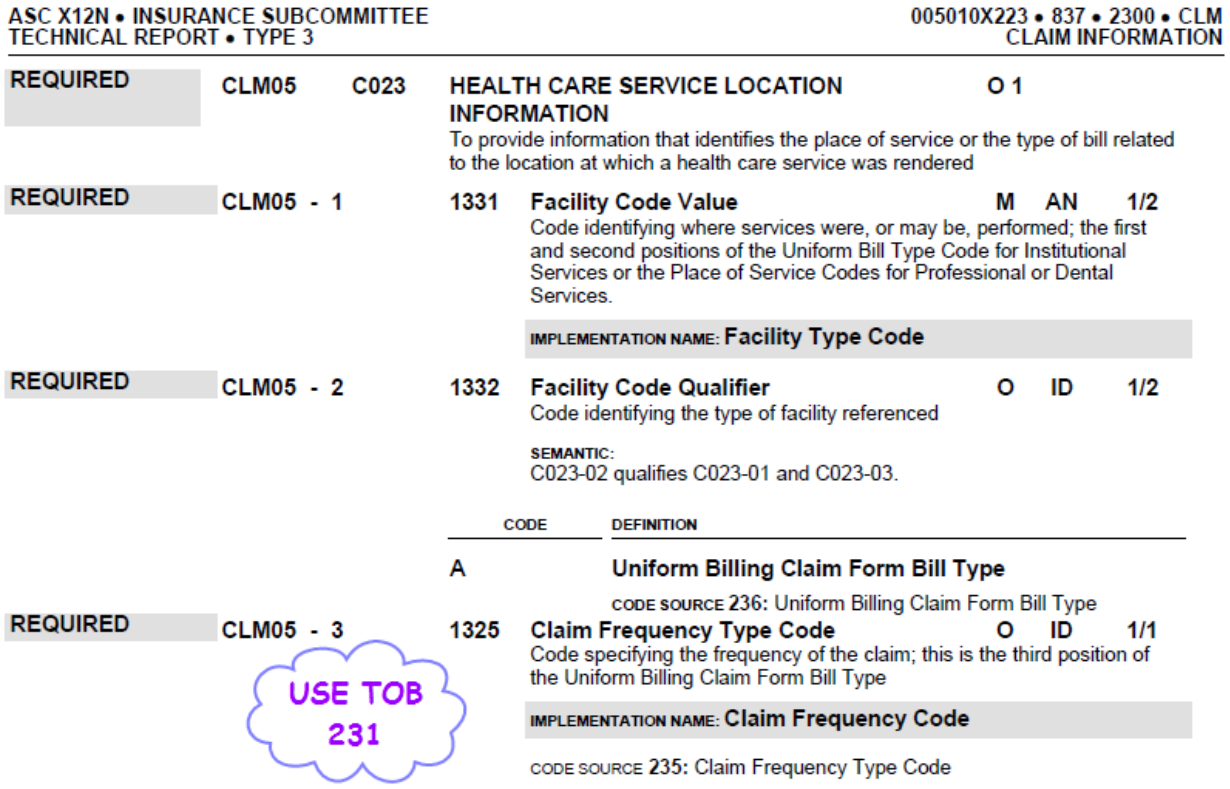
Use a Revenue Code: **0220 Special Charges General Classification**

With a HCPCS Code: **S0317 DISEASE MANAGEMENT PROGRAM; PER DIEM**

Enter the total number of Days

IF BILLING ELECTRONICALLY ON THE INSTITUTIONAL 837I

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



ASC X12N • INSURANCE SUBCOMMITTEE
TECHNICAL REPORT • TYPE 3

005010X223 • 837 • 2300 • CLM
CLAIM INFORMATION

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

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** 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.	M 1
REQUIRED	HI01 - 1	1270	**Code List Qualifier Code** Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08. CODE: BE — DEFINITION: Value CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	M ID 1/3
REQUIRED	HI01 - 2	1271	**Industry Code** Code indicating a code from a specific industry code list SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes. IMPLEMENTATION NAME: Value Code	M AN 1/30

ENTER VALUE CODE 24

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

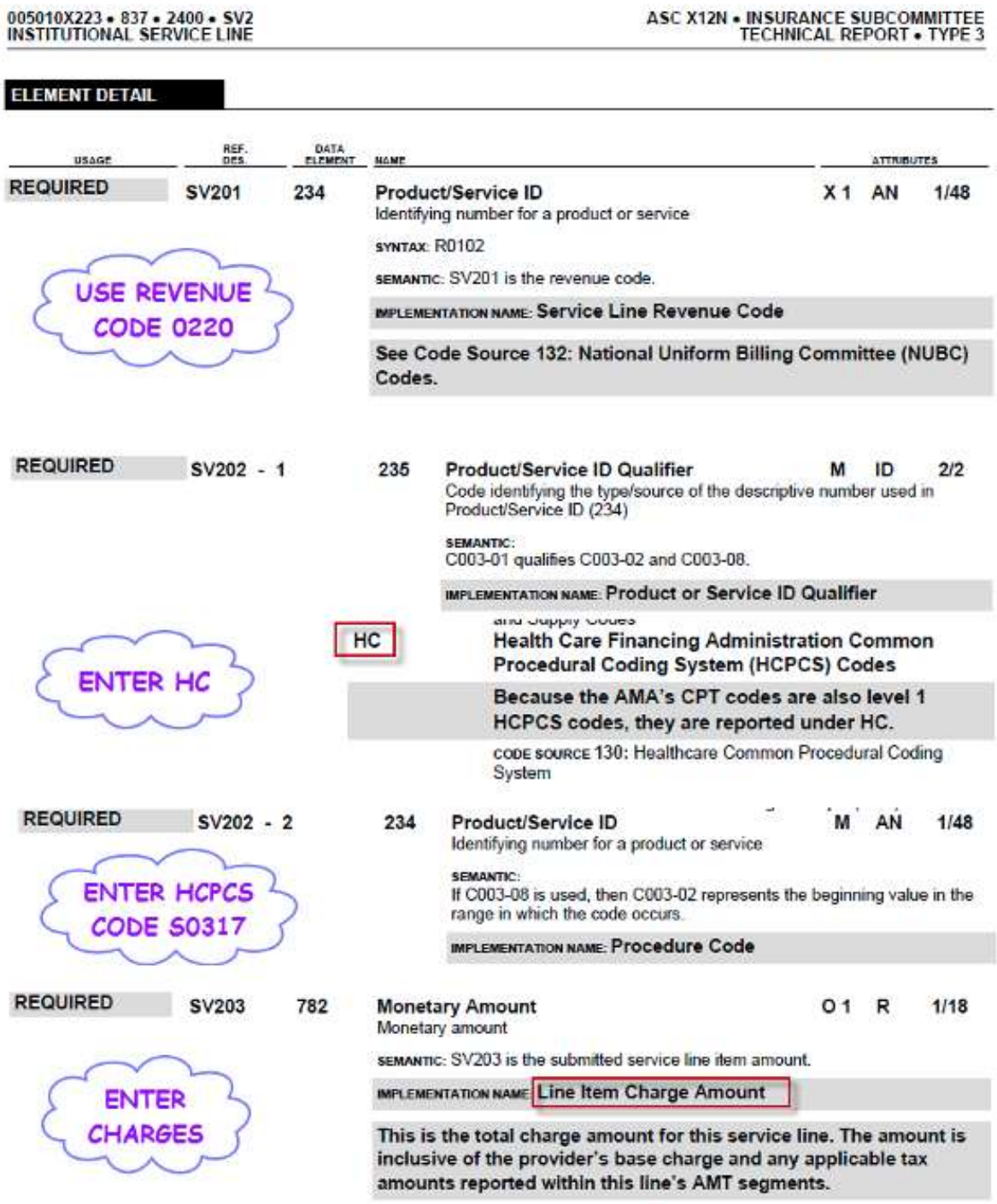


Image from page 428 of the 837I Guide, annotated to instruct Billers on inputting of required Days

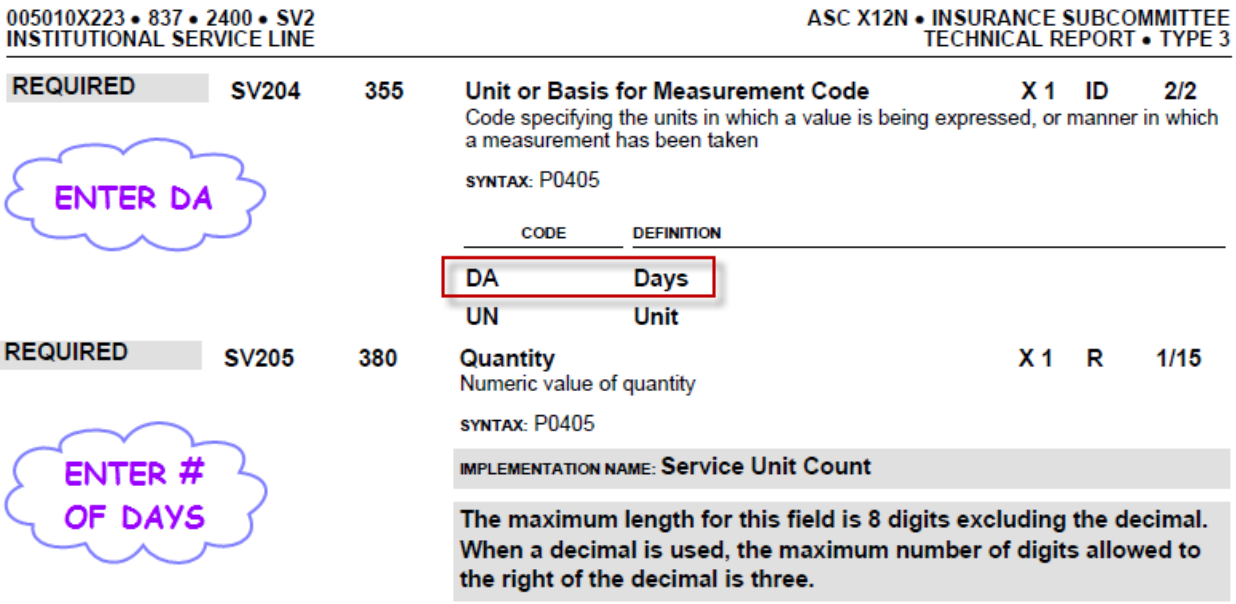


Image from pages 319-321 of the 837I Guide on the NPI requirements for Billers

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 CODE: 71 — DEFINITION: Attending Physician When used, the term physician is any type of provider filling this role.	M 1 ID 2/3
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

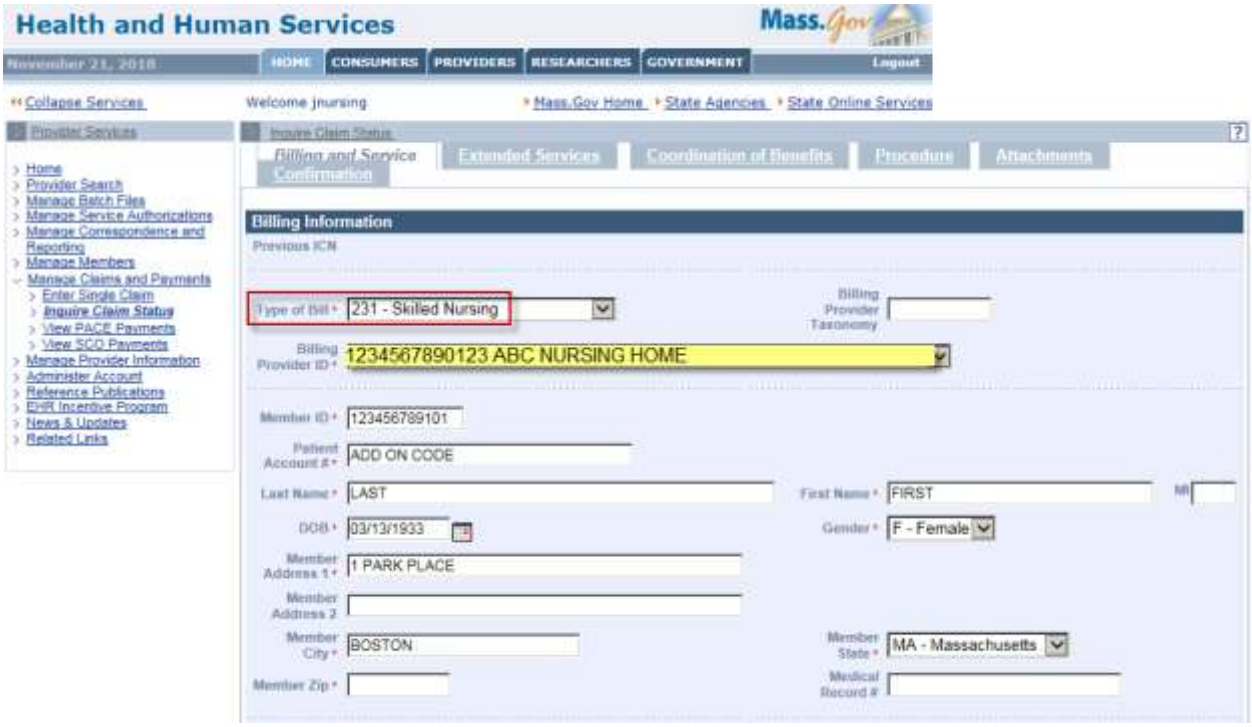
Code designating the system/method of code structure used for Identification Code (67)

SYNTAX: P0809

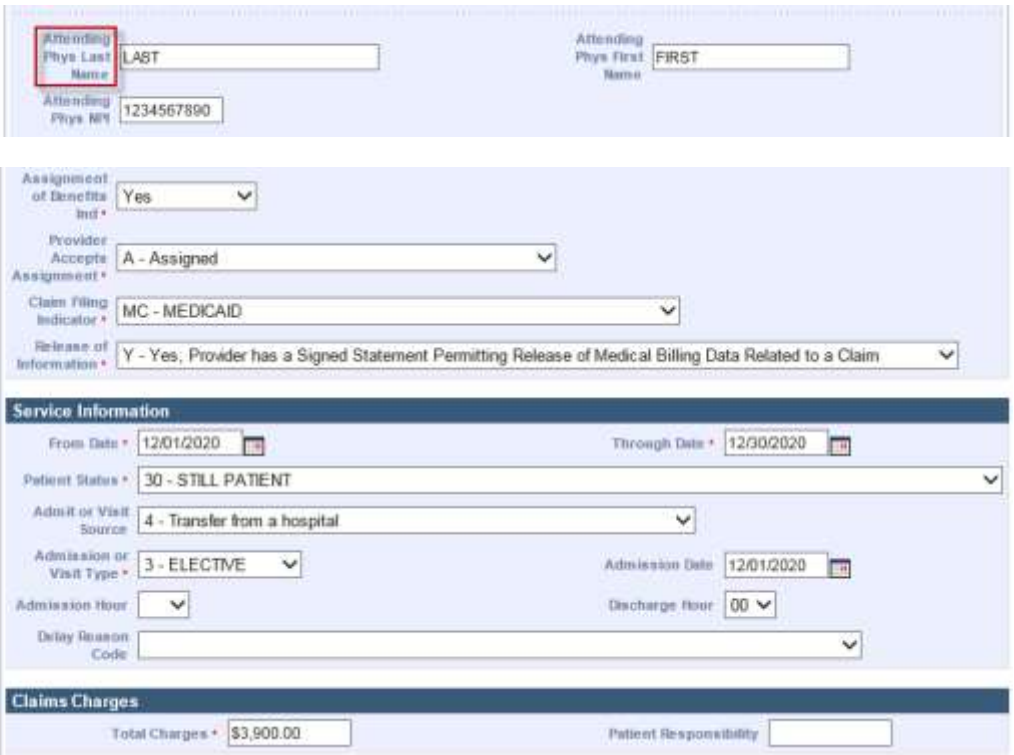
SITUATIONAL RULE: ***Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI.***
OR
Required for providers not in the United States or its territories on or after 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

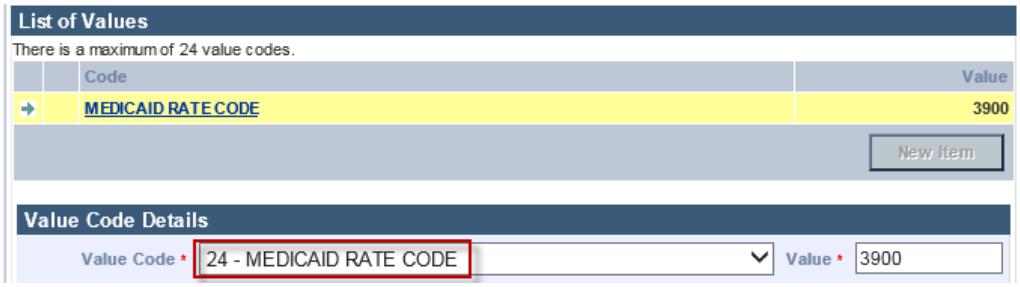
POSC SCREEN SHOTS IF MANUALLY BILLING VIA DIRECT DATA ENTRY (DDE)

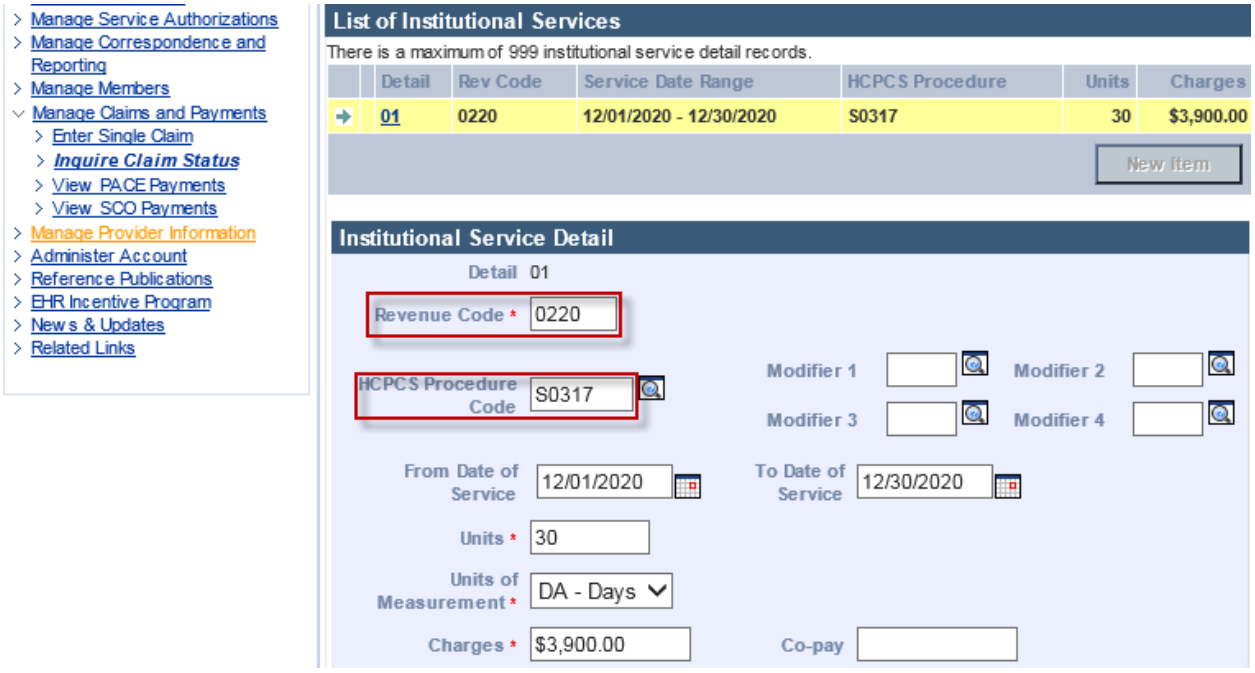


MUST INDICATE ATTENDING PROVIDER



* 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
3900
New Item
Value Code Details
Value Code *
24 - MEDICAID RATE CODE
Value *
3900


Manage Service Authorizations
Manage Correspondence and Reporting
Manage Members
Manage Claims and Payments
Enter Single Claim
Inquire Claim Status
View PACE Payments
View SCO Payments
Manage Provider Information
Administer Account
Reference Publications
EHR Incentive Program
News & Updates
Related Links
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
12/01/2020 - 12/30/2020
S0317
30
$3,900.00
New Item
Institutional Service Detail
Detail 01
Revenue Code *
0220
HCPCS Procedure Code
S0317
Modifier 1
Modifier 2
Modifier 3
Modifier 4
From Date of Service
12/01/2020
To Date of Service
12/30/2020
Units *
30
Units of Measurement *
DA - Days
Charges *
$3,900.00
Co-pay