Nursing Facility Rate Add-ons Billing Guidance Effective 10/1/2022

- Nursing facility rate add-ons are directly billable to MassHealth for MassHealth members covered by the plans below:
    - MassHealth Standard (FFS)
    - MassHealth CommonHealth
    - MassHealth Family Assistance
    - MassHealth CarePlus

- Questions about add-ons for MassHealth members enrolled in managed care plans (e.g., ACO Model "A", MCO, SCO, PACE, or OneCare plans) should be forwarded directly to the managed care plans.

- Nursing facility rate add-ons are not billable for any medical or non-medical leave days

Rate Add-ons:

- 101 CMR 206.10(7) Medicaid Transitional Add-on: Effective January 15, 2022, nursing facilities may bill an additional $200.00 per member per day for the first 60 days of a nursing facility admission if the MassHealth member is transferring from an acute or non-acute inpatient hospital setting, is not returning from a medical leave of absence, and MassHealth is the primary payer at the time of the admission.
    - *HCPCS code S0317*
    - May be billed in conjunction with the following add-ons:
        - SUD add-on ***or*** behavioral add-on
        - Tracheostomy add-on
        - Dialysis den add-ons
    - May not be billed with the following add-ons:
        - Temporary resident add-on
        - Homeless add-on

- 206.10(13) Homelessness Rate Add-on: Effective January 15, 2022, nursing facilities may bill an additional $200.00 per member per day for the first 6 months (180 days) of admission if a MassHealth member is admitted from any setting, the members homeless status has been verified and approved by EOHHS, and MassHealth is the primary payer at the time of admission.
    - *HCPCS code S0311*
    - May be billed in conjunction with the following add-ons:
        - Dialysis den add-on
        - Trach add-on
    - May not be billed with the following add-ons:
        - Behavioral add-on
        - SUD add-on
        - Temporary resident add-on
        - Transitional add-on

- 206.10(1)(b) Temporary Resident Add-on: Effective October 1, 2022, nursing facilities may bill an additional $130.00 per member per day for the first 30 days of admission if a MassHealth member is admitted directly from their home and subsequently discharges to their home within a 30-calendar day window.
    - *HCPCS code S0316*
    - May be billed in conjunction with the following add-ons:
        - Dialysis den add-on
        - SUD add-on ***or*** behavioral add-on
        - Trach add-on
    - May not be billed with the following add-ons:
        - Homelessness add-on
        - Transitional add-on
        - Enhanced temporary resident add-on (b)

- 206.10(1)(b) Enhanced Temporary Resident Add-on: Effective October 1, 2022, nursing facilities may bill an additional $250.00 per member per day for the first 30 days of admission if a MassHealth member is admitted directly from their home and subsequently discharges to their home within a 30-calendar day window, and the *MassHealth member is younger than 22 years of age.*
    - *HCPCS code S0315*
    - May be billed in conjunction with the following add-ons:
        - Den dialysis add-on
        - SUD add-on ***or*** behavioral add-on
        - Trach add-on
    - May not be billed with the following add-ons:
        - Temporary resident add-on (a)
        - Homeless add-on
        - Transitional add-on

- 206.10(15)(b) and (c) Den Dialysis Add-ons:

    a. 206.10(15)(b) Add-on Rate of $85.00 Per Member Per Dialysis Treatment: Nursing facilities with an approved on-site home dialysis services program in accordance with 101 CMR 206.10(15)(b) may receive a rate add-on of $85.00 per MassHealth member residing and receiving home dialysis services in the nursing facility, for each instance of home dialysis services received for which the following two conditions are concurrently met: a) MassHealth is not the primary payer for the members home dialysis services received in the nursing facility, and b) MassHealth is the primary payer for the members nursing facilities services at the time the home dialysis services are received in the nursing facility.
        - *HCPCS code S0353*

    b. 206.10(15)(c) Add-on Rate of $379.00 per Member per Dialysis Treatment: Nursing facilities with an approved on-site home dialysis services program in accordance with 101 CMR 206.10(15)(a) may receive a rate add-on of $379.00 per MassHealth member residing and receiving home dialysis services in the nursing facility for each instance of home dialysis received for which the following two conditions are concurrently met: a) MassHealth would be the primary payer for the dialysis services if they were received outside of the nursing facility, and b) MassHealth is the primary payer for the members nursing facilities services at the time the home dialysis services are received in the nursing facility.
        - *HCPCS code S0354*

    - Either of the above den dialysis add-ons may be billed in conjunction with the following:
        - Transitional add-on ***or*** temporary resident add-on
        - SUD add-on ***or*** behavioral add-on
        - Trach add-on

- **Or** may be billed in conjunction with the following add-on:
    - Homelessness add-on

- 206.10(6) Tracheostomy Add-on: Effective October 1, 2022, nursing facilities that provide tracheostomy services to tracheostomy dependent MassHealth members for whom MassHealth is the primary payer may bill a $220.00 per member per day add-on while the member requires and receives tracheostomy services.
    - *HCPCS code S0342*
    - May bill in conjunction with the following add-ons:
        - Dialysis den add-on
        - Transitional add-on ***or*** Temporary Resident add-on
        - SUD add-on ***or*** Behavioral Indicator add-on
    - Or may be billed in conjunction with the following add-ons:
        - Dialysis den add-on
        - Homelessness add-on
    - **May not be billed with the following add-ons:**
        - Ventilator add-on as described in 101 CMR 206.10(2), communication-limited ventilator add-on described in 101 CMR 206(3), or any special contract rate executed with the Executive Office of Health and Human Services related to ventilator or tracheostomy services.

- 206.10(16) Behavioral Indicator Add-on: Effective October 1, 2022, nursing facilities may bill for an additional $50.00 per member per day for MassHealth members residing in a nursing facility and whose most recent MDS was coded as 2 or 3 on one or more of the following Minimum data set 3.0 (MDS 3.0) indicators: Behavioral Health (E0200A, E0200B, or E0200C), Rejection of Care (E0800), or Wandering (E0900).
    - *HCPCS code S0340*
    - May be billed in conjunction with the following add-ons:
        - Dialysis den add-on
        - Transitional add-on ***or*** Temporary Resident add-on
        - Trach add-on
    - May not be billed with the following add-ons:
        - SUD add-on
        - Homelessness add-on
    - Note: If a MassHealth member has a subsequent MDS and does not meet the criteria listed above, a nursing facility may no longer bill for the additional $50.00 per day beginning the first day of the month preceding the most recent MDS assessment reference date (ARD).

- 206.10(14) SUD Add-on: Effective October 1, 2022, nursing facilities that meet the eligibility criteria as outlined in 101 CMR 206(14)(a) may bill an additional $30.00 per member per day for MassHealth members residing in the nursing facility and whose active diagnosis falls within the following eligible ICD-10 groupings: F10 through F16 (mental and behavioral disorders due to psychoactive substance), F19 (other psychoactive substance related disorders), or T40 (poisoning by, adverse effect of and underdosing of narcotics and psychodysleptics (hallucinogens).
    - *HCPCS code S0341*
    - May be billed in conjunction with the following add-ons:
        - Dialysis den add-on
        - Transitional add-on ***or*** Temporary Resident add-on
        - Trach add-on
    - May not be billed with the following add-ons:
        - Homelessness add-on
        - Behavioral Indicator add-on

- 206.15 Add-on for Members with Complicated High-cost Care Needs: Nursing facilities may receive a member-based rate add-on, in addition to the facility's standard *per diem* rate established under 101 CMR 206.00, for any member (for example, a bariatric resident), for whom reasonable and allowable direct care costs associated with providing for such member's clinical care needs are significantly greater than the standard nursing facility rate (for example, because the member's care needs necessitates the purchase or rental of specialized equipment or hiring of additional staff). The facility may receive an add-on for such member, as calculated according to 101 CMR 206.15(2), provided that all of the following conditions are met:
  (a) the member was referred to the facility by MassHealth;
  (b) the facility certified that the direct care costs associated or, if prior to admission, expected to be associated with providing services to such member are necessary to provide the services recommended by the member's physician and care team, and documented in the member's care plan;
  (c) the facility submitted a summary of expected direct care costs associated with providing services to such member demonstrating that the requirements of 101 CMR 206.15 have been met;
  (d) the facility provides the MassHealth agency with any additional or clarifying documentation in support of the actual or expected direct care costs associated with the resident's care needs; and
  (e) the facility receives approval from the MassHealth agency for the add-on.

  For general questions regarding the complicated high-cost care needs add-on, please email: Meera.E.Ramamoorthy@mass.gov, Jacqueline.Fratus@Mass.gov, Pamela.Murdock@mass.gov, and EHSDischargeSupport@Mass.gov

  Please use the following link to submit member-specific requests for the complicated high-cost care needs rate add-on: https://forms.office.com/g/9CVUFvDvsg

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, 232, 233, or 234**

From and through dates of claim: **Should include the entire month for which you are billing, excluding any units for medical or non-medical leaves of absence a member may have had in the month for which an outpatient claim is being submitted.**

Use Revenue Code: 0220 Special Charges General Classification

Use the appropriate HCPCS Code below for each add-on that you are seeking reimbursement for

HCPC	LONG DESCRIPTION	Billable Amount
S0311	Homeless Add-on - Facility specific	$ 200.00
S0315	Enhanced Temporary Resident Add-on	$ 250.00
S0316	Temporary Resident Add-on	$ 130.00
S0317	Transitional Add-on	$ 200.00
S0340	Behavioral Add-on	$ 50.00
S0341	SUD Add-on	$ 30.00
S0342	Tracheostomy add-on	$ 220.00
S0353	Den Dialysis Service fee add-on	$ 85.00
S0354	Den Dialysis - MH FFS Treatment Add-on	$ 379.00

EXAMPLE 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

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** Code identifying a specific industry code list	M ID 1/3
			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	
REQUIRED	HI01 - 2	1271	**Industry Code** Code indicating a code from a specific industry code list	M AN 1/30
			SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.	
			IMPLEMENTATION NAME: **Value Code**	

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

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 S0317

ENTER CHARGES

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

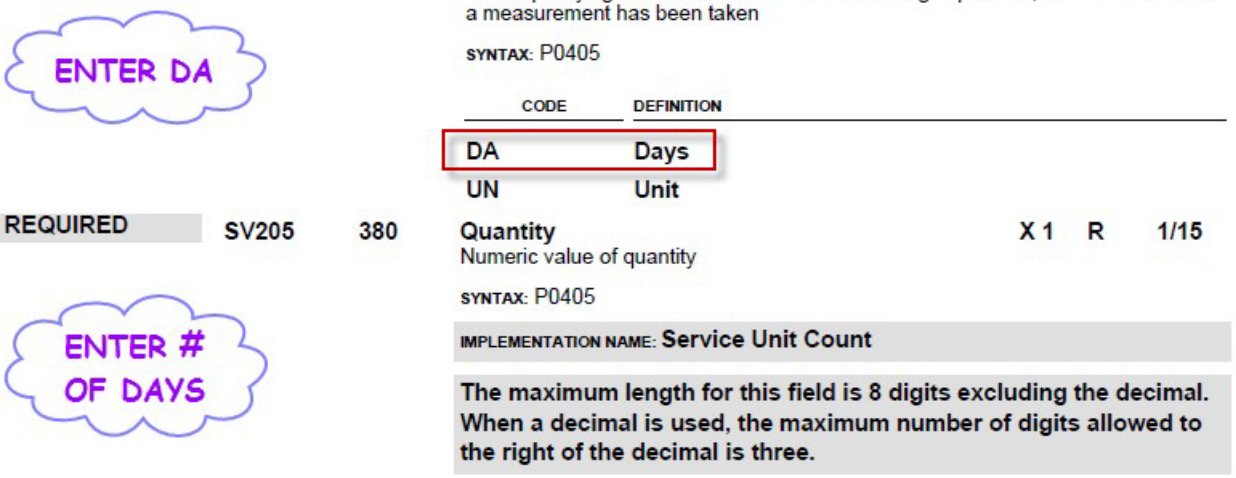


Image from pages 319-321 of the 837I Guide on the NPI requirements for Billers

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

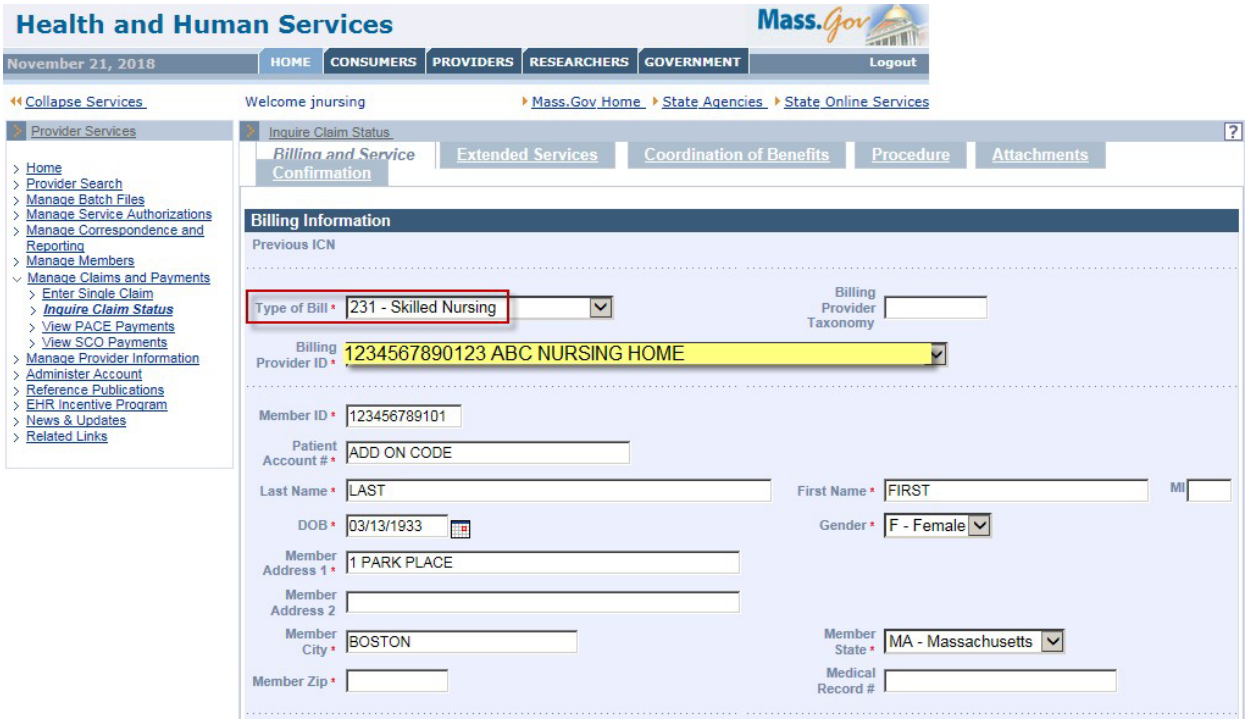
Code designating the system/method of code structure used for Identification Code (67)

SYNTAX: P0809

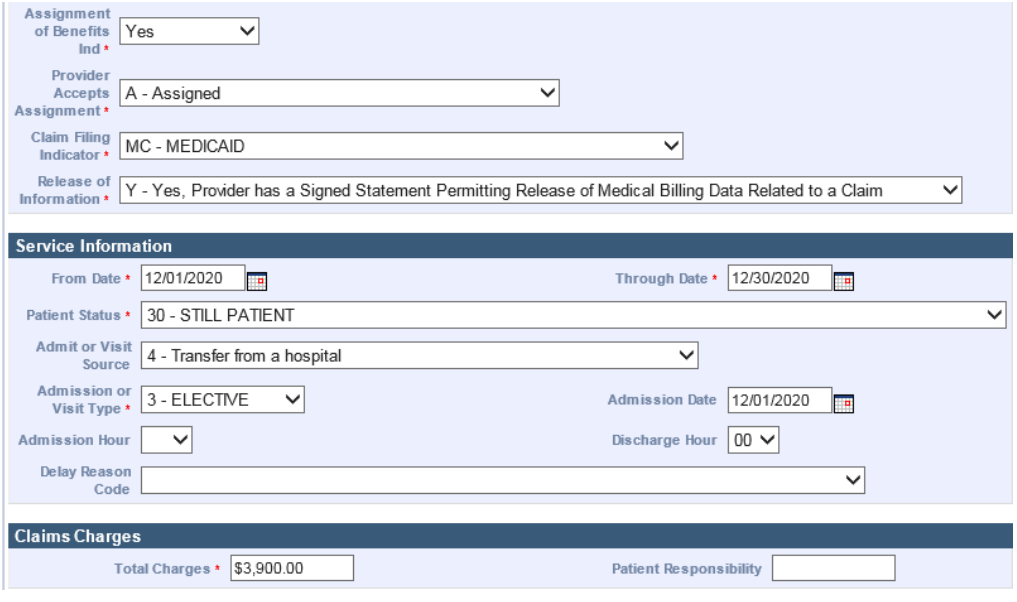
SITUATIONAL RULE: ***Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI.***
OR
Required for providers not in the United States or its territories on or after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

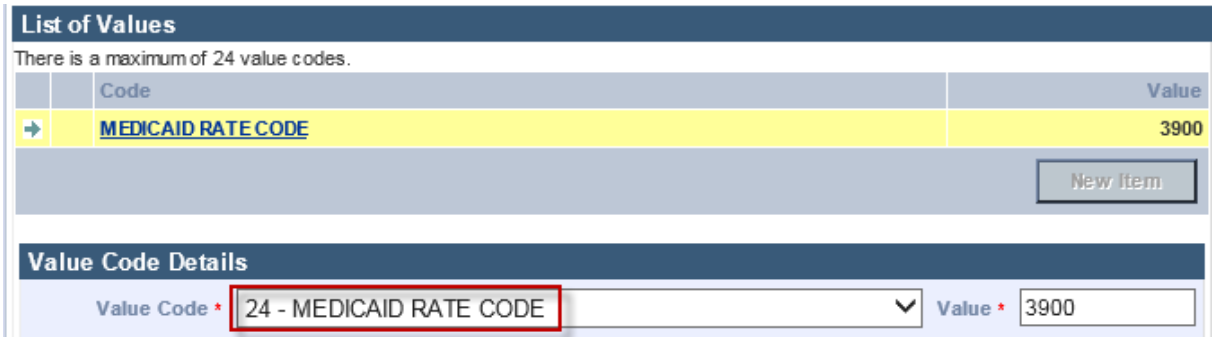
EXAMPLE POSC SCREEN SHOTS IF MANUALLY BILLING VIA DIRECT DATA ENTRY (DDE)

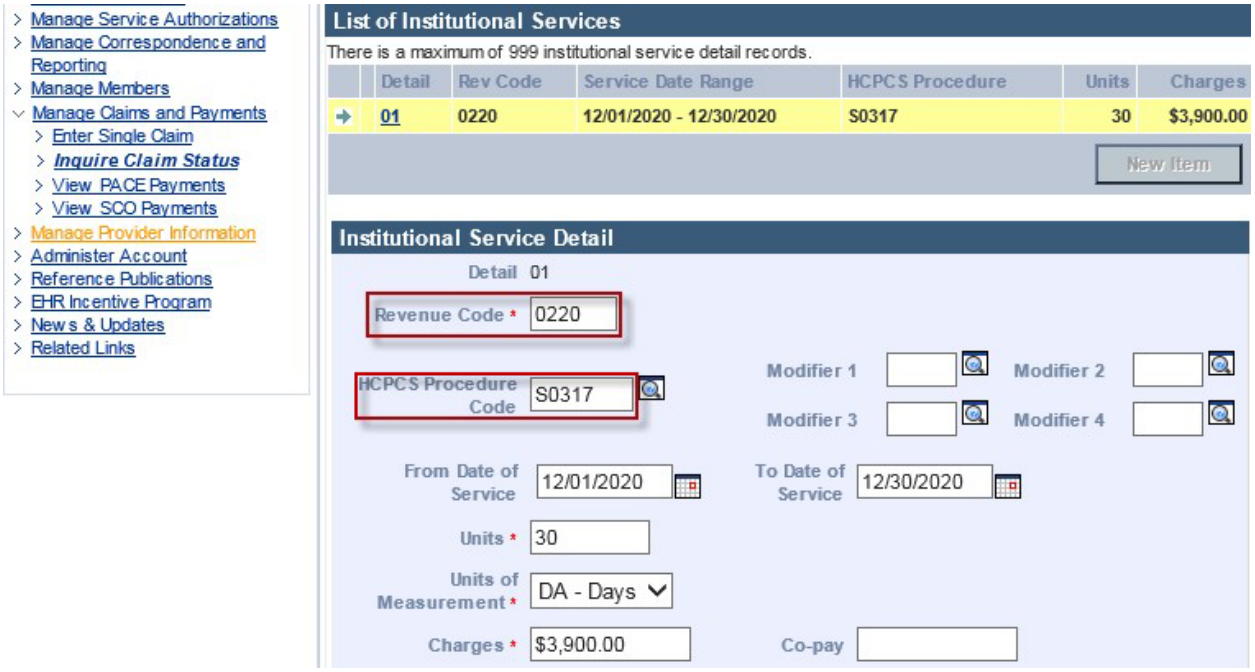


*Must indicate Attending Provider ID



*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