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Benefits Exhaust and No-Payment Billing for SNFs - Q and As

Benefits Exhaust and No-Payment Billing for Skilled Nursing Facilities (SNFs)
January 23, 2008 and January 24, 2008 Teleconference
Questions and Answers Follow Up Document

*** Please note that some of the questions above have been reworded for clarity.**

- Please clarify the following two scenarios for SNFs with distinct parts for both Medicare and Medicaid. In both cases, the assumption is that the resident has exhausted their 100 day benefit period and is still considered Medicare skilled i.e., tube feeds.

First scenario – the resident would like to move to the non-certified area. If we can move the resident, how do we avoid creating a break in the spell of illness? (There is a Change Request (CR) 3323 which talks about involuntarily moving a resident).

According to the Centers for Medicare & Medicaid Services (CMS): *When the beneficiary continues to require a Medicare skilled level of care and resides in the SNF, whether certified area or not, providers need to continue to submit benefits exhaust claims. The beneficiary would not be discharged if a need for Medicare skilled level of care exists. The only time this is not required is when the beneficiary no longer requires skilled level of care and the facility has a separate and distinct non-certified area (like a NF wing) of the facility. In this case the provider could discharge the patient and would not be required to submit monthly claims.*

Therefore, if the beneficiary voluntary moves and continues to receive a Medicare skilled level of care in order to avoid a break in the spell of illness per instructions from CMS, a monthly benefits exhaust claim would be required.

Providers should refer to the Spell of Illness chart located in Publication 100-4, *Medicare Claims Processing Manual*, Chapter 6, Section 40.8.1.

Second scenario – the resident is a Medicaid beneficiary. Since the beds are not dually certified, Medicaid will not pay for a resident to remain in a Medicare certified unit.

Per the response above if the beneficiary continues to remain at Medicare skilled level of care, monthly benefits exhaust claims should be billed to Medicare. The payer source is changing, per CR4292 for patients that continue to receive skilled level of care regardless of whether the benefits exhaust claims will be paid by Medicaid, a supplemental insurer or private pay Medicare still requires the SNF to continue to file monthly benefits exhaust claims.

- The Medicare beneficiary is taken off Medicare because their level of care no longer meets the skilled level of care criteria; he/she has 30 days to return to a skilled level of care utilizing the original qualifying stay. What happens between days 31-60?

If the beneficiary returns to a Medicare skilled level of care within the 30 day transfer requirement, the beneficiary would be entitled to utilize any of their remaining 100 days in the current benefit period. If the beneficiary remains at a nonskilled level of care for period of 60 consecutive days (indicated by the use of occurrence code 22) and is discharged to the hospital on day 61 or after the beneficiary would have to meet all the technical requirements i.e., three day qualifying stay, thirty day transfer requirement to qualify for a new benefit period. These technical requirements for coverage are contained in the *Online Internet Manual (IOM) Publication 100-2, Medicare Benefit Policy Manual*, Chapter 8, beginning in Section 20.

- Please explain when a condition code 21 is appropriate?

Providers may utilize a condition code 21 on claims where the patient's level of care has dropped to a nonskilled level. In this situation providers are required to send Medicare a final discharge and/or provider needs Medicare denial for other insurers. Claims may be submitted as frequently as monthly or may span multiple months and would include a condition code 21.

- 210 type of bill
- statement covers from and through date = days the provider is billing and will start the day following the date active care ended i.e., the day after the occurrence code 22 and date.
 - If the occurrence code 22 is 10-15-07, the 210 no-payment claim would begin on 10-16-07
- Condition code 21
- Billing for an insurance denial use appropriate patient status code
- Final discharge claim use appropriate patient status code other than 30 (still patient)

Reference: CR4292 and IOM Publication 100-4, Medicare Claims Processing Manual, Chapter 6, Section 40.8 2) (a) and (b).

- The no-payment and benefits exhaust claim requirements went into effect 10/01/06. Is it true that the SNFs only have to start doing this for admission beginning 10/01/06 – what about residents who exhaust their benefits prior to 10/01/06 and remain in the facility?

The Centers for Medicare & Medicaid Services (CMS) recognized that bill submission in benefits exhaust and no-payment situations have varied across fiscal intermediaries. CR4292 was issued on April 28, 2006 to provide a single consistent billing process to be applied to all contractors. So the instructions provided were not new billing requirements, just to provide consistency.

The instructions apply only to residents who are newly admitted or in a Part A stays on or after October 1, 2006. Therefore, on 10/01/06 if a resident has exhaust their 100 days of coverage and are still in a Part A stay the provider would be required to file monthly claims to Medicare.

- Beneficiaries who have exhausted their Part A benefits and go out on a leave of absence, does the SNF need to send a benefits exhaust claim when they come back or is the leave of absence considered a discharge.

A leave of absence (LOA) is not considered a discharge. The provider is still required to send monthly benefits exhaust claims to Medicare. The benefits exhaust claims are filed as covered claims to Medicare, therefore the LOA days would be billed in the same manner i.e., revenue code 180 and occurrence span code 74 as on any other covered claim. The manual does indicate that if

the patient status was reported as “30” on an interim bill (213) and the patient failed to return from a leave of absence within 30 days, including the day leave began, or has been admitted to another institution at any time during the leave of absence, the SNF must submit an adjustment request to correctly indicate the day the patient left as the date of discharge. (A beneficiary cannot be an inpatient in two institutions at the same time.)

Reference: The LOA instructions are contained in IOM Publication 100-4, Medicare Claims Processing Manual, Chapter 6, Section 40.3.5.2.

- Should the admission date change and the type of bill of 212 be used when a beneficiary returns to a Medicare skilled level of care?

Unless the patient was discharged from the SNF and readmitted, the admission date would remain consistent on the series of claims submitted to Medicare. The 212 TOB or the 182 TOB would only be used on the initial admission claim to Medicare (first in a series) and/or when the beneficiary is discharged and readmitted either in the same or a new benefit period.

- If a beneficiary admits/readmits as nonskilled does the SNF need to submit a 210 claim to Medicare?

There is no requirement for a SNF or Swing Bed (SB) to submit no-payment claims for beneficiary’s that are nonskilled at admission. Claims for ancillary services payable under Part B may be filed as appropriate, please review Publication 100-4, *Medicare Claims Processing Manual*, Chapter 7, Section 10.1 for a list of services when medically necessary can be covered as ancillary services under Part B.

- The value code amount of 1.00 with coinsurance was used during the teleconference and given as examples as processing in the system – our vendor has an edit in place when this is used, is there a specific publication to show them to remove the edit?

CR4292, as well as Publication 100-4, *Medicare Claims Processing Manual*, Chapter 6, Section 40.8 both provide instructions relative to the instructions on submitting monthly benefits exhaust claims for beneficiaries that continue to receive skilled services and indicate the use of value code 09 = 1.00 (if applicable, the FISS will assign the correct coinsurance amount based off the Common Working File (CWF) response). These instructions are relative to full/partial benefits exhaust, benefits exhaust with a drop in level of care, and benefits exhaust with a patient discharge.

- We were always taught that a demand bill must be submitted if requested by the beneficiary or representative, regardless of whether it is a technical denial? Is this true?

Intermediaries must conduct medical review of all patient generated demand bills with the following exception: Demand bills for services to beneficiaries who are not entitled to Medicare or do not meet eligibility requirements for payment of SNF benefits (i.e., no qualifying hospital stay) do not require medical review. A denial notice with the appropriate reasons for denial must be sent.

Reference: IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 6: Intermediate MR Guidelines for Specific Services, Section 6.1.1 – B. Demand Bills

- What is partial benefits exhaust?

Partial benefits exhaust claims, as defined in CR4292 – Benefits Exhaust and No-Payment Billing Instructions for Medicare Fiscal Intermediaries (FIs) and Skilled Nursing Facilities (SNFs), are situations where only one or some benefit days in the beneficiary’s applicable benefit period remain for the submitted statement covers from/through date of the claim.

A SNF must submit a benefits exhaust bill monthly for those patients that continue to receive skilled care and also when there is a change in the level of care regardless of whether the benefits exhaust bill will be paid by Medicaid, a supplemental insurer, or private payer. There are two types of benefits exhaust claims: 1) Full benefits exhaust claims: no benefit days remain in the beneficiary's applicable benefit period for the submitted statement covers from/through date of the claim and 2) Partial benefits exhaust claims: only one or some benefit days, in the beneficiary's applicable benefit period, remain for the submitted statement covers from/through date of the claim. These bills are required in order to extend the beneficiary's applicable benefit period posted in the CWF. Furthermore, when a change in level of care occurs after exhaustion of a beneficiary's covered days of care, the provider must submit the benefits exhaust bill in the next billing cycle indicating that active care has ended for the beneficiary.

References: CR4292/MLN4292 - Benefits Exhaust and No-Payment Billing Instructions for Medicare Fiscal Intermediaries (FIs) and Skilled Nursing Facilities (SNFs)

IOM Publication 100-04: Medicare Claims Processing Manual, Chapter 6, SNF Inpatient Part A Billing, Section 40.8 Billing Benefits Exhaust and No-Payment Situations

- If a beneficiary has one or more days remaining in their current benefit period and were cut, occurrence code 22, do we bill a 210 type of bill?

The SNF would be required to file a final discharge claim to Medicare (210 TOB) with a patient status code other than 30.

- We have beneficiaries who are covered by Medicare when they are first admitted to the SNF, and are cut after a few weeks, 14 days later covered again on antibiotics for 14 days and then cut. Usually 14 days later they are on antibiotics again and at a covered level of care. How would we bill the constant covered - noncovered scenario?

It is important to make sure the beneficiary is meeting all the requirements to be considered under a skilled level of care. Is the beneficiary receiving direct skilled rehabilitation services ordered by a physician? Do these services require a qualified therapist on a daily basis (at a minimum of five times per week)? Services must be reasonable and medically necessary for the patient's condition. These services must be related to an active treatment plan approved by the physician. Remember, the services must be provided with an exception of potential restoration. If a beneficiary is only receiving antibiotics, they would not be considered a skilled patient. It would not be a "best practice" to continually have this covered noncovered scenario.

IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 8, Section 30 states: Care in a SNF is covered if all of the following four factors are met:

- The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel (see §§30.2 - 30.4); are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services;
- The patient requires these skilled services on a daily basis (see §30.6); and
- As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF. (See §30.7.)
- The services must be reasonable and necessary for the treatment of a patient's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The

services must also be reasonable in terms of duration and quantity.

If any one of these four factors is not met, a stay in a SNF, even though it might include the delivery of some skilled services, is not covered. For example, payment for a SNF level of care could not be made if a patient needs an intermittent rather than daily skilled service.

*** Please note these requirements apply to any circumstance when a Medicare beneficiary's level of care drops to non-skilled and then returns to a skilled level of care. The coverage requirements as outlined must be met in order for the beneficiary to be at a covered level of care for Medicare.**

- A beneficiary is admitted to the facility after having exhausted benefits at another facility and remains at a skilled level of care. Is the SNF required to submit exhaust claims upon admission until level of care drops at which time they would begin submitting no-pay claims and/or until resident is discharged?

Yes, the provider is required to submit monthly benefits exhaust claims until active care has ended. Then the provider would submit no-pay claims until beneficiary is discharged.

- What recourse does the SNF have if they admit a beneficiary at a Medicare skilled level of care who had previously been in another facility where their benefits exhausted and the level dropped to non-skilled for a period of at least 60 days but their other facility neglected (or even refuses) to submit required no payment claims causing the beneficiary's CWF to indicate that no benefits are available?

Providers who do not follow Medicare regulations can be in violation of their Medicare participation agreement and possibly have a sanction imposed. The first SNF in this question would be required to file the appropriate discharge claim to Medicare.

If the other facility refuses to send in the appropriate claims as required by Medicare after attempts have been made to contact them for resolution, request an educational contact be made by Provider Outreach & Education department to the SNF in question.

- Do you need to place the Occurrence Code 22 on your no-payment claims (TOB 210)?

No, the Occurrence Code 22 goes on the last covered claim. Occurrence Code 22 allows CWF to start counting the 60 days without skilled services to calculate a new benefit period. In addition the occurrence code 22 can also be included on a benefits exhaust claim with a drop in level of care within the month. The benefits exhaust claims are billed as covered claims to Medicare i.e., 212, 213 for SNF or 182, 183 for a Swing Bed. Note: Bill type 210 or 180 should not be used for benefits exhaust claims.

Reference: IOM Publication 100-4, Medicare Claims Processing Manual, Section 40.8 1 (b).

- If a skilled patient goes to the emergency room, would it break the spell of illness?

No, this would not break the spell of illness because the emergency room visit is considered to be an outpatient service.

- What happens if the SNF fails to put the Occurrence Code 22 on their claim?

If the SNF fails to put the Occurrence Code 22 on their claim once the level of care has dropped, CWF will not be updated and will not start the count towards the 60 consecutive days of noncovered level of care and therefore, the beneficiary will not re-establish a new benefit period.

- What is the 2008 co-insurance rate for Skilled Nursing Facilities?

The 2008 coinsurance rate is \$128.00 for days 21 thru 100.

- The patient is at a NF level of care. The patient elects hospice. What coding is necessary on the claim? And, if the patient drops hospice and then goes back to a NF level of care, would a claim need to be sent to Medicare Fee-for-Service?

50 and 51 - Discharged/Transferred to a Hospice- These two patient discharge status codes are used to identify when a patient is discharged or transferred to hospice care.

The level of care that will be provided by the hospice upon discharge is essential to determining the proper code to use. NUBC clarified the following Hospice Levels of Care:

- **Routine or Continuous Home Care.** Patient discharge status code “50: Hospice home” should be used if the patient went to his/her own home or an alternative setting that is the patient’s “home,” such as a nursing facility, and will receive in-home hospice services.
- **General Inpatient Care.** Patient discharge status code “51 Hospice medical facility” should be used if the patient went to an inpatient facility that is qualified and the patient is to receive the general inpatient hospice level of care.
- **Inpatient Respite.** Patient discharge status code “51 Hospice medical facility” should be used if the patient went to a facility that is qualified and the patient is receiving hospice inpatient respite level of care. Unless a patient has already been admitted to/accepted by a hospice, level of care can not be determined. Therefore, it is recommended that, if a patient is going home or to an institutional setting with a hospice “referral only,” (without having already been accepted for hospice care by a hospice organization) the patient discharge status code should simply reflect the site to which the patient was discharged, not hospice (i.e., 01: home or self care, or 04: an intermediate care nursing facility, assuming it is not a Medicare SNF admission).

Additional Guidance on Use of Patient discharge status Code 50 or 51:

- Patient discharge status Code 50 should be used if the patient went to his/her own home or an alternative setting that is the patient’s “home,” such as a nursing facility, and will receive in-home hospice services.

Reference: Special Edition Article SE0801- Clarification of Patient Discharge Status Codes and Hospital Transfer Policies.

If the patient then elects to drop hospice and goes back to private pay NF level of care, the SNF would not have to bill Medicare Fee-for-Service.

General Summary Information

Medicare Advantage:

Billing Requirements for Beneficiaries Enrolled in Medicare Advantage (MA) Plans are outlined in Change Request (CR) 5653 and in CMS Online Internet Manuals (IOM), Publication 100-4, *Medicare Claims Processing Manual*, Chapter 6, Section 90.2. The instructions were effective January 1, 2008 and indicate that the Skilled Nursing Facility (SNF) and Swing Bed (SB) providers must submit **covered** claims with condition code 04 (information only bill) for beneficiaries enrolled in MA plans and **receiving skilled care** in order to take benefit days from the beneficiary and/or update the beneficiary's spell of illness in Common Working File (CWF).

Use of Occurrence Span Code 74:

Information on the appropriate use of occurrence span code 74 (use of span code for SNF 210 Type of Bill (TOB) that overlap previously paid SNF 22X (TOB)) is contained in IOM Publication 100-4, Medicare Claims Processing Manual, Chapter 6, Section 40.8. The instructions indicate that the providers include a span code 74 on the No-Payment Claims that equals the statement covered period of the 210 bill they are submitting.

Timely Filing Limits:

Date of Service In:	January	February	March	April	May	June
Timely Filing Date	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year
Months to File *	23	22	21	20	19	18

Date of Service In:	July	August	September	October	November	December
Timely Filing Date	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 2 year	Dec 31: Service year plus 2 year	Dec 31: Service year plus 2 year
Months to File *	17	16	15	26	25	24


* "Months to file" represents the number of full months plus the remainder of the service month.

Reference: IOM, Publication 100-4, *Medicare Claim Processing Manual*, Chapter 1, Section 70.

CMS resources available:

- The Centers for Medicare & Medicaid Services (CMS) Online Internet Manuals referenced in this document can be accessed at the following location:

www.cms.hhs.gov/manuals 

- The Change Request referenced in this document can be accessed at the following location:
www.cms.hhs.gov/MLNMattersArticles 

Skilled Nursing Facilities/Long-Term Care Open Door Forum addresses the concerns and issues of both Medicare SNF and Medicaid NF, and the nursing home industry generally. To receive information and schedule of calls access the following Web page:

www.cms.hhs.gov/OpenDoorForums 

Frequently Asked Questions are available on the CMS Web site in addition to the National Government Services Web site and can be accessed at: www.cms.hhs.gov/home/tools.asp 

Posted: 02/15/2008



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