CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1394	**Date: DECEMBER 14, 2007**
	Change Request 5840

SUBJECT: Manual Updates to Chapter 6, Skilled Nursing Facility (SNF) Inpatient Part A Billing, for No Payment and Medicare Advantage (MA) Claims

I. SUMMARY OF CHANGES: This instruction provides clarification on SNF no payment and MA claims billing procedures.

NEW / REVISED MATERIAL
EFFECTIVE DATE: ***October 1, 2006**
IMPLEMENTATION DATE: **March 17, 2008**

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	6/40.8/Billing in Benefits Exhaust and No-Payment Situations
R	6/90.2/Medicare Billing Requirements for Beneficiaries Enrolled in MA Plans

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1394	Date: December 14, 2007	Change Request: 5840

SUBJECT: Manual Updates to Chapter 6, Skilled Nursing Facility (SNF) Inpatient Part A Billing, for No Payment and Medicare Advantage (MA) Claims

EFFECTIVE DATE: October 1, 2006

IMPLEMENTATION DATE: March 17, 2008

I. GENERAL INFORMATION

A. Background: CMS is including the following clarifications to Chapter 6, SNF Inpatient Part A Billing, of the claims processing manual:

- CMS is not requiring SNF providers to submit no payment bills for non-skilled beneficiary admissions. No pay bills are only required for beneficiaries that have previously received skilled care and subsequently dropped to non-skilled care and continue to reside in the Medicare-certified area of the SNF; and

- No payment bills may span both Medicare and Provider's fiscal year end dates; and

- No payment bills are not required for beneficiaries that are in current Medicare Advantage (MA) plans and no longer require skilled care while still under the plan.

Please review the attached sections for additional clarification.

B. Policy: There are no policy changes with this instruction.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5840.1	Medicare contractors shall make providers aware of the clarifications provided in the updated manual sections attached to this instruction.	X		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5840.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X							

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Jason Kerr, Jason.Kerr@cms.hhs.gov (FI Billing)

Post-Implementation Contact(s): Appropriate Regional Office
http://www.cms.hhs.gov/RegionalOffices/01_Overview.asp

VI. FUNDING

A. *For Fiscal Intermediaries and Carriers*:
No additional funding will be provided by CMS; contractor activities are to be carried out within their current operating budgets.

B. *For Medicare Administrative Contractors (MAC)*:
The Medicare Administrative Contractor (MAC) is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as changes to the MAC Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

40.8 - Billing in Benefits Exhaust and No-Payment Situations

(Rev. 1394, Issued: 12-14-07, Effective: 10-01-06, Implementation: 03-17-08)

An SNF is required to submit a bill for a beneficiary that has started a spell of illness under the SNF Part A benefit for every month of the related stay even though no benefits may be payable. CMS maintains a record of all inpatient services for each beneficiary, whether covered or not. The related information is used for national healthcare planning and also enables CMS to keep track of the beneficiary's benefit period. These bills have been required in two situations: 1) when the beneficiary has exhausted his/her 100 covered days under the Medicare SNF benefit (referred to below as benefits exhaust bills) and 2) when the beneficiary no longer needs a Medicare covered level of care (referred to below as no-payment bills).

An 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 insure, 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 Common Working File (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.

In addition, SNF providers must submit no-payment bills for beneficiaries that have previously received Medicare-covered *skilled* care and subsequently dropped to a non-covered level of care but continue to reside in a Medicare-certified area of the facility. Consolidated Billing (CB) legislation indicates that physical therapy, occupational therapy, and speech language pathology services furnished to SNF residents are always subject to SNF CB. This applies even when a resident receives the therapy during a non-covered stay in which the beneficiary who is not eligible for Part A extended care benefit still resides in an institution (or part thereof) that is Medicare-certified as a SNF. SNF CB edits require the SNF to bill for these services on a 22x (inpatient part B) bill type.

If a facility has a separate, distinct non-skilled area or wing then beneficiaries may be discharged to this area using the appropriate patient discharge status code and no-payment bills would not be required. In addition, SNF CB legislation for therapy services would not apply for these beneficiaries.

No-payment bills are not required for non-skilled beneficiary admissions. As indicated above, they are only required for beneficiaries that have previously received covered care and subsequently dropped to non-covered care and continue to reside in the certified area of the facility.

NOTE: Providers may bill benefits exhaust and no payment claims using the default HIPPS code AAA00 in addition *to an appropriate room & board revenue code only*. No further ancillary services need be billed on these claims.

SNF providers and FIs shall follow the billing guidance provided below for the proper billing of benefits exhaust bills and no-payment bills.

1) SNF providers shall submit benefits exhaust claims for those beneficiaries that continue to receive skilled services as follows:

a) Full or partial benefits exhaust claim.

i) Bill Type = Use appropriate covered bill type (i.e., 211, 212, 213 or 214 for SNF and 181, 182, 183 or 184 for Swing Bed (SB). **NOTE:** Bill types 210 or 180 should not be used for benefits exhaust claims submission).

ii) Covered Days and Charges = Submit all covered days and charges as if beneficiary had days available.

iii) Patient Status Code = Use appropriate code.

b) Benefits exhaust claim with a drop in level of care within the month; Patient remains in the Medicare-certified area of the facility after the drop in level of care.

i) Bill Type = Use appropriate bill type (i.e., 212 or 213 for SNF and 182 or 183 for SB. **NOTE:** Bill types 210 or 180 should not be used for benefits exhaust claims submission).

ii) Occurrence Code 22 (date active care ended, i.e., date covered SNF level of care ended) = include the date active care ended; this should match the statement covers through date on the claim.

iii) Covered Days and Charges = Submit all covered days and charges as if the beneficiary had days available up until the date active care ended.

iv) Patient Status Code = 30 (still patient).

c) Benefits exhaust claim with a patient discharge.

i) Bill Type = 211 or 214 for SNF and 181 or 184 for SB (**NOTE:** Bill types 210 or 180 should not be used for benefits exhaust claims submission).

ii) Covered Days and Charges = Submit all covered days and charges as if beneficiary had days available up until the date active care ended.

iii) Patient Status Code = Use appropriate code other than patient status code 30 (still patient).

NOTE: Billing all covered days and charges allow the Common Working File (CWF) to assign the correct benefits exhaust denial to the claim and appropriately post the claim to the patient's benefit period. Benefits exhaust bills must be submitted monthly.

2) SNF providers shall submit no-payment claims for beneficiaries that previously dropped to non-skilled care and continue to reside in the Medicare-certified area of the facility using the following options.

a) Patient previously dropped to non-skilled care. Provider needs Medicare denial notice for other insurers.

i) Bill Type = 210 (SNF no-payment bill type) or 180 (SB no-payment bill type)

ii) Statement Covers From and Through Dates = days provider is billing, which may be submitted as frequently as monthly, in order to receive a denial for other insurer purposes. No-payment billing shall start the day following the date active care ended.

iii) Days and Charges = Non-covered days and charges beginning with the day after active care ended.

iv) Occurrence Span Code 74 = include the statement covers period of this claim.

v) Condition Code 21 (billing for denial).

vi) Patient Status Code = Use appropriate code.

b) Patient previously dropped to non-skilled care. In these cases, the provider must only submit the final discharge bill that may span multiple months but must be as often as necessary to meet timely filing guidelines.

i) Bill Type = 210 (SNF no-payment bill type) or 180 (SB no-payment bill type)

ii) Statement Covers From and Through Dates = days billed by the provider, which may span multiple months, in order to show final discharge of the patient. No-payment billing shall start the day following the date active care ended.

iii) Days and Charges = Non-covered days and charges beginning with the day after active care ended.

iv) Occurrence Span Code 74 = include the statement covers period of this claim.

v) Condition Code 21 (billing for denial).

vi) Patient Status Code = Use appropriate code other than patient status code 30 (still patient).

NOTE: *No pay bills may span both provider and Medicare fiscal year end dates.*

Refer to the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-*04* (CMS-1450) Data Set" for further information about billing, as it contains UB-*04* data elements and the corresponding fields in the electronic record.

90.2 - Medicare Billing Requirements for Beneficiaries Enrolled in MA Plans

(Rev. 1394, Issued: 12-14-07, Effective: 10-01-06, Implementation: 03-17-08)

If a beneficiary chooses an MA plan as his or her form of Medicare, he/she cannot look to traditional "fee for service" Medicare to pay the claim if the MA plan denies coverage.

SNF providers shall apply the following policies to MA beneficiaries who are admitted to a SNF:

- If the SNF is non-participating with the plan, the beneficiary must be *notified of his or her status because he/she MAY be private pay in this circumstance, depending upon the type of MA plan in which he/she is enrolled;*

- If the SNF is participating with the plan, pre-approve the SNF stay with the plan;

- If the plan denies coverage, appeal to the plan, not to the "fee for service" FI;

- Count the number of days paid by the plan as Part A days used (this IS the beneficiary's 100 days of Medicare SNF benefits);

- Submit a claim to the "fee for service" intermediary to subtract benefit days from the CWF records. (Note: The plans do not send claims to CWF for SNF stays). Failure to send a claim to the FI will inaccurately show days available.

- *If a beneficiary no longer requires skilled care under the MA plan the SNF may discharge the patient using a patient status code 04. No- payment bills are not required for beneficiaries that are receiving non-skilled care and are enrolled in an MA plan. If the beneficiary again requires skilled care after a period of non-skilled care, the provider should begin a new admission claim for Medicare to continue the spell of illness.*

Billing Requirements

− Submit covered claims and include a HIPPS code (use default code AAA00 if no assessment was done), room and board charges and condition code 04.

NOTE: If the beneficiary drops his or her MA plan participation during their SNF stay, the beneficiary is entitled to coverage under Medicare FFS for the number of days available that remain out of the 100 days available under the SNF benefit.