CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1252	**Date: MAY 25, 2007**
	Change Request 5583

SUBJECT: Clarification of Skilled Nursing Facility (SNF) No Pay Billing

I. SUMMARY OF CHANGES: This instruction clarifies No Pay billing instructions for SNF 210 bill types that overlap previously paid SNF 22x bill types. In addition, the SNF Spell of Illness Quick Reference Chart will be added to the manual. Also, various sections of Chapter 6 are updated with this instruction.

NEW / REVISED MATERIAL
EFFECTIVE DATE: *October 1, 2006
IMPLEMENTATION DATE: August 27, 2007

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/Table of Contents
R	6/20.2.1/Dialysis and Dialysis Related Services to a Beneficiary With ESRD
R	6/20.2.1.1/ESRD Services
R	6/20.2.1.2/Coding Applicable to Dialysis Services Provided in a Renal Dialysis Facility (RDF) or Home
D	6/20.2.1.3/Coding Applicable to Services Provided in a RDF or SNF as Home
D	6/20.2.1.4/Coding Applicable to EPO Services
D	6/20.2.1.5/Coding for Darbepoetin Alfa
R	6/20.3.1/Ambulance Services
R	6/30.1/Health Insurance Prospective Payment System (HIPPS) Rate Code
R	6/40.3.3/Same Day Transfer
R	6/40.8/Billing in Benefits Exhaust and No-Payment Situations
N	6/40.8.1/SNF Spell of Illness Quick Reference Chart

R	6/90/Medicare Advantage (MA) Beneficiaries
R	6/90.1/Beneficiaries Disenrolled from MA Plans

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1252	Date: May 25, 2007	Change Request: 5583

SUBJECT: Clarification of Skilled Nursing Facility (SNF) No Pay Billing

Effective Date: October 1, 2006

Implementation Date: August 27, 2007

I. GENERAL INFORMATION

A. Background: This instruction clarifies No Pay billing instructions for SNF 210 bill types that overlap previously paid SNF 22x bill types. In order to bypass Medicare edits that do not allow 210 bill types to process when overlapping previously paid 22x bill types, providers must include occurrence span code 74 with the statement covers period of the 210 bill they are submitting.

In addition, manual changes have been made to clarify provider billing requirements for beneficiaries that have disenrolled from Medicare Advantage (MA) plans.

The SNF Spell of Illness Quick Reference chart will be inserted in the manual with this transmittal. In addition, updates to various sections of Chapter 6 of 100-04 Claims Processing Internet-Only Manual are included.

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

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	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5583.1	Contractors shall make providers aware of revised billing instructions for SNF 210 no payment bill types which overlap previously paid SNF 22x bill types.	X		X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5583.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly	X		X								

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	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.											

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:
N/A	

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

V. CONTACTS

Pre-Implementation Contact(s): Jason Kerr, Jason.Kerr@cms.hhs.gov or Wendy Tucker, Wendy.Tucker@cms.hhs.gov

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

A. *For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC),* use only one of the following statements:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. *For Medicare Administrative Contractors (MAC),* use the following statement:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). 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.

Medicare Claims Processing Manual

Chapter 6 - SNF Inpatient Part A Billing

Table of Contents
(Rev. 1252, 05-25-07)

20.2.1 – Dialysis and Dialysis Related Services to a Beneficiary With ESRD

(Rev. 1252, Issued: 05-25-07; Effective: 10-01-06; Implementation: 08-27-07)

Beneficiaries with ESRD may receive dialysis and dialysis related services from a hospital-based or free-standing RDF, or may receive home dialysis supplies and equipment from a supplier. The following services are excluded from SNF consolidated billing:

- Certain dialysis services and supplies, including any related necessary ambulance services;
- Home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies (other than those furnished or arranged for by the SNF itself) are not included in the SNF Part A PPS rate. These services may be billed separately to the FI by the ESRD facility as appropriate; dialysis supplies and equipment may be billed to the *Durable Medical Equipment Medicare Administrative Contractor (DME MAC)* by the supplier; and
- *Erythropoiesis Stimulating Agents (ESAs)* for certain dialysis patients, subject to methods and standards for its safe and effective use (see 42 CFR 405.2163(g) and (h)) may be billed by the RDF to the FI, or by the retail pharmacy to the *DME MAC*;

20.2.1.1 - ESRD Services

(Rev. 1252, Issued: 05-25-07; Effective: 10-01-06; Implementation: 08-27-07)Home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies (other than those that are furnished or arranged for by the SNF itself) are not included in the Part A PPS payment. They may be billed separately to the FI by the hospital or ESRD facility as appropriate.

Specific coding is used to differentiate dialysis and related services that are excluded from SNF consolidated billing for ESRD beneficiaries in three cases:

1. When the services are provided in a renal dialysis facility (RDF) (including ambulance services to and from the RDF if medically necessary);

2. Home dialysis when the SNF constitutes the home of the beneficiary; and

3. When *ESA drugs* are used for ESRD beneficiaries in conjunction with dialysis, and given by the RDF.

Note that SNFs may not be paid for home dialysis supplies.

20.2.1.2 - Coding Applicable to *Dialysis* Services Provided in a Renal Dialysis Facility (RDF) *or Home*

(Rev. 1252, Issued: 05-25-07; Effective: 10-01-06; Implementation: 08-27-07)

Providers should review Chapter 8, Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims, for coding applicable to services provided in a Renal Dialysis Facility.

20.3.1 - Ambulance Services

(Rev. 1252, Issued: 05-25-07; Effective: 10-01-06; Implementation: 08-27-07)

The following ambulance transportation and related ambulance services for residents in a Part A stay are not included in the Part A PPS payment. Except for specific exclusions, consolidated billing includes those medically necessary ambulance trips that are furnished during the course of a covered Part A stay. Carriers and intermediaries are responsible for assuring that payment is made only for ambulance services that meet established coverage criteria.

In most cases, ambulance trips are excluded from consolidated billing when resident status has ended. The ambulance company then must bill the carrier or intermediary (as appropriate) directly for payment. Listed below are a number of specific circumstances under which a beneficiary may receive ambulance services that are covered by Medicare, but excluded from consolidated billing.

The following ambulance services may be billed as Part B services by the supplier in the following situations only.

- The ambulance trip is to the SNF for admission (the second character (destination) of any ambulance HCPCS modifier is N (SNF) other than modifier QN, and the date of service is the same as the SNF 21X admission date.);
- The ambulance trip is from the SNF after discharge, to the beneficiary's home (the first character (origin) of any HCPCS ambulance modifier is N (SNF)) (the second character (destination) of the HCPCS ambulance modifier is R (Residence), and date of ambulance service is the same date as the SNF through date. *Note: this includes beneficiaries discharged home to receive services from a Medicare-participating home health agency under a plan of care;*
- The ambulance trip is to a hospital based or nonhospital based ESRD facility (the first character (origin) of the HCPCS ambulance modifier is N(SNF) the second character (destination) HCPCS ambulance modifier codes is G (Hospital based dialysis facility) or J (Non-hospital based dialysis facility)) for the purpose of receiving dialysis and related services excluded from consolidated billing.
- The ambulance trip is from the SNF to a Medicare participating hospital or a CAH for an inpatient admission (the first character origin (origin) of the HCPCS ambulance modifier is N (SNF) (the second character (destination) of the HCPCS modifier (destination) is H).
- The ambulance trip after a formal discharge or other departure from the SNF to any destination other than another SNF, and the beneficiary does not return to that or any other SNF by midnight of that same day; and
- Ambulance service that conveys a beneficiary to a hospital or CAH and back to the SNF, for the specific purpose of receiving emergency or other excluded services. *(see section 20.1.2 above for list of other excluded services).*

The following ambulance services are included in SNF CB and may **not** be billed as Part B services to the intermediary or carrier when the beneficiary is in a Part A stay:

- Under the regulations at 42 CFR 411.15(p)(3)(iv), the day of departure from SNF 1 is a covered Part A day (to which consolidated billing would apply) only if the beneficiary is actually admitted to SNF 2 by midnight of the day of departure. (the first and second character of the ambulance modifier is N). Patient Status is 03.

- Ambulance transports to or from a diagnostic or therapeutic site other than a hospital or renal dialysis facility (e.g., an independent diagnostic testing facility (IDTF), cancer treatment center, radiation therapy center, wound care center, etc.). The ambulance transport is included in the SNF PPS rate if the first or second character (origin or destination) of any HCPCS code ambulance modifier is "D" (diagnostic or therapeutic site other than "P" or "H"), and the other modifier (origin or destination) is "N" (SNF). The first SNF is responsible for billing the services to the FI.

See chapter 15 for Ambulance Services.

30.1 - Health Insurance Prospective Payment System (HIPPS) Rate Code

(Rev. 1252, Issued: 05-25-07; Effective: 10-01-06; Implementation: 08-27-07)

The HIPPS rate code consists of the three-character resource utilization group (RUG) code (see Table 1 below) that is obtained from the "Grouper" software program followed by a 2-digit assessment indicator (AI) (see Table 2 below) that specifies the type of assessment associated with the RUG code obtained from the Grouper. SNFs must use the version of the Grouper software program identified by CMS for national PPS as described in the Federal Register for that year. The Grouper translates the data in the Long Term Care Resident Instrument into a case-mix group and assigns the correct RUG code. The Grouper will not automatically assign the 2-digit AI, except in the case of a swing bed MDS that is will result in a special payment situation AI (see below).

The HIPPS rate code that appears on the claim must match the assessment that has been transmitted and accepted by the State in which the facility operates. The SNF may bill the program only after:

- *An assessment has been completed and submitted to the State RAI Database;*
- *A Final Validation Report indicating that the assessment has been accepted by the state; and*
- *The covered day has actually been used.*

SNFs that submit claims that have not completed this process will not be paid. It is important to remember that the record will be accepted into the State RAI database, even if the calculated RUG code differs from the submitted values. The error will be flagged on the final validation report by issuing a warning message and listing the correct RUG code. When such discrepancies occur, the RUG code reported on the Final Validation Report shall be used for billing purposes.

TABLE 1: RUG CODES

AAA (the default code)

BA1, BA2, BB1, BB2

CA1, CA2, CB1, CB2, CC1, CC2

IA1, IA2, IB1, IB2

PA1, PA2, PB1, PB2, PC1, PC2, PD1, PD2, PE1, PE2

RHA, RHB, RHC, RHL, RHX, RLA, RLB, RLX, RMA, RMB, RMC, RML, RMX, RUA, RUB, RUC, RUL, RUX, RVA, RVB, RVC, RVL, RVX

SE1, SE2, SE3, SSA, SSB, SSC

NOTE: The following RUG Codes are only valid on or after January 1, 2006:

RHL, RHX, RLX, RML, RMX, RUL, RUX, RVL and RVX

TABLE 2 ASSESSMENT INDICATOR CODES (effective July 1, 2002)

Code	Definition
00	Default code
01	5-day Medicare-required assessment/not an initial admission assessment
02	30-day Medicare-required assessment
03	60-day Medicare-required assessment
04	90-day Medicare-required assessment
05	Readmission/Return Medicare-required assessment
07	14-day Medicare-required assessment/not an initial admission assessment
08	Other Medicare-required assessment (OMRA) with an ARD set on day 9, 10, 20, 35. 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 93, 94, 95, 96, 97, 98, 99 or 100 of the covered stay.
11	5-day (or readmission/return) Medicare-required assessment AND initial admission assessment
17	14-day Medicare-required assessment AND initial admission assessment. This code is used to signify that the bill is based on an assessment that is satisfying two requirements: the clinical requirement for an Initial Admission Assessment and the Medicare payment requirement for a 14-day assessment
18	OMRA replacing 5-day Medicare-required assessment. This code is used to signify that the bill is based on an OMRA that was performed within the window of a Medicare required 5-day assessment and "replaces" the Medicare required 5-day assessment. This combination of assessment type is extremely rare and accordingly, this code will not likely be used often.
***19**	**Special payment situation – 5-day assessment (effective July 1, 2002)**
28	OMRA replacing 30-day Medicare-required assessment. This code signifies that the HIPPS rate code is based on an OMRA with an ARD set within the window of a Medicare required 30-day assessment and thus "replaces" the Medicare required 30 day assessment.
***29**	**Special payment situation – 30-day assessment (effective July 1, 2002)**

Code	Definition
30	Significant Change in Status Assessment (SCSA) with an ARD set on day 9, 10, 20, 35. 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 93, 94, 95, 96, 97, 98, 99, or 100 of the covered stay. An SCSA is performed for clinical reasons as defined in the most current version of the Long Term Care Resident Assessment Instrument User's Manual.
31	SCSA replaces 5-day Medicare-required assessment This code signifies that the HIPPS rate code is based on a SCSA, that was performed for clinical reasons, with an ARD set within the window of a Medicare required 5-day assessment and thus "replaces" the Medicare-required 5-day assessment.
32	SCSA replaces 30-day Medicare-required Assessment. This code signifies that the HIPPS rate code is based on a SCSA with an ARD set within the assessment window for a readmission/return assessment and thus replaces the readmission/return assessment.
33	SCSA replaces 60-day Medicare-required assessment. This code signifies that the HIPPS rate code is based on a SCSA, that was performed for clinical reasons, with an ARD set within the window of a Medicare required 60-day assessment and thus "replaces" the Medicare-required 60-day assessment.
34	SCSA replaces 90-day Medicare-required assessment. This code signifies that the HIPPS rate code is based on a SCSA, that was performed for clinical reasons, with an ARD set within the window of a Medicare required 90-day assessment and thus "replaces" the Medicare-required 90-day assessment.
35	SCSA replaces a readmission/return assessment. This code signifies that the HIPPS rate code is based on a SCSA, that was performed for clinical reasons, with an ARD set within the window of a readmission/return assessment and thus "replaces" the readmission/return assessment.
37	SCSA replaces 14-day Medicare-required assessment. This code signifies that the HIPPS rate code is based on a SCSA, that was performed for clinical reasons, with an ARD set within the window of a Medicare required 14-day assessment and thus "replaces" the Medicare-required 14-day assessment.
38	Effective 10-01-00, OMRA replacing 60-Day Medicare-Required Assessment.. Prior to 10-01-00, AI 38 included both an OMRA and an SCSA with an ARD set on day 9, 10, 20, 35. 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 93, 94, 95, 96, 97, 98, 99, or 100 of the covered stay.
***39**	**Special payment situation – 60-day assessment (effective July 1, 2002)**

Code	Definition
40	Significant Correction of a Prior Assessment (SCPA) with an ARD set on day 9, 10, 20, 35. 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 93, 94, 95, 96, 97, 98, 99, or 100 of the covered stay.
41	SCPA replaces 5-day Medicare required assessment. This code signifies that the HIPPS rate code is based on a SCPA with an ARD set within the assessment window for a 5-day Medicare required assessment and thus "replaces" the Medicare required 5-day assessment.
42	SCPA replaces 30-day Medicare-required assessment. This code signifies that the HIPPS rate code is based on a SCPA with an ARD set within the assessment window for a 30-day Medicare required assessment and thus "replaces" the Medicare required 30-day assessment.
43	SCPA replaces 60-day Medicare-required assessment. This code signifies that the HIPPS rate code is based on a SCPA with an ARD set within the assessment window for a 60-day Medicare required assessment and thus "replaces" the Medicare required 60-day assessment.
44	SCPA replaces 90-day Medicare-required assessment. This code signifies that the HIPPS rate code is based on a SCPA with an ARD set within the assessment window for a 90-day Medicare required assessment and thus "replaces" the Medicare required 90-day assessment.
45	SCPA replaces a Readmission/Return assessment. This code signifies that the HIPPS rate code is based on a SCPA that was performed within the assessment window of a readmission/return assessment and thus "replaces" the readmission/return assessment.
47	SCPA replaces 14-day Medicare-required assessment. This code signifies that the HIPPS rate code is based on a SCPA with an ARD set within the assessment window for a 14-day Medicare required assessment and thus "replaces" the Medicare required 14-day assessment.
48	OMRA replaces 90-day Medicare-required assessment. This code signifies that the HIPPS rate code is based on an OMRA that was performed within the assessment window of a 90-day Medicare required assessment and thus "replaces" the Medicare required 90-day assessment.
***49**	**Special payment situation – 90-day assessment (effective July 1, 2002)**
54	90-day Medicare assessment that is also a quarterly assessment
78	OMRA replaces 14-day Medicare-required assessment. This code signifies that

Code	Definition
	the HIPPS rate code is based on an OMRA that was performed within the assessment window of a 14-day Medicare required assessment and thus "replaces" the Medicare-required 14-day assessment.
***79**	**Special payment situation – 14-day assessment (effective July 1, 2002)**

*****In some situations, beneficiaries may change payer source after admission, but fail to notify the provider in a timely manner, e.g., disenrollment from an MA, disenrollment from a hospice, change in Medicare payer status from secondary to primary, etc. Problems may also occur in payment ban situations where the SNF may not receive timely notification that a payment ban has been lifted. In these cases, the provider may not have completed the RAI assessments needed for Medicare billing. New AI codes were established for these special payment situations.

AI codes are only used for billing Medicare for covered SNF Part A stays. To the extent possible, every combination of reasons for RAI assessment relevant for payment under Part A PPS has been captured by the HIPPS AI codes. However, to avoid undue complexity and because the information is not relevant for payment, there are some combinations that are not specifically identifiable using the codes. This means that although there are instances in which all of the information contained on the long term care resident assessment instrument is not captured by the HIPPS AI code, it is still an accurate code for billing purposes. From the standpoint of Medicare payment, it does not matter if Medicare-required assessments are also used to fulfill the clinical requirements for an SCSA or a Quarterly Assessment.

40.3.3 - Same Day Transfer

(Rev. 1252, Issued: 05-25-07; Effective: 10-01-06; Implementation: 08-27-07)

The day of admission counts as a utilization day, except in the situation where the patient was admitted with the expectation that he remain overnight but was transferred to another participating provider before midnight of the same day. In this instance, the first provider completes the bill as follows:

- Indicate "0" in Covered Days;
- Insert condition code "40" to indicate the patient was transferred from one participating provider to another before midnight on the day of admission; and,
- Admission date, statement "from" and "through" dates are the same.

No payment is made to the originating participating provider. Instead, the participating provider to which the patient was transferred counts the admission day as a utilization day that includes the day of admission and may bill the HIPPS default code.

If a patient is transferred from a Medicare participating facility to a nonparticipating facility the day of admission counts as a utilization day and the Medicare-participating facility may bill the HIPPS default code.

These general rules apply to transfers between SNFs *and between a hospital and an SNF*. However, under these same circumstances, if the two providers represent an institution

composed of a participating hospital and a distinct part participating SNF, the first provider cannot bill for accommodations, but may bill for ancillary charges.

40.8 - Billing in Benefits Exhaust and No-Payment Situations

(Rev. 1252, Issued: 05-25-07; Effective: 10-01-06; Implementation: 08-27-07)

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 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.

NOTE: *Providers may bill benefits exhaust and no payment claims using the default HIPPS code AAA00 and room & board charges 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) Value Code 09 (First year coinsurance amount) or Value Code 11 (Second year coinsurance amount) = 1.00 (If applicable, the FISS will assign the correct coinsurance amount based off the CWF response).

iv) 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) Value Code 09 (First year coinsurance amount) or Value Code 11 (Second year coinsurance amount) = 1.00 (If applicable, the FISS will assign the correct coinsurance amount based off the CWF response).

v) 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) Value Code 09 (First year coinsurance amount) or Value Code 11 (Second year coinsurance amount) = 1.00 (If applicable, the FISS will assign the correct coinsurance amount based off the CWF response).

iv) 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).

Refer to the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-92 (CMS-1450) Data Set" for further information about billing, as it contains UB-92 data elements and the corresponding fields in the electronic record.

40.8.1 – SNF Spell of Illness Quick Reference Chart

(Rev. 1252, Issued: 05-25-07; Effective: 10-01-06; Implementation: 08-27-07)

Level of Care	Patient's Medicare SNF Part A Benefits Are Exhausted	Patient Is In Medicare Certified Area of the Facility *	If in non-Medicare Area, the Facility Meets the Definition of a SNF **	Is the Inpatient Spell of Illness Continued?	Billing Action
Medicare Skilled	YES	YES	N/A	YES	Submit Monthly Covered Claim
	NO	YES	N/A	YES	Submit Monthly Covered Claim
	YES	NO	YES	YES	Submit Monthly Covered Claim
	NO	NO	YES	Patient should be returned to certifed area for Medicare to be billed	N/A
	NO	NO	NO	Patient should be returned to certifed area for Medicare to be billed	N/A
Not Medicare Skille	YES	NO	NO	NO	Do not submit claim if pt came in non-skilled. Otherwise, submit no-pay claim w/ discharge status code when patient leaves the certified area.
	YES	YES	N/A	NO	Do not submit claim if pt came in non-skilled. Otherwise, submit no-pay claim w/ discharge status code when patient leaves the certified area.
	NO	YES	N/A	NO	Do not submit claim if pt came in non-skilled. Otherwise, submit no-pay claim w/ discharge status code when patient leaves the certified area.
	NO	NO	YES	NO	Do not submit claim if pt came in non-skilled. Otherwise, submit no-pay claim w/ discharge status code when patient leaves the certified area.
	YES	NO	YES	NO	Do not submit claim if pt came in non-skilled. Otherwise, submit no-pay claim w/ discharge status code when patient leaves the certified area.

* Whether the facility considers a patient's bed in the certified area to be a Medicare bed or not has no effect on whether the spell of illness continues.

** In some states, licensing laws for all nursing homes have incorporated requirements of the basic SNF definition (Social Secuirty Act §1819(a)(1)). When this is the case, any nursing home in such a state would be considered to meet this definition (see CMS Internet-Only Manual, Pub. 100-7, Chapter 2, §2164 at www.cms.hhs.gov/manuals/ on the CMS website).

90 – Medicare Advantage (MA) Beneficiaries

(Rev. 1252, Issued: 05-25-07; Effective: 10-01-06; Implementation: 08-27-07)

For billing to *MA plans*, SNFs follow the requirements of the agreement they have with the plans. In cases where the patient may have enrolled or disenrolled from the plans during the billing period, the SNF will split the bill and send the *plan's* portion to it and the remaining portion to the FI.

90.1 - Beneficiaries Disenrolled from MA Plans

(Rev. 1252, Issued: 05-25-07; Effective: 10-01-06; Implementation: 08-27-07)

If a beneficiary voluntarily or involuntarily dis-enrolls from a risk MA plan while an inpatient of an SNF and converts to original Medicare (i.e., fee for service) the requirement for a three day hospital stay will be waived if the beneficiary meets the level of care criteria found in 42 CFR 409, Subpart D, up through the effective date of dis-enrollment. The beneficiary will then be eligible for the number of days that remain out of the 100 day SNF benefit for that particular SNF stay minus those days that would have been covered by the program under original Medicare while the beneficiary was enrolled in the risk MA plan. However, in cases where the beneficiary disenrolls from a risk MA plan after discharge from the SNF, and then is readmitted to the SNF under the 30 day rule, all requirements for original Medicare (i.e., fee for service), including the 3-day hospital stay must be met. Rules regarding cost sharing apply to these cases. That is, providers may only charge beneficiaries for SNF coinsurance amounts.

If the beneficiary voluntarily disenrolls from a risk MA plan and converts to original Medicare (i.e., fee for service) before admission to a SNF then the beneficiary must meet **all** *original Medicare requirements for a SNF stay, including that of a three day inpatient hospital stay.*

SNFs submit the first fee-for-service inpatient claim with condition code "58" to indicate a patient was disenrolled from an MA plan and the 3-day prior stay requirement was not met. Claims with condition code 58 will not require the 3-day prior inpatient hospital stay . The FI must use CWF files to validate the beneficiary was enrolled in an MA organization upon admission to the SNF and that the MA enrollment period ended prior to the "from" date on the claim. The FI does not need to verify that the MA plan was the one that terminated.