CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1618	**Date: October 24, 2008**
	Change Request 6233

SUBJECT: Revision to the Reporting Requirements of Qualifying Hospital Stays on Inpatient Skilled Nursing Facility (SNF) and Swing Bed (SB) Claims

I. SUMMARY OF CHANGES: This instruction implements the requirement for SNF and SB providers to report a prior qualifying hospital stay on all covered inpatient SNF and SB claims.

New / Revised Material
Effective Date: *April 1, 2009
Implementation Date: April 6, 2009

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	6/40.8.2/Billing When Qualifying Stay or Transfer Criteria are not Met
R	6/90.1/Beneficiaries Disenrolled from 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: 1618	Date: October 24, 2008	Change Request: 6233

SUBJECT: Revision to the Reporting Requirements of Qualifying Hospital Stays on Inpatient Skilled Nursing Facility (SNF) and Swing Bed (SB) Claims

EFFECTIVE DATE: April 1, 2009

IMPLEMENTATION DATE: April 6, 2009

I. GENERAL INFORMATION

A. Background:

This instruction provides an update to the billing requirements for reporting qualifying hospital stays, or the appropriate condition code for bypassing the qualifying hospital stay, on inpatient SNF and SB claims. SNF and SB providers must submit a qualifying hospital stay or appropriate condition code, if applicable, **on all claims**, including initial and subsequent claims that are submitted as covered. This is applicable for submitted bill types 21x and 18x where "x" does not equal "0 (zero)". This includes all covered claims, including claims submitted for benefits exhaust denials.

Covered claims that do not include a qualifying hospital stay or an appropriate condition code to indicate why a qualifying hospital stay is not applicable will be denied with the appropriate reason code indicating a qualifying hospital stay is not present.

B. Policy: N/A

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	
6233.1	Medicare systems shall ensure a prior qualifying hospital stay or an appropriate condition code bypass currently indicated in any existing qualifying stay edits is included on all submitted covered inpatient SNF and SB claims.						X				
6233.1.1	The applicable bill types are 21x and 18x (where "x" does not equal "0")						X				
6233.1.2	Medicare contractors shall reject claims that do not contain occurrence span code 70 or an appropriate condition code bypass currently indicated in any existing	X		X							

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	
	qualifying stay edits.										
6233.2	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	
6233.3	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

Section 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:

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

V. CONTACTS

Pre-Implementation Contact(s): Jason Kerr, Jason.Kerr@cms.hhs.gov ; Wendy Tucker, Wendy.Tucker@cms.hhs.gov
Post-Implementation Contact(s): Appropriate Regional Office; http://www.cms.hhs.gov/apps/contacts/

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs)* use only one of the following statements:

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)*, use the following statement:

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.

40.8 - Billing in Benefits Exhaust and No-Payment Situations

(Rev. 1618, Issued: 10-24-08, Effective: 04-01-09 Implementation: 04-06-09)

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) Occurrence Span Code 70 with the qualifying hospital stay dates.

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

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 Span Code 70 with the qualifying hospital stay dates.

iii) 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.

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

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) 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.

40.8.2 - Billing When Qualifying Stay or Transfer Criteria are not Met

(Rev. 1618, Issued: 10-24-08, Effective: 04-01-09 Implementation: 04-06-09)

SNF providers are required to submit claims to Medicare for beneficiaries that receive a skilled level of care. This includes beneficiaries that do not meet the qualifying stay or transfer criteria. Although these claims will not be paid by Medicare, providers must submit these claims as covered in order to *extend existing* beneficiary spell*s* of illness in CWF. *A prior qualifying hospital stay (occurrence span code 70) would not be applicable and shall not be included with these claims. This will allow Medicare systems to deny the claim for the appropriate reason.*

Note: This instruction includes beneficiaries that were previously admitted for skilled care then subsequently drop to non-skilled for greater than 30 days and then require skilled care again but do not have a new qualifying hospital stay.

90.1 - Beneficiaries Disenrolled from MA Plans

(Rev. 1618, Issued: 10-24-08, Effective: 04-01-09 Implementation: 04-06-09)

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 *all applicable* fee-for-service inpatient *SNF* claim*s* 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.