



Related MLN Matters Article #: MM5583

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Clarification of Skilled Nursing Facility No Payment Billing

Key Words

MM5583, CR5583, R1252CP, SNF, Billing

Provider Types Affected

Skilled Nursing Facilities (SNFs) submitting claims to Medicare Fiscal Intermediaries (FIs) or Part A/B Medicare Administrative Contractors (A/B MACs) for SNF services provided to Medicare beneficiaries

Key Points

- The effective date of the instruction is October 1, 2006.
- The implementation date is August 27, 2007.
- Change Request (CR) 5583 clarifies No Pay billing instructions for SNF Type of Bill (TOB) 210 (SNF Non-covered level of care) that overlap previously paid SNF TOB 22x (SNF inpatient stay, Part B only services).
- CR5583 also clarifies providers' billing requirements for beneficiaries who have disenrolled from Medicare Advantage (MA) plans, and it updates various sections of Chapter 6 (SNF Inpatient Part A Billing) of the *Medicare Claims Processing Manual* (Publication 100-04).
- Included in these updates is the SNF Spell of Illness Quick Reference chart that is on page 3 of MLN Matters MM5583.
- **However, there are no policy changes made by CR5583.**

No Pay Billings

- In order to bypass Medicare edits that do not allow SNF TOB 210 to process when overlapping with previously paid 22X bill types, providers must include occurrence span code 74 with the statement covers period of the TOB 210 bill being submitted.

Beneficiaries Disenrolled from MA Plans

- Medicare covers SNF inpatient services for beneficiaries disenrolling from risk MA plans **when the beneficiary has not met the 3-day prior hospital stay requirement.**
 - The FI or A/B MAC will begin counting 100 days of SNF care with the SNF admission date, regardless of whether the beneficiary met the skilled level of care requirements on that date.
 - All other Medicare rules apply, including:
 - The requirement that beneficiaries meet the skilled level of care requirement (for the period for which the original Medicare fee-for-service program is billed) and
 - The rules regarding cost sharing apply to these cases. In other words, providers may only charge beneficiaries for SNF coinsurance amounts.
 - 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 hospital stay requirement was not met.
 - Claims with condition code 58 will not require the 3-day prior inpatient hospital stay.
- Where a beneficiary disenrolls from a risk MA plan, **is discharged** from the SNF, and then is readmitted to the SNF under the 30 day rule, all requirements for original Medicare, including the 3-day prior hospital stay requirement, must be met.

Important Links

The related MLN Matters article can be found at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5583.pdf> on the CMS website.

The official instruction (CR5583) regarding this change may be viewed at

<http://www.cms.hhs.gov/Transmittals/downloads/R1252CP.pdf> on the CMS website.

If providers have any questions, they may contact their FI or A/B MAC at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.