



Do you have your NPI? National Provider Identifiers (NPIs) will be required on claims sent on or after May 23, 2007. Every health care provider needs to get an NPI. Learn more about the NPI and how to apply for an NPI by visiting <http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/index.html/NationalProvIdentStand/> on the CMS website.

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Note: This article was updated on October 24, 2012, to reflect current Web addresses. All other information remains unchanged.

Benefits Exhaust and No-Payment Billing Instructions for Medicare Fiscal Intermediaries (FIs) and Skilled Nursing Facilities (SNFs)

Provider Types Affected

Skilled nursing facilities (SNFs) that bill Medicare fiscal intermediaries (FIs) for skilled nursing care benefits

Important Points to Remember

- CR4292 implements a standard process for billing claims in *benefits exhaust* and *no payment* situations. **Note:** Currently, requirements for billing such claims for SNF providers vary; this instruction implements a standard process.
- This standard process applies **only** to SNF residents who are newly admitted to, or are in, Medicare Part A stays on or after October 1, 2006.

Background

An SNF is required to submit a bill even though no benefits may be payable by Medicare. The Centers for Medicare & Medicaid Services (CMS) maintains a record of all inpatient services for each beneficiary, whether those services are covered by Medicare 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 are required in two situations:

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- When the beneficiary has exhausted their 100 covered days under the Medicare SNF benefit (referred to below as benefits exhaust bills); and
- When the beneficiary no longer needs a Medicare covered level of care (referred to below as no-payment bills).

Benefits Exhaust Situations

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 insurer, or private payer. There are two types of benefits exhaust claims:

- **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
- **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 Medicare system's 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.

No-Payment Situations

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.

Billing Guidance

Under the new standard process, effective on October 1, 2006, the billing guidance for submitting either benefits exhaust or no-payment claims is as follows:

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1. Benefits Exhaust Claims

SNF providers must submit **benefits exhaust claims** for those beneficiaries that continue to receive skilled services as follows:

Full or partial benefits exhaust claim:

- **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.
- **Covered Days and Charges** - Submit all covered days and charges as if beneficiary had days available
- **Value Code 09 (First Year Coinsurance Amount) or Value Code 11 (Second year coinsurance amount)** = 1.00 (If applicable, the Medicare system will assign the correct coinsurance amount)
- **Patient Status Code** - Use appropriate code.

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:

- **Bill Type** - Use appropriate bill type (i.e., 212 or 213 for SNF and 182 or 183 for SB).
- **Note:** Bill type 210 or 180 should not be used for benefits exhaust claims.
- **Occurrence Code 22 (date active care ended)** - include the date active care ended; this should match the statement covers through date on the claim.
- **Covered Days and Charges** - Submit all covered days and charges as if the beneficiary had days available up until the date active care ended.
- **Value Code 09 (First Year Coinsurance Amount) or Value Code 11 (Second year coinsurance amount)** = 1.00 (If applicable, the Medicare system will assign the correct coinsurance amount.)
- **Patient Status Code** - 30 (still patient)

Benefits exhaust claim with a patient discharge:

- **Bill Type** – 211 or 214 for SNF and 181 or 184 for SB.
- **Note:** Bill type 210 or 180 should not be used for benefits exhaust claims.
- **Covered Days and Charges** - Submit all covered days and charges as if beneficiary had days available up until the date of discharge.

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- **Value Code 09 (First Year Coinsurance Amount) or Value Code 11 (Second year coinsurance amount)** = 1.00 (If applicable, the Medicare system will assign the correct coinsurance amount.)
- **Patient Status Code** - Use appropriate code other than patient status code 30 (still patient).

Note: Billing all covered days and charges allows the Medicare 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. No-Payment Claims

SNF providers will 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 either of the following options.

Patient previously dropped to non-skilled care within the month. Provider needs Medicare denial notice for other insurers:

- **Bill Type** - 210 (no-payment bill type)
- **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.
- **Days and Charges** - Non-covered days and charges beginning with the day after active care ended.
- **Condition Code 21** (billing for denial)
- **Patient Status Code** - Use appropriate code.

Patient previously dropped to non-skilled care. In these cases, the provider must only submit the final discharge bill that may span multiple months:

- **Bill Type** - 210 (no-payment bill type)
- **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.
- **Days and Charges** - Non-covered days and charges beginning with the day after active care ended.
- **Condition Code 21** (billing for denial)

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

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Additional Information

The official instructions issued to your Intermediary regarding this change can be found at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R930CP.pdf> on the CMS website.

If you have questions, please contact your Medicare carrier at their toll-free number which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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