Medicare Learning Network
MLN Matters
CMS
Information for Medicare Fee-for-Service Health Care Professionals

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Revision of the Requirements for Denial of Payment for New Admissions (DPNA) for Skilled Nursing Facility (SNF) Billing

Note: This article was revised on January 17, 2018, to update Web addresses. All other information remains the same.

Provider Types Affected

SNFs impacted by payment ban situations and submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries in SNFs.

Impact on Providers

This article is based on Change Request (CR) 6116 and addresses the consequences that occur when the Centers for Medicare & Medicaid Services (CMS) impose sanctions that preclude Medicare payment for new admissions (or DPNA) to a SNF when a facility is not in substantial compliance with Medicare requirements of participation. Be sure billing staff are aware of these instructions, especially the use of occurrence span code 80 on appropriate claims.

Background

Under the Social Security Act at sections 1819(h) and 1919(h) and CMS regulations at 42 CFR 488.417, CMS may impose a DPNA against a SNF when a facility is not in substantial compliance with requirements of participation.

Medicare policy indicates that beneficiaries admitted before the effective date of a DPNA situation and taking temporary leave, whether to receive inpatient hospital care, outpatient services, or as therapeutic leave, are not considered new admissions, and **are not subject to the denial of payment upon return.**

Medicare instructions previously indicated that SNFs should append a condition code 57 (SNF readmission) for those patients in which the DPNA does not apply. However, the definition for condition code 57 indicates the patient previously received Medicare covered SNF care within 30 days of this readmission and would not necessarily apply in all payment ban situations.

For example, a readmission could apply to patients that resided in the SNF prior to the imposition of the ban, whether on private pay or covered under another insurer, then went out to a hospital for a qualifying stay and returned directly back to the SNF upon discharge of the hospital. If the patient, in this scenario, did not receive Medicare SNF covered care within 30 days of the readmission then the condition code 57 would not be appropriate.

Therefore, CMS is updating DPNA instructions to require SNF providers to append occurrence span code 80 (definition below), for same-SNF readmissions, to indicate the most recent prior same-SNF stays dates of the patient prior to their discharge to the hospital for a qualifying hospital stay. **As long as the patient resides in the SNF prior to the imposition of a payment ban and the patient discharges to the hospital then directly back to the same SNF from the hospital the claim would be considered a readmission for DPNA purposes and a payment ban will not be applicable.**

In addition, if the patient resides in the SNF prior to the imposition of the ban and goes on a LOA, the patient will not be subject to a ban upon their return to the SNF should a payment ban be applicable during their return. Providers must be sure to bill the LOA period on their claim.

Key Points of CR6116

Chapter 6, Section 50 of the Medicare Claims Processing Manual covers SNF payment bans and related DPNA actions. That section is revised by CR6116 as follows:

Billing for Admissions Not Covered by the Payment Ban

Effective January 1, 2009, when a SNF that is under a payment ban needs to submit a claim for a Medicare beneficiary readmission that is not subject to the payment ban, the SNF must use **occurrence span code 80 for reporting prior same-SNF stay dates**. The definition of **"**Prior Same-SNF Stay Dates for Payment Ban Purposes" is: **The from/through dates of a prior same-SNF stay indicating a patient resided in the SNF prior to, and if applicable, during a payment ban period up until their discharge to a hospital. (**Previously, SNFs used condition code 57 for this purpose, but that code does not apply to all payment ban situations.)

Effect on Utilization Days and Benefit Period

In situations where the beneficiary's SNF admission is subject to the payment ban, but the **provider fails to issue the proper beneficiary liability notice, the provider is liable** for all services normally covered under the Medicare Part A benefit. Since the

beneficiary is receiving benefits, the days will be considered Part A days and charged against the beneficiary's benefit period. The SNF may collect any applicable copayment amounts from the beneficiary. **These days will be charged against the patient's utilization** as is currently done with other types of technical denials (i.e., late filing, late denial notices to the patient, etc.).

If the SNF issues the appropriate beneficiary liability notice, and the beneficiary agrees to make payment either personally or through a private insurer, the days will not be charged towards the 100-day benefit period.

Effect of an Appeal to A DPNA on Billing during the Period the SNF Is Subject to a DPNA

In those situations where the SNF decides to appeal the imposition of a DPNA, it must still bill the program as set forth in the provider liability billing instructions in the revised Section 50, which is attached to CR6116. In essence, the SNF needs to file a covered bill with the FI or A/B MAC using occurrence span code 77 that indicates the facility is liable for the services in situations where the SNF failed to issue the proper beneficiary liability notice and any applicable copayments will be charged to the beneficiary's Part A benefit period. In addition, the SNF needs to file a non-payment bill for non-covered Part A services using **condition code 21 that indicates beneficiary liability**. Remember that services that would have been eligible for Part A benefits in the absence of sanctions may not be billed as Part B charges to Medicare.

Conducting Resident Assessments

If, during the sanction period, staff do not perform Medicare-required assessments for beneficiaries in covered Part A stays, no payment is made and the SNF must submit a claim using the Health Insurance Prospective Payment System (HIPPS) default rate code and an occurrence code 77 indicating provider liability, in order to ensure that the beneficiary's spell of illness (benefit period) is updated.

When the SNF does not receive timely notification that a payment ban has been lifted, and staff is unaware of the need to start the Medicare-Required schedule (the beneficiary meets all applicable eligibility and coverage requirements), the SNF may bill the Medicare 5-day and 14 day assessment using the HIPPS code generated by the 14-day Omnibus Budget Reconciliation Act (OBRA) required assessment. If the SNF did not perform any assessments with an assessment reference date during the assessment window for the Medicare-Required five day or 14 day assessment, the SNF must bill the default rate for those covered days associated with the assessment. Where the SNF did not perform an assessment with an assessment reference date (ARD) that fell in the applicable Medicare-Required Assessment window for the 30, 60 and 90 day Medicare-Required Assessments it shall bill the default rate. If the SNF did perform an assessment, including a Significant Change in Status Assessment (SCSA), where the ARD fell in the window of a 30, 60 or 90-day Medicare-Required Assessment (including grace days), the SNF shall bill using the HIPPS code generated from the assessment in accordance with the payment policies found in Chapter 28 of the Provider

Reimbursement Manual. The date the sanction is lifted is Day ONE for purposes of the Medicare assessment schedule.

Example 1: The SNF is notified on June 15th that its payment ban was lifted effective June 1. The beneficiary was admitted on June 1. The SNF did not perform any of the Medicare-Required Assessments. However, the SNF did perform the initial OBRA assessment. The initial OBRA assessment shall be used to bill the five-day Medicare-Required Assessment for up to 14 days. Day 15 is day 1 for purposes of starting the Medicare-required assessment schedule and a five-day Medicare required assessment shall be performed.

Example 2: The SNF is notified on August 15 that its payment ban was lifted on June 1. The beneficiary was admitted on June 1. The SNF did not perform any of the Medicare-Required Assessments. However, the SNF did perform the initial OBRA Assessment. The initial OBRA assessment shall be used to bill the five -day Medicare required assessment and the 14-day Medicare required assessment. The 30-day assessment may be billed through day 44 at the default rate. Day 45 is day 1 for purposes of starting the Medicare- required assessment schedule and a five-day Medicare required assessment shall be performed.

Additional Information

For complete details regarding this CR please see the official instruction (CR6116) issued to your Medicare contractor. Current Medicare instructions for DPNA billing reside in sections 50-50.7 of Chapter 6 (SNF Inpatient Part A Billing) of the *Medicare Claims Processing Manual*. These sections are revised by CR6116 and you may review these revised sections in the attachment to this CR 6116 at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1555CP.pdf** on the CMS website.

If you have questions, please contact your Medicare contractor 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.

Document History

- July 21, 2008 – Initial article released.
- January 17, 2018 – The article is revised to update Web addresses. All other information remains the same.

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