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The *Medicare Guide to Rural Health Services: Information for Providers, Suppliers, and Physicians* (Second Edition), which provides rural information pertaining to rural health facility types, coverage and payment policies, and rural provisions under the 2003 MMA and the Deficit Reduction Act of 2005 is now available in downloadable format at http://www.cms.gov/MLNProducts/downloads/MedicareRuralHealthGuide.pdf on the CMS website

MLN Matters Number: MM5583
Related Change Request (CR) #: 5583
Related CR Release Date: May 25, 2007
Effective Date: October 1, 2006
Related CR Transmittal #: R1252CP
Implementation Date: August 27, 2007

Clarification of Skilled Nursing Facility (SNF) No Payment Billing

Note: This article was revised on January 3, 2014, to add a reference to MLN Matters® article MM8490 (http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM8490.pdf) to alert SNFs that "No Payment Bills" are only required for beneficiaries that have previously received skilled care and subsequently dropped to non-covered care and continue to reside in the certified area of the facility. All other information remains the same.

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.

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 5583, which clarifies Skilled Nursing Facility (SNF) No-Payment Billing when the no-pay services overlap periods covered by a previously paid SNF type of bill 22X.

 CAUTION – What You Need to Know

Providers must include occurrence span code 74 with the 'statement covers period' of the 210 bill being submitted in order to bypass Medicare edits that do not allow SNF TOB 210 (SNF Non-covered level of care) to process when overlapping with previously paid 22x bill types (SNF inpatient stay, Part B only services (Part A exhausted)). CR 5583 also clarifies provider 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). However, there are no policy changes made by CR5583.

 GO – What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding these clarifications.

Background

No Pay Billings

Change Request (CR) 5583 clarifies No Pay billing instructions for Skilled Nursing Facility (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).

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 210 bill being submitted.

Beneficiaries Disenrolled from Medicare Advantage (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. (Where a beneficiary disenrolls from a risk MA, is discharged from the SNF, and then is re-admitted to the SNF under the 30 day rule, all requirements of Original Medicare will apply, including the 3-day prior hospital stay.)

Your 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 stay requirement was not met.

Claims with condition code '58' will not require the 3-day prior inpatient hospital stay.

CR5583 updates various sections of Chapter 6 of the *Medicare Claims Processing Manual* and these updates are provided as enclosures to CR5583 including the following SNF Spell of Illness Quick Reference chart:

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 Skilled	YES	NO	NO	NO	Do not submit claim if patient (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.

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
	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 Security 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 http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html on the CMS website).

Additional Information

The official instruction, CR 5583, issued to your FI and A/B MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1252CP.pdf on the CMS website.

If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found on the CMS web site 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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