SKILLED NURSING FACILITY (SNF) BILLING REFERENCE

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Table of Contents

SNF Coverage **1**
- Coverage Requirements 1
- Benefit Period 2
- Communication With Beneficiaries 3

SNF Payment **4**
- Medicare Part A 4
  - Consolidated Billing 4
- Medicare Part B 5

SNF Billing Requirements **5**
- Billing Tips 6
- Special Billing Situations 7
  - Readmission Within 30 Days 7
  - Benefits Exhaust 8
  - No Payment Billing 9
  - Expedited Review Results 10
  - Noncovered Days 11
  - Other SNF Billing Situations 12

Resources **14**

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Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

Medicare Part A covers skilled nursing and rehabilitation care in a Medicare-certified Skilled Nursing Facility (SNF) or swing bed hospital under certain conditions for a limited time. This billing reference provides information for SNF providers about:

- Coverage;
- Payment; and
- Billing.

It also provides resources for more detailed information.

SNF Coverage

Coverage Requirements

To qualify for Medicare Part A coverage of SNF services, the following conditions must be met:

- The beneficiary was an inpatient of a hospital for a medically necessary stay of at least 3 consecutive days.
- The beneficiary transferred to a participating SNF within 30 days after discharge from the hospital (unless the beneficiary's condition makes it medically inappropriate to begin an active course of treatment in a SNF immediately after discharge and it is medically predictable at the time of the hospital discharge that the beneficiary will require covered care within a predeterminable time period).
- The beneficiary requires skilled nursing services or skilled rehabilitation services on a daily basis. Skilled services must be:
  - Ordered by a physician;
  - Performed by or under the supervision of professional or technical personnel; and
  - Rendered for an ongoing condition for which the beneficiary had also received inpatient hospital services or for a new condition that arose during the SNF care for that ongoing condition.

3 Day Prior Hospitalization

The 3 consecutive day stay requirement can be met by inpatient stays totaling 3 consecutive days in one or more hospitals. The day of admission, but not the day of discharge, is counted as a hospital inpatient day.

Time spent in observation or in the emergency room prior to admission does not count toward the 3-day qualifying inpatient hospital stay.

Skilled Services

Skilled nursing and skilled rehabilitation services are those services furnished pursuant to physician orders that:

- Require the skills of qualified technical or professional health personnel, such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, and speech-language pathologists or audiologists; and
- Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the beneficiary and to achieve the medically desired result.

- The daily skilled services can be provided only on an inpatient basis in a SNF if:
  - They are not available on an outpatient basis in the beneficiary's area; or
  - When compared to an inpatient setting, transportation to a facility would be:
    - An excessive physical hardship;
    - Less economical; or
    - Less efficient or effective.
- The services delivered are reasonable and necessary for the treatment of the beneficiary's inpatient illness or injury and are reasonable in terms of duration and quantity.

Benefit Period

Coverage for care in SNFs is measured in "**benefit periods**" (sometimes called a "spell of illness"). A benefit period begins the day the Medicare beneficiary is admitted to a hospital or SNF as an inpatient and ends after the beneficiary has not been an inpatient of a hospital (or received skilled care in a SNF) for 60 consecutive days. Once the benefit period ends, a new benefit period begins when the beneficiary has an inpatient admission to a hospital or SNF. New benefit periods do not begin due to a change in diagnosis, condition, or calendar year.

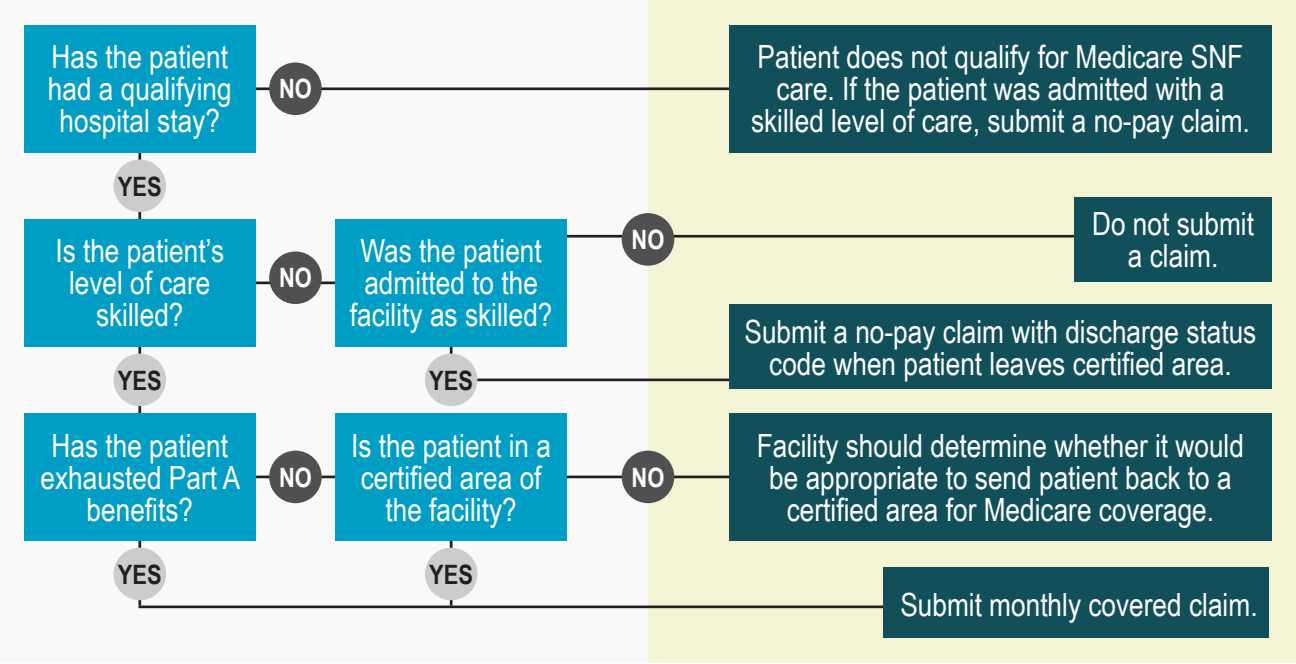
Understanding the benefit period concept is important because SNFs must sometimes submit claims for which they do not expect to receive payment to ensure the benefit period is properly tracked in the CWF.

Common Working File (CWF)

The CWF contains information about Medicare beneficiaries that Medicare Administrative Contractor (MAC) claims processing systems access to ensure proper payment of claims. The CWF tracks the SNF benefit period.

Figure 1 helps you understand the relationships between coverage, skilled care, the benefit period, and whether you submit a claim to Medicare.

Figure 1. Summary of SNF Coverage and Billing



Communication With Beneficiaries

Providers should discuss with the beneficiary if SNF care is right for them. Skilled care is furnished to improve or maintain the beneficiary's current condition or delay it from getting worse. For more detailed information about this, refer to MM8458 on the Centers for Medicare & Medicaid Services (CMS) website.

Have Questions About the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)?

Visit the Fee-For-Service (FFS) SNFABN and SNF Denial Letters web page at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFSSNFABNandSNFDenialLetters.html on the CMS website.

Discuss SNF coverage requirements with the beneficiary and determine whether or not those requirements have been met prior to ordering SNF care. If the requirements have not been met, inform the beneficiary they may not be eligible for Medicare Part A coverage and provide a SNF Advance Beneficiary Notice (SNFABN) or one of the SNF denial letters. For tips on communicating with beneficiaries, refer to the "Communicating With Your Medicare Patients" fact sheet on the CMS website.

SNF Part B Billing

Some services must be billed to Part B. Bill repetitive services monthly or at the conclusion of treatment. Bill one-time services on completion of the service.

For more information on SNF Part B billing, refer to Chapter 7 of the "Medicare Claims Processing Manual" on the CMS website.

Advise the beneficiary that for each benefit period, Medicare Part A covers up to 20 days of care in full. After that, Medicare Part A covers up to an additional 80 days with the beneficiary paying coinsurance for each day. After 100 days, the SNF coverage available during that benefit period is "exhausted," and the beneficiary pays for all care, except for certain Medicare Part B services. For additional information for beneficiaries about costs, coverage, and eligibility, refer to "Medicare Coverage of Skilled Nursing Facility Care" on the Internet.

SNF Payment

Medicare Part A

The SNF Prospective Payment System (PPS) pays for all SNF Part A inpatient services. Part A payment is primarily based on the Resource Utilization Group (RUG) assigned to the beneficiary following required Minimum Data Set (MDS) 3.0 assessments. As a part of the Resident Assessment Instrument (RAI), the MDS 3.0 is a data collection tool that classifies beneficiaries into groups based on the average resources needed to care for someone with similar needs. The MDS 3.0 provides a core set of screening, clinical, and functional status elements, including common definitions and coding categories. It standardizes communication about resident problems and conditions. For more information, review the "Medicare-Required SNF PPS Assessment" educational tool with a scheduled assessment calendar tool on the CMS website.

General Payment Tips

- Medicare will not pay under the SNF PPS unless you bill a covered day.
- Ancillary charges are only allowed for covered days and are included in the PPS rate.

Consolidated Billing

Payment for the majority of services provided to beneficiaries in a Medicare-covered Part A SNF stay, including most services provided by entities other than the SNF, are included in a bundled prospective payment made through a Medicare Administrative Contractor (MAC) to the SNF. The SNF must bill these bundled services to the MAC in a consolidated bill. For services subject to consolidated billing (CB) and provided by entities other than the SNF, the entity looks to the SNF for payment and must not bill Medicare separately for those services.

CB Resources

For more information, take the SNF CB web-based training course on the Medicare LearningNetwork® (MLN) Learning Management and Product Ordering System at https://learner.mlnlms.com on the Internet. To help determine how CB applies to specific services, refer to the flow charts in the "Skilled Nursing Facility Prospective Payment System" fact sheet on the CMS website.

Medicare Part B

Medicare Part B may pay for:

- Outpatient services rendered to beneficiaries who are not inpatients of a SNF;
- Services excluded from SNF PPS and SNF CB; and
- Some services provided to beneficiaries residing in a SNF whose benefit period exhausted or who are not otherwise entitled to payment under Part A.

SNF Billing Requirements

SNFs bill Medicare Part A using Form CMS-1450 (also called the UB-04) or its electronic equivalent. Send claims sequentially, monthly, and upon:

- Decrease to less than skilled care;
- Discharge; or
- Benefit period exhaustion.

NOTE: When benefits exhaust, follow the guidance in Table 3 on page 8 to ensure the claims processing system accurately tracks the benefit period.

For general information on billing with Form CMS-1450, refer to Chapter 25 of the "Medicare Claims Processing Manual" on the CMS website. In addition to the fields required for all claims, SNFs must populate the elements in Table 1 for Part A claims.

Table 1. SNF Billing Requirements

UB-04 Field	Report
FL 04 Type of Bill (TOB)	21X for SNF inpatient services. 18X for swing bed services.
FL 06 Statement Covers Period – From/Through	The "from" date must be the admission date or, for a continuing stay bill, the day after the "through" date on the prior bill. The "through" date is the last day of billing for the period.
FL 31 – FL 34 Occurrence Code/Date	50 with the Assessment Reference Date (ARD) for each assessment period represented on the claim with revenue code 0022 (not required for the default Health Insurance Prospective Payment System [HIPPS] code).
FL 35 & FL 36 Occurrence Span Code – From/Through	70 with the dates of the 3-day qualifying stay.
FL 42 Revenue Code	0022 to indicate you are submitting the claim under the SNF PPS. You can use this revenue code as often as necessary to indicate different rate codes and periods.

Table 1. SNF Billing Requirements (cont.)

UB-04 Field	Report
FL 44 Healthcare Common Procedure Coding System (HCPCS)/ Rate/HIPPS code	HIPPS rate code (a five-digit code consisting of a three-digit RUG code and a two-digit Assessment Indicator [AI] code*). Must be in the order in which the beneficiary received that level of care. Certain HIPPS rate codes require additional rehabilitation therapy ancillary revenue codes. The MAC returns claims for resubmission when these corresponding codes are missing.
FL 46 Units of Service	The number of covered days for each HIPPS rate code.
FL 47 Total Charges	Zero for 0022 revenue code lines.
FL 67 Principal Diagnosis Code	International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) code for the principal diagnosis.
FL 67a – FL67q Other Diagnoses	ICD-CM codes for up to eight additional conditions.

* The AI code describes the assessment that determined the RUG code. For a full explanation of the assessments required, refer to Chapter 6, Section 30 of the "Medicare Claims Processing Manual" on the CMS website.

Billing Tips

- Bill in sequence. MACs return a continuing stay bill if the prior bill has not processed. If you previously submitted the prior bill, hold the returned continuing stay bill until you receive the Remittance Advice (RA) for the prior bill.
- Generally, the day of discharge or death, or a day on which a patient begins a leave of absence (LOA), is not counted as a utilization day.
- If a beneficiary is discharged and returns before midnight on the same day, Medicare does not count this as a discharge.
- The HIPPS rate code that appears on the claim must match the assessment that was transmitted and accepted by the state in which the facility operates. For additional HIPPS information, visit https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/HIPPSCodes.html on the CMS website.

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Special Billing Situations

Certain situations require variations from the billing practices just described. In some cases, Medicare requires submission of a claim even though you do not expect payment. Tables 2–7 provide additional information to help you decide how to bill Part A for various situations. Remember that you must be able to support the information reported on claims with adequate documentation.

Specific Billing Questions

For assistance with billing situations not described here, contact your MAC. For MAC contact information, visit https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map on the CMS website.

Readmission Within 30 Days

Readmission occurs when the beneficiary is discharged and then readmitted to the SNF as skilled within 30 days of discharge. The same is true if the beneficiary remains in the SNF for custodial care after a covered stay and then develops a new need for skilled care within 30 consecutive days.

Table 2. Readmission Within 30 Days Situations

If…	Then…
You sent a discharge claim **prior to readmission**.	Submit another bill and report: • The current admission date as the admission day for the current stay; • Condition code 57; and • Occurrence span code 70 with the dates of the qualifying hospital stay.
The beneficiary is **readmitted before you send a discharge claim**.	Submit an interim bill and report: • The current admission date as the admission day for the current stay; • Condition code 57; • Occurrence span code 70 with the dates of the qualifying hospital stay; and • Occurrence span code 74 showing “from” and “through” dates for the LOA and the number of noncovered days.

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Benefits Exhaust

When benefits exhaust (fully or partially), continue to submit monthly bills as long as the beneficiary remains in a Medicare-certified area of the facility.

Full and Partial Benefits Exhaust

Full benefits exhaust: The beneficiary had no benefit days available between the "from" and "through" dates on the claim.

Partial benefits exhaust: The beneficiary had some benefit days available between the "from" and "through" dates on the claim.

Table 3. Benefits Exhaust Situations

If…	Then…
The beneficiary **moves to a non-Medicare-certified area** of the facility.	Discharge the beneficiary using the appropriate discharge status code. Do not submit Part B services with TOB 22X until the benefits exhaust claim processes. If applicable, the claims processing system will apply an A3 occurrence code with the last day for which benefits were available. Report: • Appropriate covered TOB (not 210); • HIPPS AAA00; • All days and charges as covered; • Occurrence span code 70 with the dates of the qualifying hospital stay; • Value code 09 with $1.00; and • Appropriate patient status code. Submit any Part B services provided after skilled care ended, including therapy, on a 22X bill type.

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Table 3. Benefits Exhaust Situations (cont.)

If…	Then…
The beneficiary **drops to a nonskilled level of care** while benefits are exhausted **and remains in a Medicare-certified area** of the facility.	Report: • Appropriate TOB (not 210); • Occurrence span code 70 with the dates of the qualifying hospital stay; • Value code 09 with $1.00; • Occurrence code 22 with date covered SNF care ended; and • Patient status code 30. Submit any Part B services provided after skilled care ended, including therapy, on a 22X bill type.
The beneficiary **drops to a nonskilled level of care** while benefits are exhausted and **moves to a non-Medicare-certified area of the facility** or otherwise discharges.	Report: • TOB 211 or 214 for SNFs and 181 or 184 for swing beds; • Value code 09 with $1.00; and • Appropriate patient status code (other than 30). Submit any Part B services provided after skilled care ended, including therapy, on a 22X bill type

No Payment Billing

For no payment billing, the beneficiary drops to a nonskilled level of care and remains in a Medicare-certified area of the facility.

Table 4. No Payment Billing Situations

If…	Then…
If you **need a denial notice** so another insurer will pay, send the initial no payment claim with the “from” date as the date SNF care ended. Then, continue to send claims as often as monthly.	Report: • All days and charges as noncovered, beginning the day following the day SNF care ended; • Condition code 21; • Appropriate patient status code; • TOB 210 for SNFs or 180 for swing beds; and • HIPPS AAA00. Submit any Part B services provided after skilled care ended, including therapy, on a 22X bill type.

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Table 4. No Payment Billing Situations (cont.)

If…	Then…
If you **do not need a denial notice**, you only need to send one final discharge claim. The claim may span both the SNF and Medicare Fiscal Year (FY) end dates.	Report: • "From" date as the day SNF care ended; • "Through" date as the date of discharge; • All days and charges as noncovered, beginning the day following the day SNF care ended; • Condition code 21; • Appropriate patient status code (other than 30); • TOB 210 for SNFs or 180 for swing beds; and • HIPPS AAA00. Submit any Part B services provided after skilled care ended, including therapy, on a 22X bill type.

Expedited Review Results

Provider-initiated discharges for coverage reasons associated with SNF and inpatient swing bed claims require an expedited determination notice. You must report the outcomes of expedited determinations on the claim.

Table 5. Expedited Review Results Situations

If…	Then…

The Quality Improvement Organization (QIO)/ Qualified Independent Contractor (QIC) **upholds the discharge decision**.	Report:
	• A discharge for the billing period that precedes the determination;
	• Condition code C4; and
	• If the beneficiary is liable for any care days, report:
	  ○ Occurrence span code 76 with the days the beneficiary incurred liability;
	  ○ Zero charges for the beneficiary-liable days; and
	  ○ Modifier TS for any HCPCS codes for those days.

The QIO/QIC authorizes **continued coverage with no specific end date**.	Report: • A continuing claim for the current billing or certification period; and • Condition code C7.

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Table 5. Expedited Review Results Situations (cont.)

If…	Then…
The QIO/QIC authorizes **continued coverage only for a limited period of time**, and **the time extends** beyond the end of the normal billing or certification period.	Report: • A continuing claim for the current billing or certification period; • Condition code C3; and • Occurrence span code M0 with the beginning date of QIO/QIC-approved coverage and the claim "through" date.
The QIO/QIC **authorizes continued coverage only for a limited period of time**, and **the time does not extend** beyond the end of the normal billing or certification period.	Report: • A discharge; • Condition code C3; and • Occurrence span code M0 with the beginning and end dates of QIO/QIC-approved coverage.
The provider is liable due to failure to give information to the QIO/QIC timely or to provide valid notice to the beneficiary.	Report services as noncovered with modifier GZ.

Noncovered Days

The patient does not meet Medicare SNF coverage requirements.

Table 6. Noncovered Days Situations

If…	Then…
The **beneficiary is liable**.	Report occurrence span code 76. Submit the claim as covered if the beneficiary is skilled.
The **SNF is liable**.	Report occurrence span code 77. Submit the claim as covered if the beneficiary is skilled.

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Other SNF Billing Situations

Table 7. Other SNF Billing Situations

Situation	If…	Then…
No Qualifying Hospital Stay	The beneficiary is admitted as skilled but does not have a qualifying hospital stay. This includes beneficiaries who were initially admitted as skilled, following a qualifying hospital stay, dropped to a nonskilled level of care for more than 30 days (thus ending their connection to the original qualifying hospital stay), and then become skilled again without a new qualifying hospital stay.	Bill as you would otherwise, but do not report occurrence span code 70.
Same Day Transfer	The beneficiary is admitted to the SNF and is expected to remain overnight, but transfers before midnight on the same day to a Medicare-participating facility.	Report: • The same admission, “from” and “through” dates • Zero covered days; and • Condition code 40.
LOA	The beneficiary leaves the SNF but is not admitted as an inpatient to any other facility.	Report: • Revenue code 018X; • Number of LOA days as units; • Zero charges; and • Occurrence span code 74 showing “from” and “through” dates for the LOA and the number of noncovered days.
Forced Discharge	The beneficiary leaves the SNF and is admitted as an inpatient to another facility.	Bill as a discharge. If the beneficiary is readmitted to the SNF within 30 days, follow the instructions for “Readmission Within 30 Days” in Table 2.
Nonskilled Discharge	The beneficiary drops to a nonskilled level of care and moves to a non-Medicare-certified area of the facility.	Discharge the beneficiary on a final discharge claim. Submit services rendered after discharge on a 23X bill type.

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Table 7. Other SNF Billing Situations (cont.)

Situation	If…	Then…
Demand Billing	The SNF believes covered skilled care is no longer medically necessary, and the beneficiary disagrees.	Report: • Condition code 20; and • Occurrence code 22 with the date SNF care ended or occurrence code 21 with the date the utilization review (UR) notice was received.
Medicare Advantage (MA) Plan Information Only Billing	The beneficiary is enrolled in an MA Plan.	Submit information-only claims to Medicare so the CWF can track the benefit period. Report: • Appropriate HIPPS code based on assessment or HIPPS AAA00 if no assessment was done; • Room and board charges; and • Condition code 04.
Disenroll from MA Plan	• The beneficiary disenrolls from an MA Plan (voluntarily or otherwise) and returns to Original Medicare coverage; • The beneficiary meets the level of care criteria through the effective date of disenrollment, Medicare waives the requirement for a qualifying hospital stay; and • The beneficiary is eligible for the number of days that remain out of the 100-day benefit period for that stay, minus the days that would have been covered by Original Medicare while the beneficiary was enrolled in the MA Plan.	Report condition code 58.

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Resources

For more information for SNFs, visit https://www.cms.gov/Center/Provider-Type/Skilled-Nursing-Facility-Center.html on the CMS website. Table 8 provides additional resources about SNF services.

Table 8. Resources

Resource	Website
MDS 3.0	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30.html
"Medicare Benefit Policy Manual"	Chapter 8 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf
"Medicare Claims Processing Manual"	Chapter 6 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf Chapter 7 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c07.pdf
MLN Guided Pathways (GPs)	"Provider Specific Medicare Resources" https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf
MLN Matters® Article MM8458, "Manual Updates to Clarify Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT) Coverage Pursuant to *Jimmo vs. Sebelius*"	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8458.pdf
Skilled Nursing Facility section of "Medicare Billing Information for Rural Providers and Suppliers"	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243515.html
SNF CB	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/ConsolidatedBilling.html

Table 8. Resources (cont.)

Resource	Website
SNF PPS	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243671.html
Swing Bed Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243409.html

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