

CMS Manual System
Department of Health & Human Services (DHHS)

Pub 100-04 Medicare Claims Processing
Centers for Medicare & Medicaid Services (CMS)

Transmittal 1290
Date: July 13, 2007

Change Request 5653

SUBJECT: Clarification of Skilled Nursing Facility (SNF) Billing Requirements
for Beneficiaries Enrolled in Medicare Advantage (MA) Plans

I. SUMMARY OF CHANGES: This instruction clarifies SNF provider billing
requirements for beneficiaries enrolled in MA plans.

NEW / REVISED MATERIAL
EFFECTIVE DATE: *January 1, 2008
IMPLEMENTATION DATE: January 7, 2008

Disclaimer for manual changes only: The revision date and transmittal number
apply only to red italicized material. Any other material was previously
published and remains unchanged. However, if this revision contains a table of
contents, you will receive the new/revised information only, and not the entire
table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D
Chapter / Section / Subsection / Title

N
6/90.2/Medicare Billing Requirements for Beneficiaries Enrolled in MA Plans

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be
carried out within their FY 2008 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

*Unless otherwise specified, the effective date is the date of service.

Medicare Claims Processing Manual
Chapter 6 - SNF Inpatient Part A Billing

Table of Contents
(Rev. 1290, 07-13-07)

90.2 - Medicare Billing Requirements for Beneficiaries Enrolled in MA Plans

90.2 - Medicare Billing Requirements for Beneficiaries Enrolled in MA Plans
(Rev.1290, Issued: 07-13-07, Effective: 01-01-08, Implementation: 01-07-08)

If a beneficiary chooses an MA plan as his or her form of Medicare, he/she cannot look to traditional "fee for service" Medicare to pay the claim if the MA plan denies coverage.

SNF providers shall apply the following policies to MA beneficiaries who are admitted to a SNF:

- If the SNF is non-participating with the plan, the beneficiary must be notified of his or her status because he or she is a private pay patient in this circumstance;
- If the SNF is participating with the plan, pre-approve the SNF stay with the plan;
- If the plan denies coverage, appeal to the plan, not to the "fee for service" FI;
- Count the number of days paid by the plan as Part A days used (this IS the beneficiary's 100 days of Medicare SNF benefits);
- Submit a claim to the "fee for service" intermediary to subtract benefit days from the CWF records. (Note: The plans do not send claims to CWF for SNF stays). Failure to send a claim to the FI will inaccurately show days available.

Billing Requirements

- Submit covered claims and include a HIPPS code (use default code AAA00 if no assessment was done), room and board charges and condition code 04.

Note: If the beneficiary drops his or her MA plan participation during their SNF stay, the beneficiary is entitled to coverage under Medicare FFS for the number of days available that remain out of the 100 days available under the SNF benefit.

Attachment - Business Requirements

Pub. 100-04
Transmittal: 1290

Date: July 13, 2007
Change Request: 5653

SUBJECT: Clarification of Skilled Nursing Facility (SNF) Billing Requirements for Beneficiaries Enrolled in Medicare Advantage (MA) Plans

Effective Date: January 1, 2008

Implementation Date: January 7, 2008

I. GENERAL INFORMATION

A. Background: This instruction manualizes SNF billing requirements for beneficiaries that are enrolled in MA plans. Previous billing instructions were provided in the Prospective Payment System and Consolidated Billing Update for SNFs manual originally created in 2001. For the purpose of posting MA claims to the benefit period without payment a prior three day qualifying hospital stay is not a requirement. SNF and Swing Bed (SB) providers must submit covered claims with the condition code 04 (information only bill) for beneficiaries enrolled in MA plans and receiving skilled care in order to take benefit days from the beneficiary and/or update the beneficiary's spell of illness in the Common Working File (CWF).

In addition, system changes are being made to allow the Fiscal Intermediary Standard System (FISS) hospital qualifying stay edits to be overridden by contractors. This change is necessary in case of a disaster or emergency-related situation, or some other circumstance indicated by CMS, which requires special processing instructions.

B. Policy: There are no policy changes with this transmittal.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number
Requirement
Responsibility (place an "X" in each applicable column)

A/B

MAC
DME

MAC
FI
CARRIER
DMERC
RHHI
Shared-System Maintainers
OTHER

FISS

MCS
VMS
CWF

5653.1

Medicare systems shall bypass SNF prior hospital qualifying stay edits when condition code 04 is present on an 18x or 21x bill type regardless of the claim's dates of service.

X

5653.2

Medicare systems shall ensure no reimbursement is made on 18x or 21x bill types when a condition code 04 is present.

X

5653.3

Medicare systems shall disable SNF prior qualifying stay edits which are duplicative of current FISS edits.

X

5653.4

Medicare systems shall ensure benefits days are deducted and/or the beneficiary's spell of illness is updated upon receipt of a covered 21x or 18x bill type when a condition code 04 is present.

X

5653.5

Medicare systems shall modify SNF prior hospital qualifying stay edits to allow contractors to manually override these edits regardless of the claim's dates of service.

X

III. PROVIDER EDUCATION TABLE

Number
Requirement
Responsibility (place an "X" in each applicable column)

A/B

MAC
DME

MAC
FI
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DMERC
RHHI
Shared-System Maintainers
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5653.6

A provider education article related to this instruction will be available at <http://www.cms.hhs.gov/MLNMattersArticles/> shortly. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

X

X

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref

Requirement

Number

Recommendations or other supporting information:

N/A

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Jason Kerr, Jason.Kerr@cms.hhs.gov or Wendy Tucker, Wendy.Tucker@cms.hhs.gov

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

A. For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC):

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2008 operating budgets.

B. For Medicare Administrative Contractors (MAC):

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

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