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Additional Clarification of Bill Types 22x and 23x Submitted by Skilled Nursing Facilities with Instruction for Involuntarily Moving a Beneficiary Out of the SNF and Ending a Benefit Period

Note: This article was updated on April 5, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Skilled Nursing Facilities (SNFs)

Provider Action Needed

SNFs should note that this article provides clarification of the difference between bill types 22x, for SNF residents, and 23x, for non-residents. It also provides instruction on when you can and cannot move a beneficiary involuntarily.

Note that this clarification replaces CR2674.

Background

Using the Correct Bill Type

Section 313 of the Benefits Improvement and Protection Act of 2000, P.L 106-554 revised the "resident" definition to include only individuals who are actually placed in the Medicare-certified part of the SNF. For those residents, bill type 22x should be used. Individuals who are placed in the Medicare non-certified area of the institution will no longer be considered "residents," and bill type 23x should be used for those non-residents.

When a SNF limits its Medicare participation to a distinct part unit (DPU) and moves a beneficiary who no longer meets Medicare skilled level of care (required

for a cover Part A stay) from the Medicare-certified DPU to a non-certified part of the institution, the beneficiary has technically ceased to reside in the Medicare-certified SNF and, thus, is appropriately billed as a non-resident of the SNF using bill type 23x.

Incorrectly using bill type 22x could inappropriately trigger SNF consolidated billing edits for therapy services that the beneficiary receives in an outpatient setting. However, in the case in which the entire facility qualifies as a Medicare-certified SNF, all Part B therapies must continue to be billed by the SNF on a 22x bill type.

Involuntarily Moving a Resident Out of a Medicare-Certified SNF or DPU

The requirements for participation specify the limited circumstances under which a resident can be involuntarily moved out of a Medicare-certified SNF or DPU. These circumstances can include the resident's health improving to the point that he/she no longer requires SNF care. However, if a resident has exhausted his/her Part A benefits but continues to require SNF care, he/she cannot be moved out of the Medicare-certified SNF or DPU for reasons other than those stated in the regulations. (For example, the resident cannot be moved to avoid consolidated billing requirements, or to establish a new benefit period.)

The determination to move a beneficiary out of the Medicare-certified SNF or DPU must not be made on the basis that the beneficiary has exhausted his/her benefits, but rather on the beneficiary's lack of need for further SNF care. If a resident of a Medicare-certified DPU ceases to require SNF care, he/she may be moved from the DPU to the Medicare non-certified area of the institution. Keep in mind that such a move would end the beneficiary's status as a SNF resident for consolidated billing purposes.

Ending a Benefit Period

A benefit period ends 60 days after the beneficiary ceased to be an inpatient of a hospital and has not received inpatient skilled care in a SNF during the same 60-day period.

If the SNF resident's health has improved to the point that he/she no longer needs or receives the level of skilled care required for Part A coverage, the SNF must bill one of the two following scenarios:

1.) For residents who leave the Medicare-certified SNF or DPU:

- Submit a final discharge bill.
- Submit on a 23x any services rendered after the discharge and billed by the SNF.

2.) For residents who remain in the Medicare-certified SNF or DPU after the skilled level of care ends:

- Submit the last skilled care claim with an occurrence code 22 to indicate the date active care has ended.
- Submit on a 22x any services rendered and billed by the SNF after the skilled care ended.
- All therapies must be billed by the SNF on the 22x.

For additional instructions on ending a benefit period, go to the Medicare General Information, Eligibility and Entitlement manual, chapter 3, section 10.4.3.2.

The lack of a beneficiary's need for skilled care in a SNF triggers the start of the 60-day count toward ending a benefit period. However, it is physical location of the beneficiary within the certified part of the facility that confers resident status for the purposes of the SNF Part B consolidated billing rule for therapies. It is possible for a beneficiary to no longer need or receive skilled care resulting in ending a benefit period, but still be a resident of the SNF or Medicare-certified DPU requiring the SNF to bill for all therapies rendered to the resident.

Additional Information

CR3323 replaces CR2674, which was issued as Transmittal A-03-040 on May 9, 2003. To view the full instruction and the revised Medicare manual changes that are attached to the instruction, visit http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R229CP.pdf on the CMS website.

If you have questions, please contact your intermediary 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.