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Skilled Nursing Facility Billing Basics

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Objective

This session will focus on the basics of SNF inpatient billing, including the required fields on SNF claims, timeframes for claim submission and how proper billing impacts payment.

Today's Presenters

- Provider Outreach and Education Consultants
  - Kathy Mersch
  - Andrea Freibauer

Agenda

- Claim Submission Guidelines
- Preparing IP Claims
- Preparing OP Claims
- Resources and References
- Questions?

Claim Submission Guidelines

Part A and Part B Entitlement

- Beneficiaries must have
  - Medicare Part A to cover inpatient claims
  - Medicare Part B to cover outpatient claims
- Registration/admission staff should verify entitlement prior to claim submission
  - Verify information on Medicare card via
    - FISS DDE
      - *FISS DDE Provider Online Guide*
    - NGSConnex
      - *NGSConnex User Guide*

Two Sets of Requirements - SNF IP Coverage

- **Technical** (must meet all)
  - Medicare-certified SNF
  - Beneficiary enrolled Medicare Part A
  - SNF days available in benefit period
  - Three-day QHS
  - 30-day transfer from QHS
- **Medical** (must meet either)
  - Daily skilled care for condition treated or arose during QHS, or
  - Rehabilitation services ordered by physician

Medical Coverage Criteria Not Met

- Issue appropriate notice to beneficiary/authorized representative to transfer liability to beneficiary
  - Care does not meet “reasonable and medically necessary” criteria
  - Considered custodial care
- Make sure to use correct and current form for beneficiary notice
  - SNF Part A items and services – SNF ABN CMS-10055
    - Revised form mandatory as of 10/31/2024
  - Swing-bed determinations – Preadmission/Admission HINN (HINN 1)
  - Part B items and services – ABN Form CMS-R-131
- Must be completed accurately and issued prior to delivery of service
  - If not, may be deemed provider-liable

Optional Beneficiary Notices

- Beneficiary notice not required to be issued when
  - Service not a Medicare benefit (such as personal comfort items)
  - Beneficiary did not meet technical requirement
    - No three-day stay or 30-day transfer
  - Beneficiary exhausted benefits
    - Used 100 SNF days in current benefit period
  - Beneficiary enrolled in Medicare HMO/MAO plan
- Allowed to issue proper form as “informational” notice
  - No appeal rights

Covered SNF Services

- Semi-private room and board
  - Private when medically necessary
- PT, OT and/or SLP services furnished by SNF or under arrangement
- Medical social services
- Nursing care provided by, or under supervision of, registered professional nurse
- Medically necessary medical services and other diagnostic or therapeutic services furnished by SNF or under arrangement
- Certain drugs, biologicals, supplies, appliances and equipment

Benefit Period

- Tracks benefit days used during inpatient stay(s)
- Limited number of days per benefit period
- Defined start and end circumstances
  - Begins when admitted to qualified hospital or SNF as inpatient after Medicare entitlement date
  - Ends 60 consecutive days from date of discharge from qualified hospital or SNF when patient either
    - Facility free
    - No skilled care for 60 days in a row

SNF Benefit Period

- 100 SNF inpatient days (renewable)
  - Days 1–20: Full days
    - Medicare pays for medically necessary services covered under SNF benefit
    - Patient or SNF responsible for non-covered services
  - Days 21–100: Coinsurance days
    - Beneficiary (or supplemental insurance) pays $209.50/day (CY 2025)
    - Medicare pays remainder (up to SNF PPS payment due)
  - Day 101 and beyond: Benefits exhausted
    - Beneficiary (or supplemental insurance) responsible for payment
    - No Medicare payment made

SNF Benefit Days

- Benefits exhausted (100 days used)
  - No Medicare payment made under Part A after day 100
  - Some services covered under Part B
  - Benefits can be renewed
    - Facility-free for 60 consecutive days
    - Nonskilled level of care for 60 consecutive days

SNF CB

- SNF has billing responsibility for entire package of care that beneficiaries receive while in covered Part A SNF stay
  - During non-covered Part A stay, only PT, OT and SLP services included under SNF CB
- Limited number of services specifically excluded from CB and separately payable
  - SNF CB reference files (HCPCS/CPT codes)
  - Neither SNF or other providers/practitioners may bill Medicare for services under Part B unless specifically excluded

SNF CB Exceptions

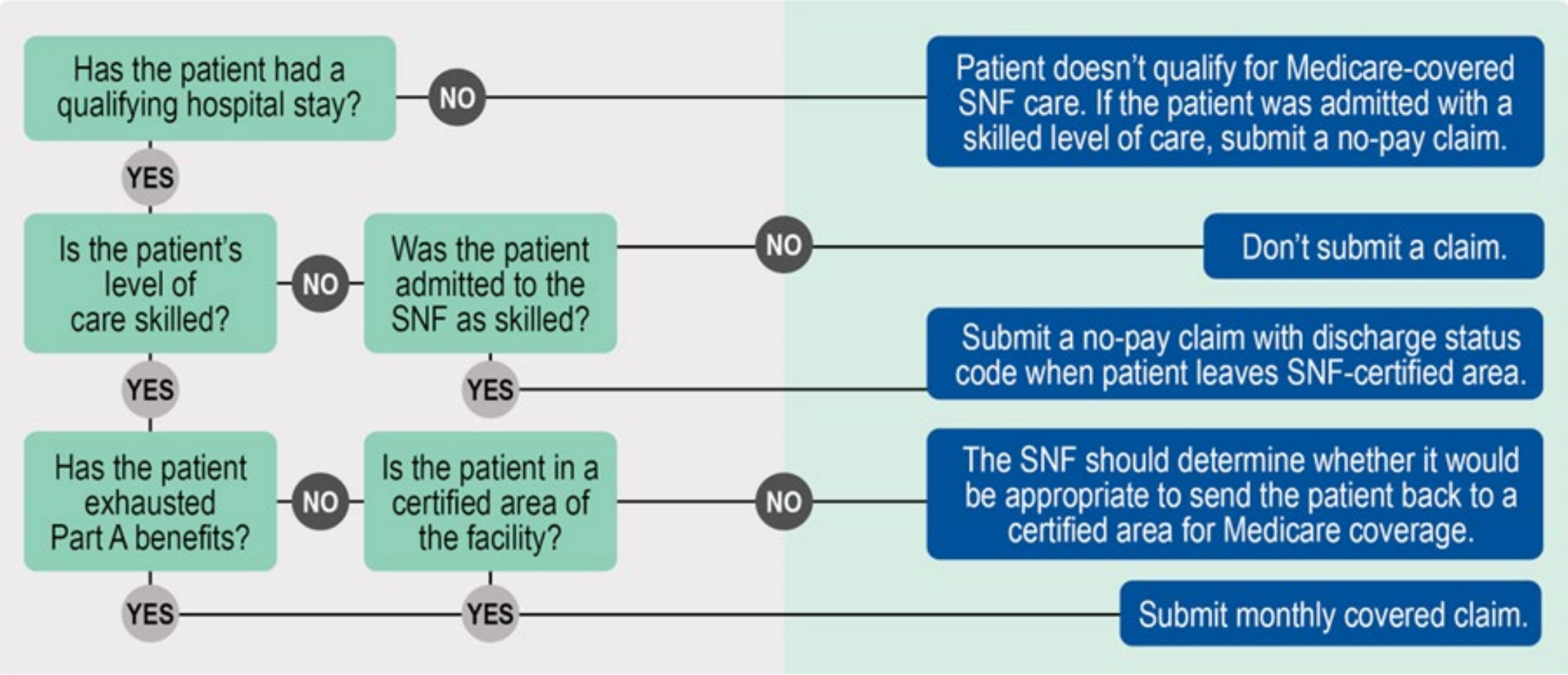
- Medicare beneficiaries in covered Part A stay
  - Physician's professional services
  - Certain dialysis-related services
  - Certain ambulance services
  - Erythropoietin for certain dialysis patients
  - Certain chemotherapy drugs and chemotherapy administration services
  - Radioisotope services
  - Customized prosthetic devices
- Medicare beneficiaries in noncovered stay
  - All non-therapy covered SNF services

Preparing IP Claims

How Are Medicare Claims Submitted?

- FISS DDE
  - Direct entry and online submission through mainframe
- Software program through approved third-party vendor or clearinghouse
  - Batch or individual claims
- Paper form CMS Form CMS-1450 (UB-04)
  - Must have approved ASCA waiver
    - Administrative Simplification Compliance Act Self Assessment

IP SNF Claim Decision Tree



SNF Covered Part A Claims

- All Medicare covered Part A services considered within scope or capability of SNF considered paid under PDPM
  - Part A payment based primarily on beneficiary's case-mix classification group
  - HIPPS rate code(s) appearing on claim must match assessment submitted and accepted by CMS' national database (iQIES system)
- Submit all covered services rendered to patient and considered included in SNF PPS on SNF claim
  - Even if services are rendered by outside provider of service (CB)
  - No separate payment made

Frequency of Claim Submission

- Inpatient claims
  - Monthly (DOS)
  - Upon discharge
  - When benefits exhaust (100 days in benefit period)
  - Drops to nonskilled level of care
- Outpatient claims
  - Monthly (or at conclusion of treatment) for services received
  - Upon completion of “one-time” service(s)

Submit Inpatient Bills in Sequence

- All inpatient SNF claims must be submitted one month at a time, in sequential order
  - Subsequent claims in stay should not be submitted until prior month's claim processed and finalized (appears on remittance advice)
- Avoid RTP reason code 38119
  - Before submitting next claim in sequence, verify status of prior month's claim
    - FISS Inquiry Claim Summary – FISS DDE Provider Online Guide
    - IVR
    - *NGSConnex User Guide*

Timely Filing Guidelines

- Effective for all Medicare Part A and Part B claims
  - Also applies to adjustment claims
- All claims must be submitted to Medicare within one year (365 days) from DOS
  - “From” date for single DOS claims
  - “Through” date for institutional claims with date span
- Note! Claims in RTP location not considered “submitted” to Medicare

General Guidelines

- Need to follow all general claim preparation requirements
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 25 – Completing and Processing the Form CMS-1450 Data Set
  - CMS MLN® Educational Tool: *Skilled Nursing Facility Billing Reference* (MLN006846)

TOB (FL 04)

- Based on facility type
  - 21X for SNF inpatient services
  - 18X for hospital swing bed services
- Third digit
  - XX1 – Admit to discharge
  - XX2 – First claim in a series of claims
  - XX3 – Continuation of series of claims, covered or discharged but still resides in facility
  - XX4 – Discharge
  - XX0 – No-pay claims

Patient Status (FL 17)

Code	Description
01	Discharged to home
02	Discharged/transferred to short term general hospital for IP care
03	Discharge/transferred to Medicare-certified SNF
41	Deceased in SNF
30	Still patient

Dates and Days on Claim

- Statement Covers Period (FL 06), also known as DOS
  - From date
    - Admission date or day after through date on prior claim (continuing stay)
  - Through date
    - Last day of the billing period
- Admission Date (FL 12)
  - Required on inpatient claims
  - Date must be consistent on series of claims

Counting Days

- Midnight-to-Midnight Rule
  - Method used to calculate days of care for Medicare reporting purposes
  - Does not count as discharge when beneficiary discharged but returns before the following midnight
- How to count
  - Day of admission counts as full day
  - Day of discharge, death, or day beneficiary begins leave of absence not counted as days
  - Day of admission and discharge (or death) occurring on same day counted as one inpatient day

Common CCs (FL 18–28)

Code	Description
55	SNF bed not available (admission delayed more than 30 days after hospital discharge because SNF bed not available)
56	Medical appropriateness (admission delayed more than 30 days after hospital discharge as beneficiary's condition made it inappropriate to begin active care within that period)
57	SNF readmission when beneficiary previously received Medicare covered SNF care within 30 days of current SNF admission
58	Beneficiary terminated MAO plan enrollment (waive three-day qualifying stay requirement)

OC (FL 31–34) and OSCs (FL 35–36)

- OC 50 and date
  - ARD for each assessment period represented on claim with revenue code 0022
  - Not needed when billing default Health Insurance Prospective Payment System (HIPPS) code (ZZZZZ)
- OSC 70 with from and through dates
  - Dates of QHS

Payment Line(s)

Claim Field	Description
HCPCS/Rate/HIPPS Code (FL 44)	HIPPS Rate Code, must be in same order beneficiary received that level of care
Revenue Code (FL 42)	0022 for each HIPPS rate code and assessment period
Units of Service (FL 46)	Number of covered days under corresponding HIPPS rate
Total Charges (FL 47)	Zero ($0), not blank

Understanding HIPPS Codes

- SNFs paid for covered Part A stays under PDPM, which requires beneficiary assessments to be performed at specific intervals
  - 5-day Assessment
  - Interim Payment Assessment (IPA)
  - PPS Discharge Assessment
- HIPPS rate code appearing on claim must match assessment submitted and accepted by iQIES system
  - When assessment not done or performed late, must bill default code (ZZZZZ)

Other Charge Lines on Claim

- Room and board revenue code with days and charges
  - Example: 0120 semi-private two beds
- Ancillary services provided during claim DOS billed using appropriate revenue code and CPT/HCPCS codes
  - Note – Certain HIPPS rate codes need more rehabilitation therapy ancillary revenue codes
- Total charges (0001) line must add up all lines correctly

Preparing OP Claims

SNF Outpatient Billing

- Situations in which SNF may submit claim for Part B services
  - Certain medical and other health services provided to beneficiaries when Part A BE or not otherwise entitled to have claims paid under Part A benefit
  - OP services (not SNF inpatients)
  - Preventive services (not included on IP claim during covered Part A stay)
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 7, Section 10 for full list of covered services
  - Diagnostic X-ray and laboratory tests
  - Outpatient PT, SLP, OT
  - Preventive services
  - Certain drugs (immunosuppressive, oral anti-cancer)

Swing Bed Providers

- Cannot bill Part B IP
  - Ancillary services billed under hospital as IP Part B services (TOB 12X)
  - Beneficiary eligible for same benefits available to hospital IP in Part B stay
- Hospital provider of SNF level swing bed services must also file Part A nonpayment bill monthly using appropriate nonpayment code (TOB 180)

SNF Outpatient Billing

- Most services paid under MPFS or CLFS
- Repetitive services billed on single individual monthly bill or through end of treatment

Claim Field	Description
TOB	22X (entire facility qualifies as Medicare-certified) 23X (OP and beneficiaries in non-Medicare certified bed)

Screening and Preventive Services

- Submit separate Part B inpatient bill during covered IP stay

Claim Field	Description
TOB	22X (Beneficiary in covered Part A stay) 23X (OP and beneficiaries in non-Medicare certified bed) 12X (Swing bed providers where beneficiary in covered Part A stay)

Resources and References

CMS IOMs

- Publication 100-01, *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 1
- Publication 100-04, *Medicare Claims Processing Manual*
  - Chapter 6, Inpatient Part A Billing and SNF Consolidated Billing
  - Chapter 7, SNF Part B Billing (Including Inpatient Part B and Outpatient Fee Schedule)
  - Chapter 25, Completing and Processing the Form CMS-1450 Data Set
  - Chapter 30, Financial Liability Protections, Section 70 (SNF ABN)

References and Resources

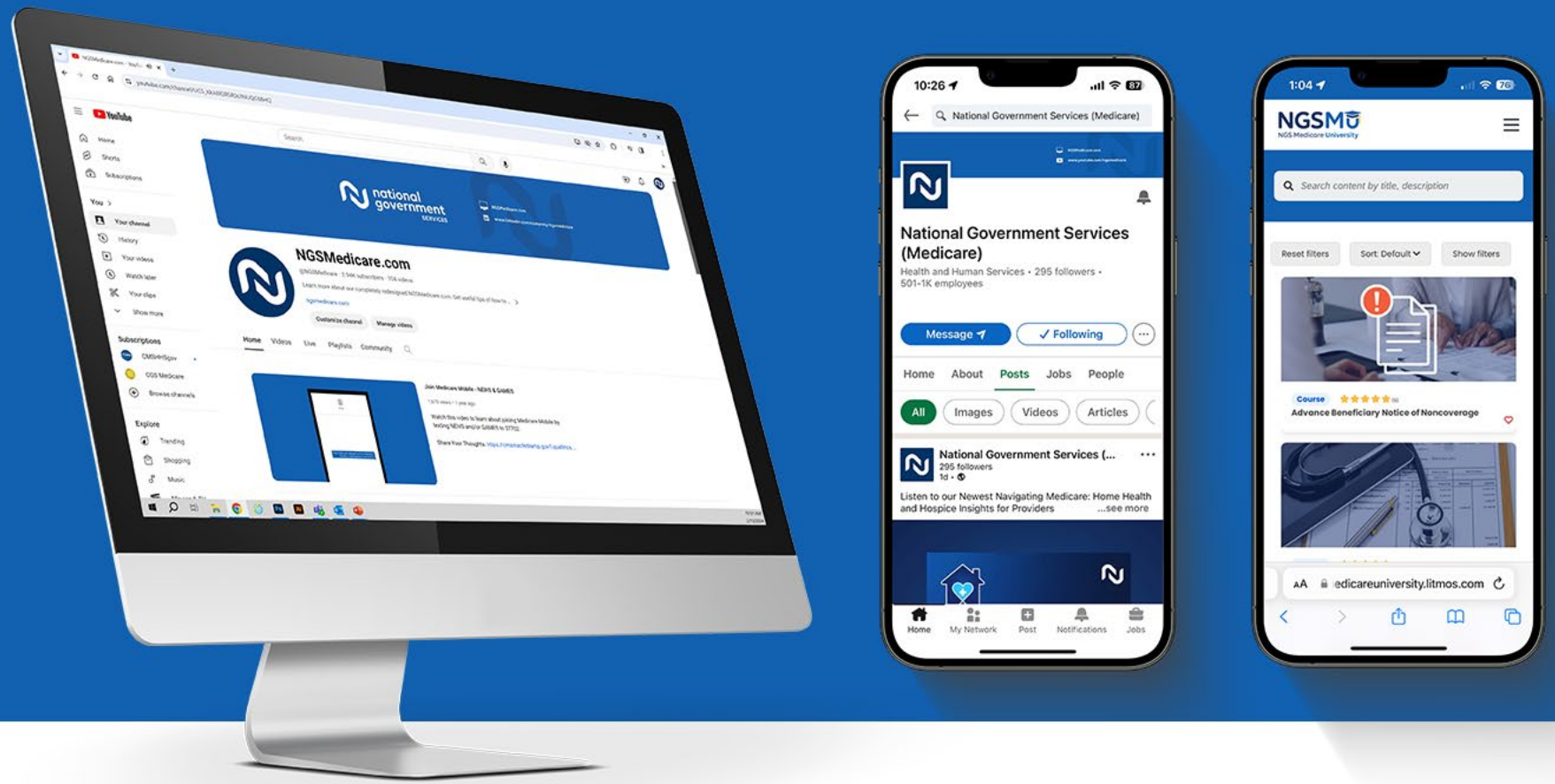
- CMS
  - Skilled Nursing Facility Center
  - CMS MLN® Educational Tool: *Skilled Nursing Facility Billing Reference* (MLN006846)
  - SNF Consolidated Billing
  - Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) Form CMS-10055
  - Web Pricer Skilled Nursing Facility PPS
  - Skilled Nursing Facilities/Long-Term Care Open Door Forum
- Other
  - National Uniform Billing Committee

NGS References and Resources

- Fundamentals of Medicare Manual, Section 2: Medicare Basics - Skilled Nursing Facility Inpatient Care
- *NGSConnex User Guide*
- EDI Enrollment
- *FISS DDE Provider Online Guide*
- Provider Contact Center
- Education resources
  - Specialty spotlight: Skilled Nursing Facility

Questions?

Thank you!



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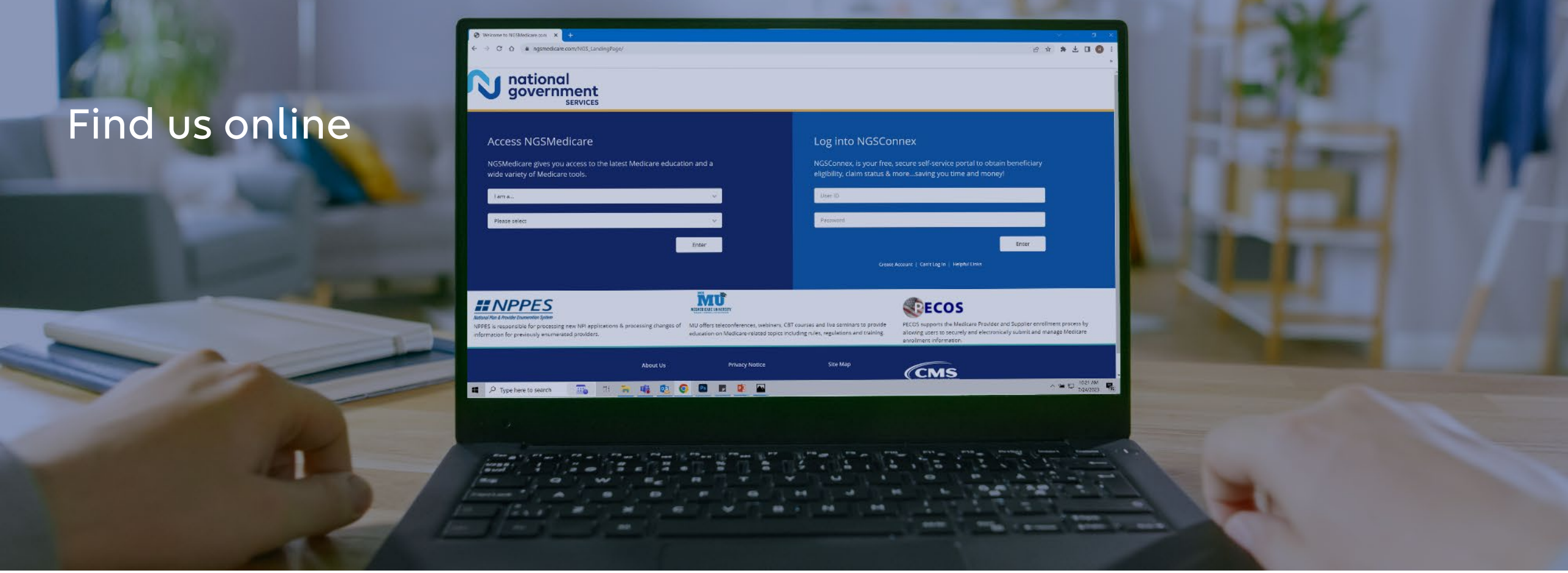

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