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Skilled Nursing Facility Billing Basics

11/5/2024

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Objective

Educate SNF staff on basic SNF billing requirements for Medicare.

Today's Presenters

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

Agenda

Claim Submission Guidelines

Preparing IP Claims

Special IP Billing Situations

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 qualifying hospital inpatient stay
  - 30-day transfer from qualifying hospital stay
- Medical (must meet either)
  - Daily skilled care for condition treated or arose during qualifying hospital stay, or
  - Rehabilitation services ordered by physician

Medical Coverage Criteria Not Met

- SNF ABN transfers liability to beneficiary for services rendered when SNF care
  - Does not meet “reasonable and medically necessary” coverage criteria
  - Considered custodial care
- SNF ABN not required to be issued
  - When service is not Medicare benefit (such as personal comfort items)
  - If patient did not meet technical requirement (no three-day stay or 30-day transfer)
  - When patient has exhausted benefits (used 100 SNF days in current benefit period)
  - For Medicare HMO/MAO plan enrollees

Medical Coverage Criteria Not Met

- Make sure to use correct and current form
  - 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
- When to submit claim to Medicare
  - When beneficiary chooses Option 1 on ABN/SNF ABN in order to obtain determination
  - If denial from Medicare needed for supplemental payer

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

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

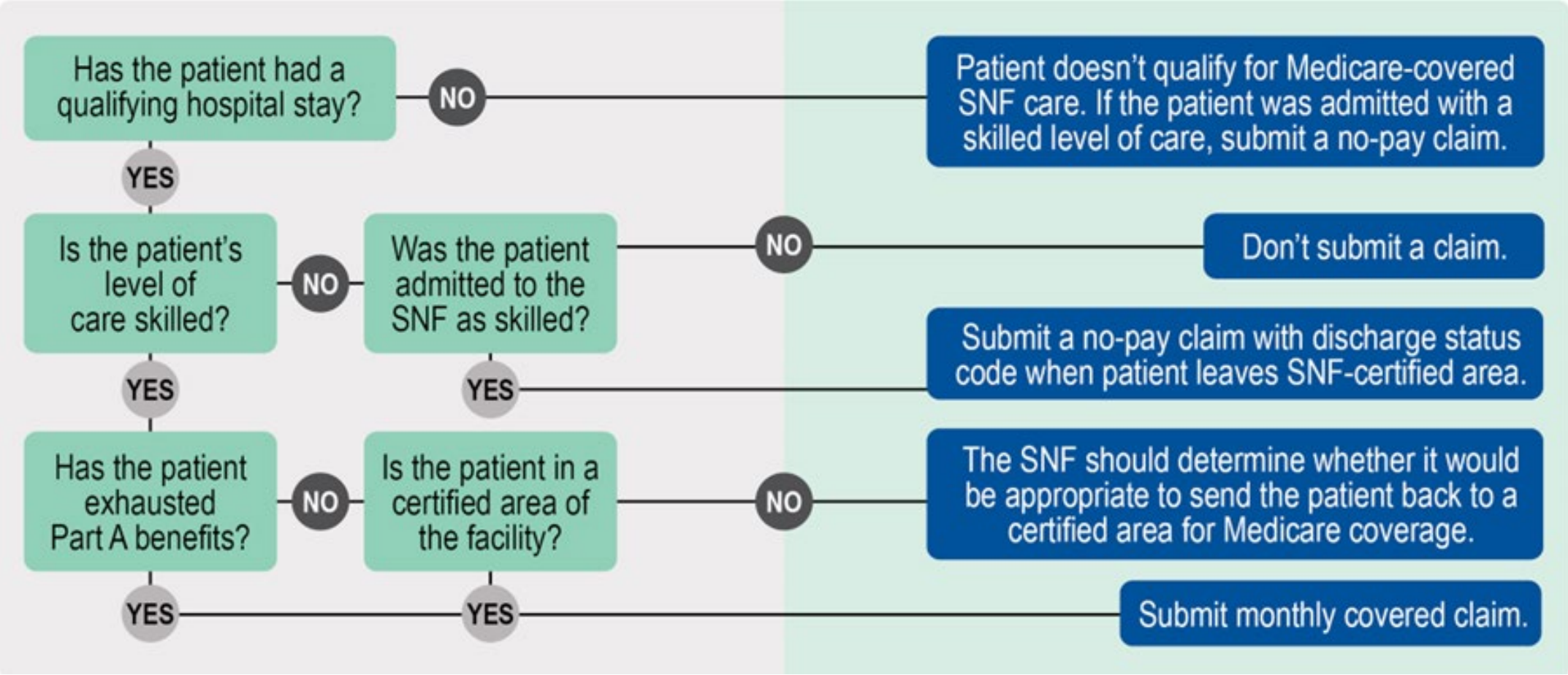
- Effective for all Medicare Part A & Part B claims
  - Also applies to adjustment claims
- All claims must be submitted to Medicare within one year (365 days) from DOS
  - “From” date for single DOS claims
  - “Through” date for institutional claims with date span
- Note! Claims in RTP location not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

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

Preparing IP Claims

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

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 consolidated billing (separately payable)
  - SNF Consolidated Billing 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 non-covered stay
  - All non-therapy covered SNF services

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
- 3rd 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

Important - 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
- Beneficiary entitled to 100 SNF days per benefit period
  - 20 full days
  - 80 coinsurance days
    - Beneficiary pays $204 per day (2024)

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 three-day qualifying hospital stay (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 Default code (used when assessment late) = ZZZZZ
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

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
- Total charges (0001) line must add up all lines correctly

Special IP Billing Situations

No Three-Day QHS

- Beneficiary at skilled LOC but does not have three-day QHS
  - Includes patients initially admitted as covered who dropped to non-skilled LOC for more than 30 days before becoming skilled again but no new QHS
- Bill as covered claim but do not report OSC 70

Readmission Within 30 Days – Discharge Claim Already Submitted

- Submit new claim for new admission

Claim Field	Description
Admission Date	Admission day for current stay
CC	57 (readmission)
OSC and dates	70 (QHS)

Readmission Within 30 Days – Before Discharge Claim Submitted

- Submit interim claim

Claim Field	Description
Admission Date	Admission day for current stay
CC	57 (readmission)
OSC and dates	70 (QHS) 74 (LOA) showing from and through dates between admissions

Beneficiary Enrolled in HMO/MAO Plan

- Submit information-only claims to Medicare for benefit period tracking purposes

Claim Field	Description
CC	04 (HMO/MAO Plan)
Days and Charges	Covered days and charges (include room and board charges)
Revenue Code	0022 with appropriate HIPPS code or ZZZZZ if no assessment performed

Beneficiary Disenrolls in HMO/MAO Plan

- When beneficiary returns to traditional Medicare FFS during IP stay and meets skilled LOC criteria
  - QHS stay requirement waived and beneficiary eligible to use any days remaining in current benefit period
- Note – If beneficiary disenrolls before admission, must meet all regular criteria for coverage

Claim Field	Description
CC	58 (Disenroll from HMO/MAO Plan)
Days and Charges	Covered days and charges

MSP

- Situations where another payer primary to Medicare
  - Beneficiary meets one or more MSP provisions such as working aged, disabled, worker's compensation, auto/liability
- Must submit claim to primary payer first
- Once primary payer makes determination, send claim to Medicare
  - On Medicare claim, complete with all required coding as well as MSP-specific coding
    - Prepare and Submit an MSP Claim
    - Prepare and Submit an MSP Conditional Claim

Same Day Transfer

- Beneficiary expected to stay overnight but transfers before midnight to different Medicare-participating facility

Claim Field	Description
TOB	Use 211 or 181
DOS	Same from and through dates
Admission Date	Same as DOS
Patient Status Code	As appropriate
CC	40 (same day transfer)
Days and Charges	Report zero covered days and charges

Benefits Exhaust (BE) Claims

- Beneficiary exhausts 100 days in current benefit period
- Billing depends on LOC area of facility beneficiary is in
  - Skilled LOC
    - Stays in Medicare-certified area (MCA) of facility
    - Moves to non-MCA of facility
  - Drops to a non-skilled level of care at some point after benefits exhaust
    - Stays in MCA of facility
    - Moves to non-MCA of facility or otherwise discharges

Full or Partial BE Claim - Remains in MCA

Claim Field	Description
TOB	Use covered TOB – not 210/180
Patient Status Code	As appropriate
OSC	70 (QHS dates)
VC	09 (First year coinsurance amount) - report 1.00 FISS will assign correct coinsurance amount
Days and Charges	Report all covered days and charges as if days available

Drop LOC After BE but Remains in MCA

Claim Field	Description
TOB	Use covered TOB – not 210/180
DOS	Bill through date SNF LOC ended, not end of month
Patient Status Code	30 (still patient) or appropriate discharge code
CC	22 (Date SNF LOC ended, match claim through date)
OSC	70 (QHS dates)
VC	09 (First year coinsurance amount) - report 1.00 FISS will assign correct coinsurance amount
Days and Charges	Report all covered days and charges as if days available up to date active care ended

BE - Moves to Non-MCA

Claim Field	Description
TOB	Use covered TOB – not 210/180
DOS	Bill through date moved to non-MCA
Patient Status Code	Appropriate discharge status code
OSC	70 (QHS dates)
Days and Charges	Report all covered days and charges as if days available
HIPPS Code	ZZZZZ (default code)

Drop to Non-Skilled LOC after BE and Moves to Non-MCA or Discharges

Claim Field	Description
TOB	Use covered TOB 211, 214, 181 or 184 – not 210/180
DOS	Bill through date SNF LOC ended, not end of month
Patient Status Code	Appropriate discharge status code
OSC	70 (QHS dates)
Days and Charges	Report all covered days and charges as if days available

Previously Dropped to Non-Skilled LOC and Remains in MCA

- SNF needs Medicare denial notice for other insurers

Claim Field	Description
TOB	Use 210 or 180
DOS	Submitted as often as monthly, billing starts day following date active care ended
Patient Status Code	As appropriate
CC	21 (billing for denial)
Days and Charges	Report all non-covered days and charges beginning with day after active care ended

Discharge After Non-Skilled LOC and Remained in MCA

- Final discharge claim must be submitted
  - Can span multiple months and provider/Medicare FYE date(s)
  - Must meet timely filing requirement

Claim Field	Description
TOB	Use 210 or 180
DOS	Billing starts day following date active care ended
Patient Status Code	As appropriate
CC	21 (billing for denial)
Days and Charges	Report all non-covered days and charges beginning with day after active care ended

SNF Benefit Period Quick Reference – Beneficiary at Skilled LOC

BE?	MCA?	Non-Medicare Area but Facility Meets SNF Definition	Is Benefit Period Continued?	Billing Action
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	Yes	Return beneficiary to certified area for Medicare coverage, submit monthly covered claim
No	No	No	No	Determine if appropriate to return beneficiary to certified area for Medicare coverage

SNF Benefit Period Quick Reference – Beneficiary Not at Skilled LOC

BE?	MCA?	Non-Medicare Area but Facility Meets SNF Definition	Is Benefit Period Continued?	Billing Action
Yes	No	No	No	Do not submit claim if non-skilled LOC at admission If skilled LOC at admission, submit no-pay claim with discharge status code when patient leaves certified area
No	Yes	Yes	No	
Yes	No	Yes	No	
No	No	No	No	
No	Yes	No	No	

Demand Billing

- Beneficiary disagrees that skilled care no longer necessary and requests determination from Medicare

Claim Field	Description
CC	20 (demand bill)
OC and date	22 (date active SNF care ended) -or- 21 (date facility received utilization review notice)

Beneficiary or Provider Liable Periods

- Submit claim as covered when beneficiary at skilled LOC
- Claims can have both beneficiary and provider liable periods, when applicable

Claim Field	Description
OSC and dates	76 (provider liable) 77 (beneficiary liable)

Leave of Absence (LOA)

- Beneficiary leaves facility but not admitted as IP to any other facility (does not meet midnight census)
  - If exceeds 30 days, must meet QHS and 30-day transfer requirements
- Cannot bill beneficiary for LOA days
  - Beneficiary can choose to make bed-hold payments to facility

Claim Field	Description
OSC and dates	74 (LOA) with from and through dates
Days and Charges	LOA days noncovered and zero charges
Revenue Code	018X with number of LOA days as units

Interrupted Stay

- "Interruption window"
  - Beneficiary discharged from Part A-covered stay but resumes SNF care in same SNF for Part A-covered stay within three day period

Claim Field	Description
OSC and dates	74 with from and through dates, report for each interruption of more than one day • From date = date of discharge • Through date = last day beneficiary not in SNF by midnight
Revenue Code	018X with total number of interrupted stay days as units and no charges

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
  - Outpatient 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 Internet-Only Manuals (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

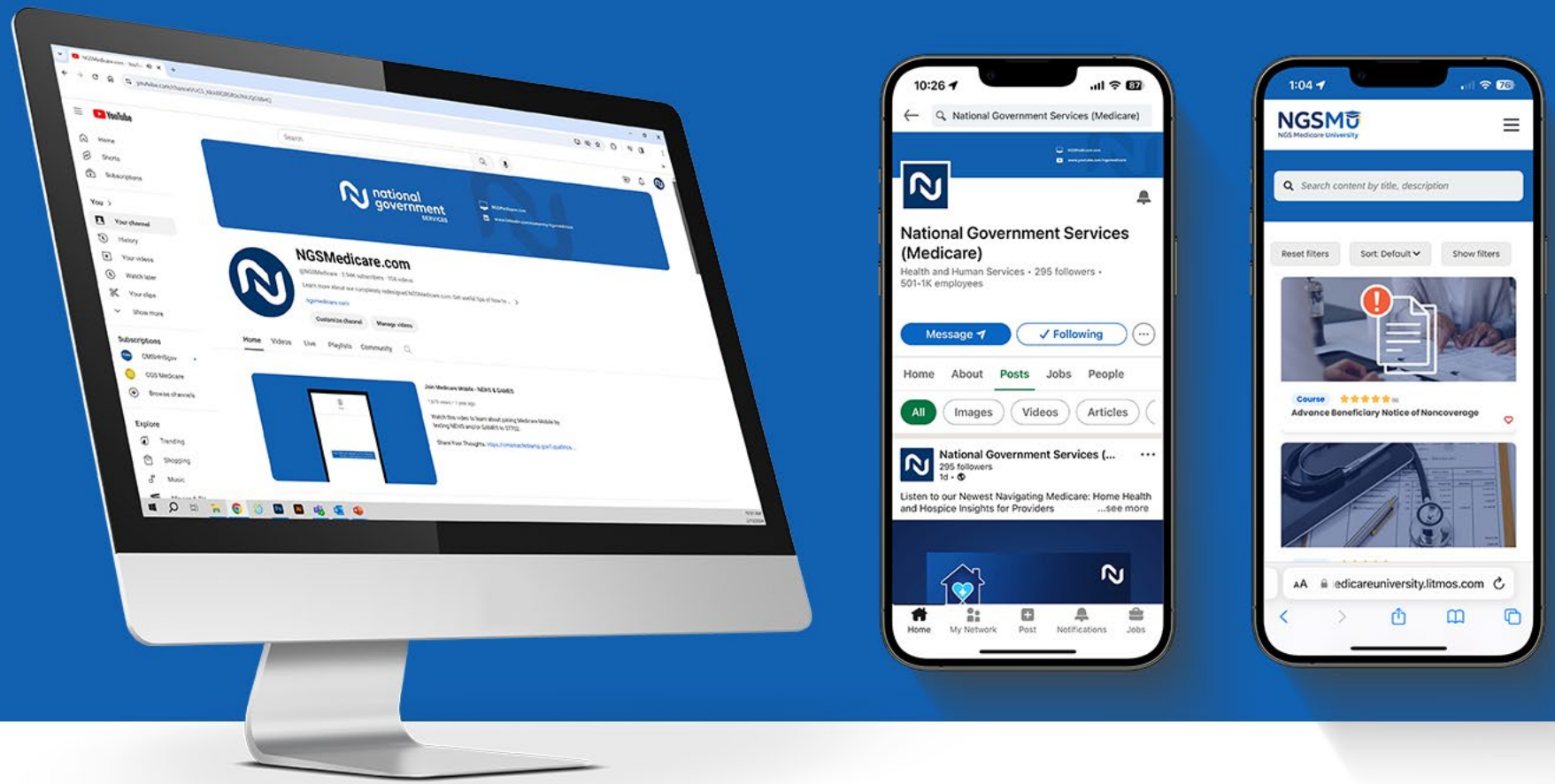
- CMS
  - Skilled Nursing Facility Center
  - CMS MLN® Educational Tool: *Skilled Nursing Facility Billing Reference (MLN006846)*
  - SNF Consolidated Billing
  - Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) Form CMS-10055
  - Web Pricer Skilled Nursing Facility PPS
  - Skilled Nursing 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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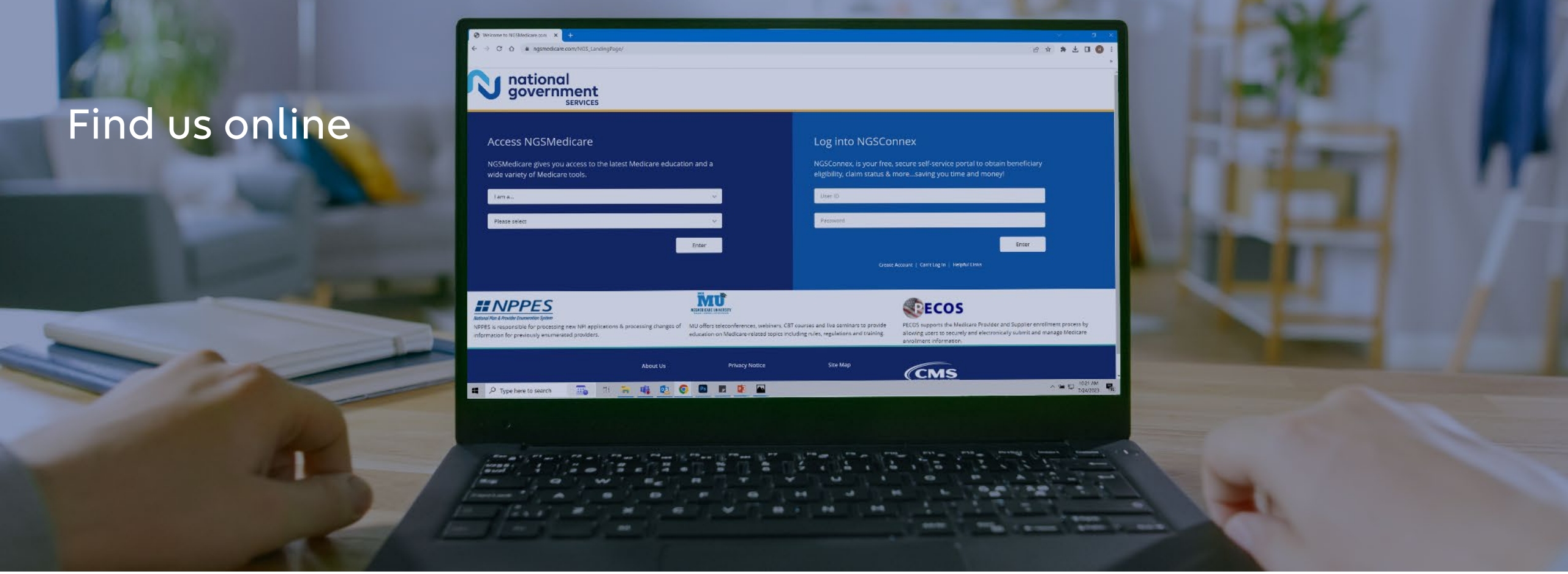

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