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Navigating Skilled Nursing Facility Inpatient Billing Situations

4/2/2025

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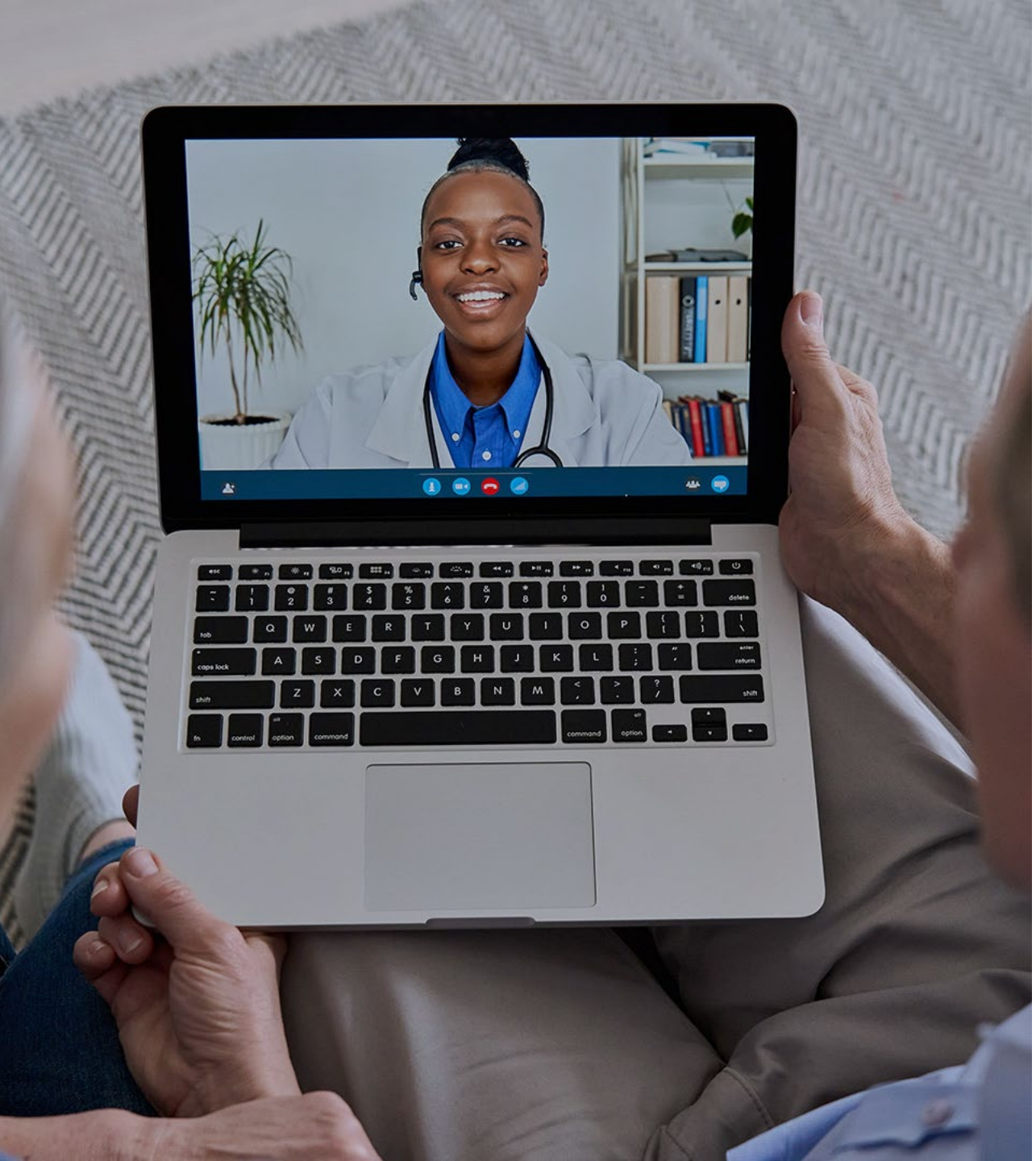

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Objective

Educate SNF staff on how to properly submit Medicare claims for the various situations that occur with SNF inpatients

Today's Presenters

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

Agenda

Claim Submission Guidelines

Non-Covered Stuations

MA Plans (MAO/HMO)

MSP

Situations During Covered Stay

Benefits Exhausted

Resources and References

Q&A

Claim Submission Guidelines

Part A and Part B Entitlement

- Beneficiaries must have
  - Medicare Part A to cover IP claims
  - Medicare Part B to cover OP 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 IP 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

General Guidelines

- Must 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)

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

Non-Covered Situations

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 not a Medicare benefit (such as personal comfort items)
  - If patient did not meet technical requirement (no three-day stay or 30-day transfer)
  - When patient exhausted benefits (used 100 SNF days in current benefit period)
  - For Medicare HMO/MAO plan enrollees

Medical Coverage Criteria Not Met

- Important! 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 to obtain determination
  - If denial from Medicare needed for supplemental payer

Demand Billing

- Beneficiary requests determination from Medicare because they disagree that skilled care not needed or no longer necessary
  - ADR may be issued to provider requesting medical records
- Charges
  - All non-covered services on demand bill must be in dispute
  - At least one non-covered line must appear on claim related to services in dispute
  - Unrelated covered charges allowed on same claim

Demand Billing (2)

Claim Field	Description
TOB	Covered TOB (21X, 18X) unless all services on claim noncovered then use 210/180
CC	20 (demand bill)
OC and Date	22 (date active SNF care ended) -- OR -- 21 (date facility received utilization review notice)
Days and Charges	Covered days and charges (include room and board)
Revenue Code	0022 with appropriate HIPPS code or ZZZZZ if no assessments performed

Request Denial Notice For Other Insurer

- Can be billed monthly
- May span both provider and Medicare FY end dates

Claim Field	Description
TOB	Noncovered TOB 210/180
CC	21 (billing for denial)
Days and Charges	Noncovered days and charges (include room and board)
Revenue Code	0022 with appropriate HIPPS code or ZZZZZ if no assessments performed

No QHS or 30-Day Transfer

- Beneficiary at skilled LOC but QHS or 30-day transfer requirement not met
  - 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

MA Plans (MAO/HMO)

Beneficiary Enrolled in MA Plan

- Provider submits claims to both MA plan (MAO/HMO) and traditional Medicare
  - Claim to MA plan for payment
    - Must follow rules of plan (pre-approval, participating provider, etc.)
    - If MA plan denies coverage, need to appeal with MA plan
      - Do not submit claim to Medicare for payment
  - Information-only claim to Medicare
    - Used for benefit period tracking purposes (days count towards 100 days)
    - When beneficiary no longer requires skilled care under MA plan, may discharge patient using patient status code 04
      - No-payment bills not required by Medicare for MA plan enrollees at non-skilled LOC
        - Submit new admission claim if beneficiary requires skilled care after period of non-skilled care

Information-Only Claim (MA Beneficiary)

- Submit monthly claims

Claim Field	Description
TOB	Covered TOB (21X/18x, not 210/180)
CC	04 (MA Plan)
Days and Charges	Covered days and charges (include room and board)
Revenue Code	0022 with appropriate HIPPS code or ZZZZZ if no assessments performed

Beneficiary Disenrolls From MA Plan

- When beneficiary returns to traditional Medicare during IP stay and meets skilled LOC criteria
  - QHS stay requirement waived
- Beneficiary eligible to use any days remaining in current benefit period
- Split claim if enrollment/disenrollment within billing month

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

Beneficiary Disenrolls Before Admission

- If beneficiary voluntarily disenrolls from MA plan (MAO/HMO) before admission
- Must meet all regular criteria for coverage, including QHS
  - QHS not waived if beneficiary readmitted within 30 days from stay covered by MA plan
- Submit claims in usual manner

MSP

MSP

- Situations where another payer primary to Medicare because beneficiary/insurance meets criteria of at least one MSP provision
- Submit claim to primary payer(s) first
  - Medicare can be secondary or tertiary payer
- After primary payer makes determination, submit IP claims to us
  - Submit MSP claims with all required coding as well as MSP-specific coding
  - May submit conditional claims if primary payer did not pay for valid reason or did not pay promptly (within 120 days; accidents only)
    - Conditional claims look like MSP claims but primary payment = $0
  - Not required to submit MSP claims for OP services if primary payer paid in full and no remaining Medicare Part B deductible due

When to Submit MSP vs. Conditional Claim

- MSP claim
  - Primary payer paid in part or in full on IP claim
    - In part = Paid less than Medicare-covered charges or than amount you agreed to accept, per contract or law, as full payment of Medicare-covered charges
    - In full = Paid Medicare-covered charges or amount you agreed to accept, per contract or law, as full payment of Medicare-covered charges
- Conditional claim
  - Primary payer paid $0 on IP claim
    - Primary payer did not pay at all for a valid reason (not because Medicare primary) or did not pay promptly (within 120 days; accidents only)

MSP Claims vs. Conditional Claims

- For both MSP and conditional claims
  - Submit monthly covered claims with Medicare-covered charges
    - Do not just submit MSP claims for balance remaining
    - Follow Medicare's usual claim submission guidelines (technical, medical and billing requirements)
    - Do not split bill monthly claims if primary payer stops/starts paying in middle of month
  - Report required MSP coding or conditional coding
    - Prepare and Submit an MSP Claim
    - Prepare and Submit an MSP Conditional Claim

MSP Claims

Claim Field	Description
TOB	Covered TOB (not 210/180)
CCs, OCs, and VC	As appropriate, refer to MSP Billing Code Table
Days and Charges	Covered days and charges (include room and board)
Revenue Code	0022 with appropriate HIPPS code or ZZZZZ if no assessments performed
Payer	Primary payer on Payer Line A, Medicare on Payer Line B (or C if Medicare tertiary payer)
CAGCs and CARCs	As appropriate, refer to External Code Lists (X12)

Conditional Claims

Claim Field	Description
TOB	Covered TOB (not 210/180)
CC, OC, VC and Remarks	As appropriate, refer to Conditional Billing Code Table Remarks = code that indicates why primary payer did not pay or did not pay promptly
Days and Charges	Covered days and charges (include room and board)
Revenue Code	0022 with appropriate HIPPS code or ZZZZZ if no assessments performed
Payer	Primary payer on Payer Line A, Medicare on Payer Line B (or C if Medicare tertiary payer)
CAGCs and CARCs	As appropriate, refer to External Code Lists (X12)

Situations During Covered Stay

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
  - Provider-liable example – DPNA (denial of payment for new admissions)

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

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

Leave of Absence (LOA) - Overview

- Beneficiary leaves facility (absent) but not discharged or admitted as IP to any other facility
  - Does not return before midnight census
- If exceeds 30 days, must meet QHS and 30-day transfer requirements to use remaining SNF days
- Cannot bill beneficiary for LOA days
  - Beneficiary can choose to make bed-hold payments to facility
    - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 1, Section 30.1.1.1

LOA

- Submit as part of monthly covered claim
- Claims can include multiple LOAs

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 - Overview

- Impacts assessment schedule and variable per diem adjustment
  - New stay versus continuation of same SNF stay (resident status)
  - Does not impact consolidated billing regulations
- "Interruption window"
  - Begins on first non-covered day following discharge from Part A-covered stay
    - Physically leaves SNF = day of departure
    - Discontinues Part A coverage but remains in SNF = day after final day of coverage
  - Ends at 11:59 PM of third consecutive non-covered calendar day

Interrupted Stay

- Submit as part of monthly covered claim
- Claims can include multiple interrupted stays

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

Interrupted Stay – Discharge Example

- DOS 10/01/2024 – 10/31/2024
- Patient discharged and left facility on 10/20/2024 but returned before midnight census on 10/23/2024

Claim Field	Description
OSC and Dates	74 with 10/20/2024 (day of departure) – 10/22/2024 (last day not present for midnight census)
Revenue Code	018X with three interrupted stay days as units and no charges

Interrupted Stay – Drop LOC Example

- DOS 10/01/2024 – 10/31/2024
- Patient discontinued Part A coverage on 10/20/2024 but remained in SNF and returned to covered care before midnight census on 10/23/2024

Claim Field	Description
OSC and Dates	74 with 10/21/2024 (day after last covered day) – 10/22/2024 (last day not present for midnight census)
Revenue Code	018X with two interrupted stay days as units and no charges

Readmission Within 30 Days – Before Discharge Claim Submitted

- Submit interim claim (212/213 or 182/183 TOB)

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

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) with QHS from and through dates

Benefits Exhausted

Benefits Exhaust (BE) Claims

- Beneficiary exhausts 100 days in current benefit period
  - Fully
    - No benefit days available between From and Through dates of claim
  - Partially
    - Had benefit days available between From and Through dates of claim
- Billing depends on LOC and area of facility beneficiary in
  - Skilled LOC
    - Stays in Medicare-certified area (MCA) of facility
    - Moves to non-MCA of facility
  - Drops to non-skilled LOC 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 - 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 - 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 - 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 - 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	

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
    - Section 40 – Special Inpatient Billing Instructions
    - Section 50 – SNF Payment Bans or DPNA
    - Section 90 – Medicare Advantage (MA) Beneficiaries
    - Section 120.2 – Interrupted Stay Policy
  - 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)

CMS References and Resources

- Skilled Nursing Facility Center
- CMS MLN® Educational Tool: *Skilled Nursing Facility Billing Reference* (MLN006846)
- Patient Driven Payment Model (PDPM)
  - Interrupted Stay Policy (ZIP)
- SNF Consolidated Billing
- Web Pricer Skilled Nursing Facility PPS
- Skilled Nursing Facilities/Long-Term Care Open Door Forum

Other References and Resources

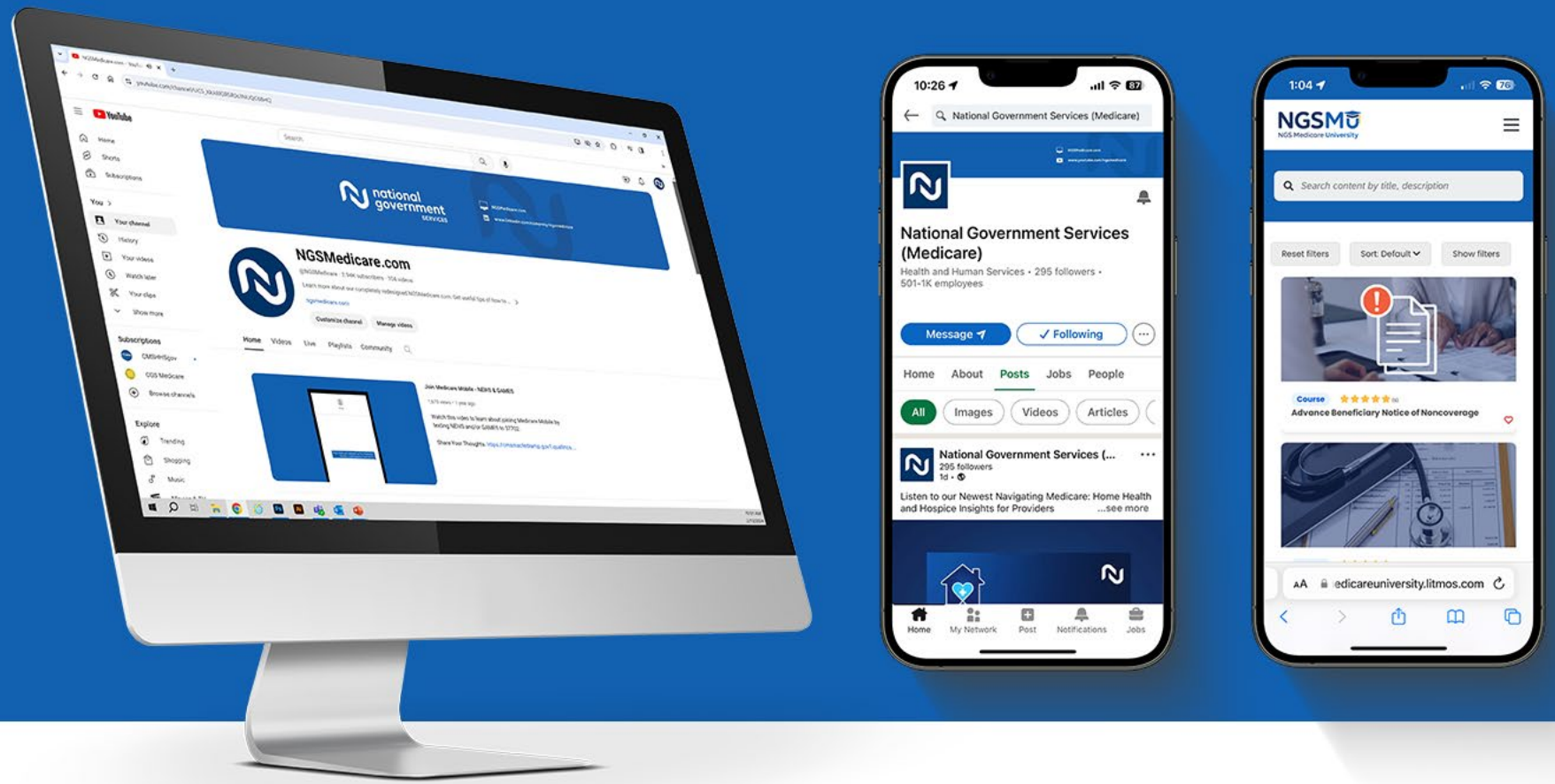
- External Code Lists
- National Uniform Billing Committee

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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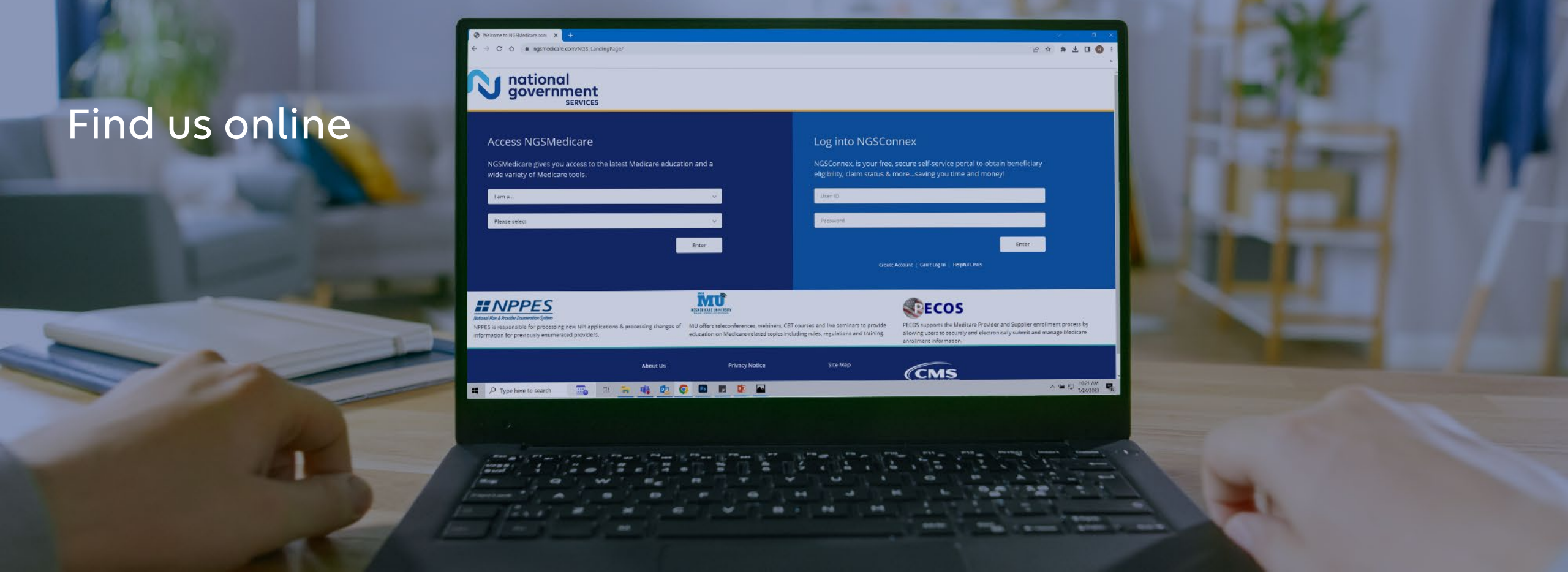

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