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National Government Services

2022 NGS Medicare Spring Virtual Conference **Medicare for You**

Back to the Basics of Skilled Nursing Facility Billing

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

- Kathy Windler
  - Provider Outreach and Education Consultant
- Andrea Freibauer
  - Provider Outreach and Education Consultant

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Objectives

- Educate SNF billing staff on the basics of the SNF benefit and billing requirements for Medicare

Agenda

- SNF Benefit
- Benefit Periods
- Medicare General Claim Submission Guidelines
- Inpatient Part A Claim Submission
- SNF Part A Reimbursement
- Outpatient Claim Submission
- Resources and Wrap Up

Skilled Nursing Facility Benefit

Skilled Nursing Facility Definition

- Facility setting primarily engaged in providing
  - Skilled nursing care and related services for residents who require medical or nursing care; or
  - Skilled rehabilitation services for rehabilitation of injured, disabled, or sick persons
- Not primarily for care or treatment of mental diseases
- Meets facility and transfer agreement requirements set forth in the Act

Skilled Nursing Facility Definition

- Provides level of care different than
  - Level of intensive care furnished by general hospital
  - Level of custodial or supportive care furnished by nursing homes (daily services above room and board)
- Emphasis on skilled care and skilled restorative services for patients
- Facility must have wide range of specialized medical services and employ variety of paramedical and skilled nursing personnel

Swing Beds

- In rural settings, acute-care hospitals and Critical Access Hospitals can be approved to be "swing bed hospitals"
  - When hospital meets certain criteria, acute care inpatient beds can be used for post-acute SNF care as needed
    - No dedicated unit or section required
  - Coverage requirements, billing and payment same as SNF
    - Exception-SNF swing bed in CAH exempt from using list of Major Categories for SNF consolidated billing

Part A and Part B Entitlement

- Beneficiaries must have Medicare Part A to cover inpatient claims
- Beneficiaries must have Medicare Part B to cover outpatient claims
- Registration/admission staff should verify entitlement prior to claim submission
  - Verify information on Medicare card via IVR and NGSConnex

SNF Inpatient Coverage Requirements

- Two types of requirements under Medicare for inpatient coverage in SNF
  - Technical
  - Medical
- Must meet both sets of requirements for claim to be considered for payment under Medicare

SNF Inpatient Coverage Requirements

- Technical requirements (must meet all)
  - Beneficiary enrolled Medicare Part A
  - Medicare-certified SNF
  - SNF days available in benefit period
  - Three day qualifying hospital inpatient stay
  - 30-day transfer from qualifying hospital stay

Three Day Qualifying Hospital Stay

- One or more hospitals – consecutive stays
- Use midnight-to-midnight rule
  - Does not count time spent in observation or ED before admission
- May be waived in certain situations
  - Official Public Health Emergency (COVID-19)
  - MA plan, 1876 Cost or PACE Plans
  - Shared Savings Program Accountable Care Organizations (ACOs)

Midnight-to-Midnight Rule

- Method used to calculate days of care for Medicare reporting purposes
  - 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

30-day Transfer Requirement

- Transferred to Medicare-certified SNF within 30 days after hospital discharge unless
  - Patient's condition makes it medically inappropriate to begin treatment in SNF immediately after discharge AND
  - Medically predictable at time of hospital discharge that patient needs covered care within pre-determined time period and care begins within that time

SNF Coverage Requirements

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

What Is Skilled Care?

- Require skill of qualified technical or professional health personnel
  - Registered nurses, licensed practical nurses, physical therapists, occupational therapists, and speech-language pathologists or audiologists
- Directly provided, or under general supervision of, such personnel to ensure safety of patient and achieve medically desired results

Certification of Medical Necessity

- CERT alert - SNF Inpatient Stays
- Must be documented in medical record
- No specific format or procedure for documentation of certification
- Must be dated and with signature of certifying physician or nonphysician practitioner

Certification of Medical Necessity

- Medical necessity certification must contain
  - Individual needs skilled nursing care (furnished directly by or requiring supervision of skilled nursing personnel) or other skilled rehabilitation services
  - Such services required on daily basis
  - Such services can only be practically provided in SNF or swing-bed hospital on inpatient basis
  - Such services for ongoing condition for which individual received inpatient care in hospital

Covered SNF Services

- When all requirements for coverage met, Medicare can pay for
  - Room & board (semiprivate room)
    - Private room under certain conditions
  - Therapies (PT, OT, and SLP)
  - Skilled nursing services
  - Certain off-site services provided during stay

When Medical Coverage Criteria Not Met

- Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) Form CMS-10055
  - Must be completed when SNF care not medically reasonable and necessary or considered custodial care
  - Transfers liability to the patient for services rendered
  - Must be completed appropriately and accurately
  - Must be provided with advance notice so patient can make informed decision
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 30, Section 70

SNF ABN Not Required

- Not Medicare benefit
  - Such as personal comfort items
- Patient did not meet technical requirement
  - No three day stay or 30-day transfer
- Patient exhausted benefit days

Benefit Periods

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
    - Facility free - **or** – No skilled care for 60 days in a row

Benefit Period

- Hospital and SNF Benefit Period
  - Hospital and SNF days used separately, linked to same benefit period
  - Not bound by calendar year
  - Benefit days cannot be carried from one benefit period to the next
    - Use or lose

Benefit Period Example

- On 7/28/2021, Mr. Robinson entered a participating general hospital. After he had been in the hospital for two weeks, Mr. Robinson was discharged on 8/11/2021.
- He then entered a participating SNF on 8/15/2021, and remained an inpatient there until his discharge on 10/27/2021. He had no further inpatient stays in 2021 or 2022.
- If he was admitted as a hospital inpatient today, is he entitled to a new benefit period?

Benefit Period Example

- Mr. Wilson had an inpatient hospital stay from 12/14/2021 through 12/23/2021. He was then transferred to a SNF on 12/26/2021, and remained at a covered level of care until discharge on 1/21/2022. Mr. Wilson is being admitted to a hospital on 3/11/2022.
- Does a new benefit period start?

SNF Inpatient Days

- Beneficiary has 100 SNF days (renewable)
  - Medicare will cover in full
    - Days one-20
  - Beneficiary or supplemental insurance pays daily charge for
    - Days 21-100 (Coinsurance Days)
  - Benefits exhaust
    - No Medicare payment

30-Day Transfer Requirement

- Readmission to SNF after SNF discharge may occur within 30 days of last covered day
- If beneficiary past 30-day window
  - Needs new three-day qualifying hospital stay to access same spell of illness if any benefit period days remain
- If beneficiary nonskilled for 60 consecutive days
  - Needs new qualifying stay day to access new benefit period
  - Will receive new set of 100 days

Did You Know?

- Coinsurance amount for 2022 is $194.50
- SNF coinsurance amount – do the math!
  - Current year's inpatient hospital deductible divided by eight,
  - Or half of current year's hospital coinsurance amount,
  - Or current year's lifetime reserve amount divided by four

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

Medicare General Claim Submission Guidelines

Resources for Submitting Medicare Claims

- UB-04: Official claim form Medicare Part A claims
  - CMS form CMS-1450
- CMS IOM, Publication 100-04, *Medicare Claims Processing Manual,* Chapter 25 – Completing and Processing the Form CMS-1450 Data Set
- National Uniform Billing Committee

How Are Medicare Claims Submitted?

- FISS DDE
  - Direct entry and online submission through mainframe
- Other electronic format
  - Software based electronic submission format (batch or individual claims)
  - Use a software program through approved third party vendor or clearinghouse

Timely Filing Guidelines

- One-year timely filing rule, based on date of service
- Effective for all Medicare Part A & Part B claims
- THROUGH date determines timely filing for institutional claims containing span level DOS
  - "FROM" and a "THROUGH" date span
- Adjustment claims must also follow timely filing regulations

Inpatient Part A Claim Submission

General Billing Requirements

- SNF required to submit bill for patient that has started benefit period under Part A for every month of stay
  - Monthly bill required even though no benefit may be payable
- Bill reporting enables CMS to keep track of benefit period/national healthcare planning

Submit Bills in Sequence

- SNFs must submit bills in sequence for each beneficiary
  - Same sequence in which services performed
    - We will return continuing stay bill if prior bill has not been processed
- Out of sequence claim for continuous stay received - search history for prior adjudicated claim
  - Prior bill has not finalized – RTP incoming bill
    - Reason code 38119 – high volume

Inpatient Claim Submission

- Submit Medicare Part A SNF claims using Form CMS-1450 (also called UB-04) or its electronic equivalent
- Claims submitted
  - Monthly (date of service)
  - Upon discharge
  - When benefits exhaust (100 days in benefit period)
  - Drops to nonskilled level of care

Inpatient Claim Submission

- Admission Date
  - Required on inpatient claims
  - Date consistent on series of claims
  - MM/DD/YY format

SNF Type of Bill

- 211 - Admit/Discharge
- 212 - First Claim in a series of claims
- 213 - Continuation of series of claims
- 213 - Discharged but resides in facility
  - Use OC 22, date skilled care ended
- 214 - Discharged
  - Does not include leave of absence (LOA)
- 210 - Nopay claims

SNF Type of Bill

- 22X - Ancillary inpatient claims
- 23X - Non-SNF resident comes to SNF for outpatient services

Patient Status Codes

- 01 - Discharged to home
- 02 - Discharged/transferred to short term general hospital or inpatient care
- 03 - Discharge/transferred to SNF
- 30 - Still patient
- 66 - Discharged/transferred to CAH

Condition Codes

- 04 - Medicare Advantage Organization
  - MAO is responsible for making payment on claim
- 20 – Demand bill
  - Beneficiary requested billing
- 21 - Billing for denial notice
- 55 - SNF bed not available
- 56 - Medical appropriateness SNF
- 57 - SNF readmission

Occurrence Codes

- Enter appropriate code and date
- OC 50
  - Assessment Reference Date for each assessment period represented on claim with revenue code 0022

Occurrence Span Codes

- Enter appropriate code and two dates (from/through)
- OSC 70
  - Qualifying hospital dates
- OSC 74
  - Noncovered level of care or LOA

Charges

- 0022 revenue code required
  - Can use on multiple lines to indicate different rate codes and periods
  - On each 0022 line, enter
    - Units of service = HIPPS rate code with number of covered days under this rate
    - Charges = zero ($0) not blank

Charges

- 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

SNF Special Billing Situations

SNF Billing Situations

- Billing when readmitted within 30 days
- Medicare Secondary Payer
- LOA
- Noncovered level of care
- Other billing situations

Readmission Within 30 Days

- Discharge bill already submitted
  - Submit new claim with
    - Current stay admission date
    - Condition code 57
    - Occurrence span code 70 with QHS dates
- Readmission before discharge claim submitted
  - Submit interim claim with
    - Current stay admission date
    - Condition code 57
    - Occurrence span code 70 with QHS dates
    - OSC 74 showing LOA “From” and “Through” dates and number of noncovered days

Medicare Secondary Payer

- Situations where Medicare does not pay primary
  - **Not** HMO/MAO plans
- Examples - Working aged, disabled, worker's comp, VA
- Must submit claim to primary payer first
- On Medicare claim, all regular coding must be on claim as well as MSP-specific coding
  - Refer to Prepare and Submit an MSP Claim on our website

LOA

- Beneficiary does not meet midnight census
- No Medicare Part A benefit day taken
- Upon return to SNF, current assessment schedule continued
- Claim must reflect
  - Revenue code 0180 with number of LOA days as units and zero charges
  - OSC 74 showing “From” and “Through” dates for LOA and number of noncovered days

Noncovered Level of Care

- Resident no longer at skilled level of care
- Issue appropriate SNF ABN
- Claim must reflect
  - OC 22 to signal system to start counting towards new benefit period
  - Date level of care dropped
  - Patient status

Did You Know…

- SNF must submit monthly benefits exhaust bills for those patients that continue to receive skilled care and also when there is change in level of care regardless of whether benefits exhaust bill will be paid by Medicaid, supplemental insurer, or private payer

Other SNF Billing Situations

- Refer to CMS MLN® Educational Tool: *SNF Billing Reference*
  - Interrupted says
  - When benefits exhaust
  - No payment billing, noncovered days
  - No QHS
  - Same day transfer
  - Demand billing
  - When patient has HMO/MAO plan

SNF Part A Reimbursement

SNF Prospective Payment System

- SNF Part A inpatient services paid under prospective payment system
- PPS payment based on Patient Driven Payment Model
  - Effective for dates of services on or after 10/1/2019
- For more information visit CMS' Patient Driven Payment Model web page

SNF Prospective Payment System

- All Medicare covered Part A services considered within scope or capability of SNF considered paid under PPS rate
- 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 (consolidated billing)
  - No separate payment made

SNF Consolidated Billing

- Requirement in section 1862(a)(18) of Social Security Act
  - Effective 7/1/1998
- Places responsibility on SNF for all services its patients receive during Part A stay
  - Except for services indicated by CMS as EXCLUDED
    - Refer to SNF Consolidated Billing web page for reference files

SNF PPS Reminder

- Neither SNF or another provider or practitioner may bill Medicare for services under Part B
  - Except for services specifically excluded from PPS payment and associated CB requirements

Outpatient Claim Submission

SNF Outpatient Billing

- Three situations in which SNF may submit claim for Part B services
  - Certain medical and other health services provided to beneficiaries in Part B inpatient stay
    - Patients residing in SNF whose Part A benefits exhausted or who are not otherwise entitled to have claims paid under Part A benefit
  - Outpatient services (patients who are not SNF inpatients)
  - Excluded from SNF PPS and SNF CB

Covered Outpatient Services

- Separate billing for certain Part B services rendered to Medicare beneficiaries in covered SNF Part A stay
  - Physician's professional services
  - Certain dialysis-related services
  - Certain ambulance services
  - Certain chemotherapy drugs and administration services
  - Radioisotope services
  - Customized prosthetic devices

SNF Outpatient Billing

- Claim submitted on UB-04/CMS-1450 or electronic equivalent
- TOB depends on the type of facility/bed
  - 22X – when entire facility qualifies as Medicare-certified
  - 23X – outpatients and residents residing in non-Medicare certified bed
- Most services paid under MPFS or CLFS

Covered Part B Services

- Repetitive services billed on single individual monthly bill or through end of treatment
- Refer to CMS IOM Publication100-04, *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)

Resources and Wrap Up

Resources

- CMS IOM Publication 100-01, *Medicare General Information*, Eligibility and Entitlement Manual, Chapter 1
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 6, Inpatient Part A Billing and SNF Consolidated Billing
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 7, SNF Part B Billing (Including Inpatient Part B and Outpatient Fee Schedule)
- CMS Skilled Nursing Facility Center

Resources

- CMS Skilled Nursing Facilities/Long-Term Care Open Door Forum
- National Government Services Fundamentals of Medicare Manual
  - Section 2: Medicare Basics - Skilled Nursing Facility Inpatient Care
- NGSConnex User Guide
  - Inpatient and SNF Spell History
- CMS.gov Web Pricer Skilled Nursing Facility PPS

Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?
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