CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 930

Department of Health & Human Services (DHHS)

Center for Medicare & Medicaid Services (CMS)

Date: APRIL 28, 2006

Change Request 4292

SUBJECT: Benefits Exhaust and No-Payment Billing Instructions for Medicare Fiscal Intermediaries (FIs) and Skilled Nursing Facilities (SNFs)

I. SUMMARY OF CHANGES: This instruction implements a standard process for benefits exhaust and no-payment billing for Skilled Nursing Facilities. In addition, this instruction restores information in Chapter 1, Section 50.2.1 inadvertently deleted in CR 3671, Transmittal 493, dated March 4, 2005, regarding hospitals in Maryland under the jurisdiction of the Health Services Cost Review Commission and interim billing for inpatient psychiatric facilities.

NEW/REVISED MATERIAL

EFFECTIVE DATE: October 1, 2006

IMPLEMENTATION DATE: October 2, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R = REVISED, N = NEW, D = DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1/50.2.1/Inpatient Billing From Hospitals and SNFs
R	6/Table of Contents
R	6/40.6/Total and Noncovered Charges
R	6/40.7/Ending a Benefit Period
R	6/40.8/Billing in Benefits Exhaust and No-Payment Situations
N	6/40.9/Other Billing Situations

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment – Business Requirements

Pub. 100-04	Transmittal: 930	Date: April 28, 2006	Change Request: 4292

SUBJECT: Benefits Exhaust and No-Payment Billing Instructions for Medicare Fiscal Intermediaries (FIs) and Skilled Nursing Facilities (SNFs)

I. GENERAL INFORMATION

A. Background: A SNF is required to submit a bill for a beneficiary that has started a spell of illness under the SNF Part A benefit for every month of the related stay even though no benefits may be payable. CMS maintains a record of all inpatient services for each beneficiary, whether covered or not. The related information is used for national healthcare planning and also enables CMS to keep track of the beneficiary's benefit period. These bills have been required in two situations: 1) when the beneficiary has exhausted his/her 100 covered days under the Medicare SNF benefit (referred to below as benefits exhaust bills) and 2) when the beneficiary no longer needs a Medicare covered level of care (referred to below as no-payment bills).

A SNF must submit a benefits exhaust bill monthly for those patients that continue to receive skilled care and also when there is a change in the level of care regardless of whether the benefits exhaust bill will be paid by Medicaid, a supplemental insurer or private pay. There are two types of benefits exhaust claims: 1) Full benefits exhaust claims: no benefit days remain in the beneficiary's applicable benefit period for the submitted statement covers from/through date of the claim and 2) Partial benefits exhaust claims: only one or some benefit days, in the beneficiary's applicable benefit period, remain for the submitted statement covers from/through date of the claim. These bills are required in order to extend the beneficiary's applicable benefit period posted in the Common Working File (CWF). Furthermore, when a change in level of care occurs after exhaustion of a beneficiary's covered days of care, the provider must submit the benefits exhaust bill in the next billing cycle indicating that active care has ended for the beneficiary.

In addition, SNF providers must submit no-payment bills for beneficiaries that have previously received Medicare-covered care and subsequently dropped to a non-covered level of care but continue to reside in a Medicare-certified area of the facility. Consolidated Billing (CB) legislation indicates that physical therapy, occupational therapy, and speech language pathology services furnished to SNF residents are always subject to SNF CB. This applies even when a resident receives the therapy during a non-covered stay in which the beneficiary who is not eligible for Part A extended care benefit still resides in an institution (or part thereof) that is Medicare-certified as a SNF. SNF CB edits require the SNF to bill for these services on a 22x (inpatient part B) bill type.

The CMS has recognized that bill submission in benefits exhaust and no-payment situations have varied across FIs. This instruction shall provide a single consistent billing process to be applied to all contractors. In addition, this instruction only applies to residents who are newly admitted or in Part A stays on or after October 1, 2006.

SNF providers and FIs shall follow the billing guidance provided in the policy section below for the proper billing of benefits exhaust bills and no-payment bills.

B. Policy: Providers shall follow the billing guidance provided below when submitting either benefits exhaust or no-payment claims:

1) SNF providers shall submit benefits exhaust claims for those beneficiaries that continue to receive skilled services as follows:
   a) **Full or partial benefits exhaust claim.**
      i) Bill Type = Use appropriate covered bill type (i.e. 211, 212, 213 or 214 for SNF and 181, 182, 183 or 184 for Swing Bed (SB). NOTE: Bill types 210 or 180 should not be used for benefits exhaust claims submission)
      ii) Covered Days and Charges = Submit all covered days and charges as if beneficiary had days available
      iii) Value Code 09 (First year coinsurance amount) or Value Code 11 (Second year coinsurance amount) = 1.00 (If applicable, the FISS will assign the correct coinsurance amount based off the CWF response)
      iv) Patient Status Code = Use appropriate code.

   b) **Benefits exhaust claim with a drop in level of care within the month; Patient remains in the Medicare-certified area of the facility after the drop in level of care.**
      i) Bill Type = Use appropriate bill type (i.e. 212 or 213 for SNF and 182 or 183 for SB. NOTE: Bill types 210 or 180 should not be used for benefits exhaust claims submission.)
      ii) Occurrence Code 22 (date active care ended, i.e., date covered SNF level of care ended) = include the date active care ended; this should match the statement covers through date on the claim.
      iii) Covered Days and Charges = Submit all covered days and charges as if the beneficiary had days available up until the date active care ended.
      iv) Value Code 09 (First year coinsurance amount) or Value Code 11 (Second year coinsurance amount) = 1.00 (If applicable, the FISS will assign the correct coinsurance amount based off the CWF response)
      v) Patient Status Code = 30 (still patient)

   c) **Benefits exhaust claim with a patient discharge.**
      i) Bill Type = 211 or 214 for SNF and 181 or 184 for SB (NOTE: Bill types 210 or 180 should not be used for benefits exhaust claims submission.)
      ii) Covered Days and Charges = Submit all covered days and charges as if beneficiary had days available up until the date of discharge.
      iii) Value Code 09 (First year coinsurance amount) or Value Code 11 (Second year coinsurance amount) = 1.00 (If applicable, the FISS will assign the correct coinsurance amount based off the CWF response)
      iv) Patient Status Code = Use appropriate code other than patient status code 30 (still patient).

NOTE: Billing all covered days and charges allow the Common Working File (CWF) to assign the correct benefits exhaust denial to the claim and appropriately post the claim to the patient's benefit period. Benefits exhaust bills must be submitted monthly.

2) SNF providers shall submit no-payment claims for beneficiaries that previously dropped to non-skilled care and continue to reside in the Medicare-certified area of the facility using the following options.

a) **Patient previously dropped to non-skilled care. Provider needs Medicare denial notice for other insurers.**
   i) Bill Type = 210 (SNF no-payment bill type)
   ii) Statement Covers From and Through Dates = days provider is billing, which may be submitted as frequently as monthly, in order to receive a denial for other insurer purposes. No-payment billing shall start the day following the date active care ended.
   iii) Days and Charges = Non-covered days and charges beginning with the day after active care ended.
   iv) Condition Code 21 (billing for denial)
   v) Patient Status Code = Use appropriate code.

b) **Patient previously dropped to non-skilled care. In these cases, the provider must only submit the final discharge bill that may span multiple months.**
   i) Bill Type = 210 (SNF no-payment bill type)
   ii) Statement Covers From and Through Dates = days billed by the provider, which may span multiple months, in order to show final discharge of the patient. No-payment billing shall start the day following the date active care ended.
   iii) Days and Charges = Non-covered days and charges beginning with the day after active care ended.
   iv) Condition Code 21 (billing for denial)
   v) Patient Status Code = Use appropriate code other than patient status code 30 (still patient).

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4292.1	Medicare contractors shall adjust their internal systems to process claims according to the provider billing instructions provided under Section I. B. above.	X								
4292.2	Medicare systems shall disable any front-end benefits exhaust edits for 18x and 21x bill types in order to allow the CWF to properly assign benefit days to a claim.	X				X				
4292.3	Medicare systems shall reject claims indicating full benefits exhaust when the CWF response received indicates no benefit days are available.					X				

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4292.3.1	Medicare systems shall change all covered days and charges to non-covered.					X				
4292.3.2	Medicare systems shall populate the non-pay code field with a "B" (benefits exhausted).					X				
4292.4	Medicare systems shall apply a partial benefits exhaust reject code and reduce the covered units reported on the 0022 revenue code line based off the CWF's response indicating only partial benefits are available for the claim.					X				
4292.4.1	Medicare systems shall apply the partial benefits exhaust reject code to the appropriate 0022 revenue code line, where multiple 0022 revenue code lines are present on claim, based on the reported line item date of service.					X				
4292.4.2	Medicare systems shall change those days for which no benefit days remain to non-covered days.					X				
4292.4.3	Medicare systems shall automatically assign the benefits exhaust date under the Occurrence Code A3 on the claim based off the CWF response.					X				
4292.4.4	Medicare systems shall calculate the coinsurance amount, if applicable, based off the CWF response.					X				
4292.4.4.1	Medicare systems shall report the correct amount under the value code 09 (first year coinsurance amount) or value code 11 (second year coinsurance amount).					X				
4292.5	Medicare systems shall modify the existing CWF SNF consolidated billing therapy edit for non-covered SNF stays to read claim history to look for a 21x bill type that contains an Occurrence code 22 (date active care ended) and a Patient Status code 30 (still patient) where there is no subsequent SNF discharge claim from the same provider.								X	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4292.5.1	Medicare systems shall reject claims with dates of service after the posted SNF claim containing Occurrence Code 22 and Patient Status 30 until a SNF 21x discharge claim is processed. Claims received with dates of service after a SNF 21x discharge claim's dates of service shall not receive this edit.								X	
4292.6	Medicare systems shall not bypass the therapy consolidated billing edit for bill types 12x, 13x, 23x, 34x, 74x, 75x, 83x, or 85x when an overlapping 21x bill type posted to history has a no-payment code equal to 'B', 'N', or 'R'.								X	
4292.7	Medicare systems shall modify any monthly billing requirement edits for 21x bill types in order to allow only 1 paid claim and multiple non-payment claims with the same admit date, within the same month, to be processed.					X				
4292.7.1	Medicare systems shall ensure that 21x bill types submitted with the same admission date, within a month, do not contain overlapping dates of service.					X				

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4292.8	A provider education article related to this instruction will be available at www.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive notification of the article release via the established "MLNMatters" listserv. Contractors shall post this article, or a direct link to this	X								

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions
4292.1	FIs shall disable any SuperOp events, local edits, etc. that may conflict with the billing instructions identified in Section I.B.
4292.3	The FISS shall assign full benefits exhaust reject code 39508 to the claim.
4292.4	The FISS shall assign partial benefits exhaust reject code 39509 to those days for which no benefits are exhausted.
4292.5	The CWF shall set SNF CB edit C7251.
4292.6	The CWF shall update the SNF CB edit C7251 to remove the bypasses.

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: October 1, 2006 **Implementation Date:** October 2, 2006 **Pre-Implementation Contact(s):** Jason Kerr @ Jason.Kerr@cms.hhs.gov or Yvonne Young @ Yvonne.Young@cms.hhs.gov **Post-Implementation Contact(s): Appropriate Regional Office**	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

50.2.1 – Inpatient Billing From Hospitals and SNFs

(Rev. 930, Issued: 04-28-06, Effective: 10-01-06, Implementation: 10-02-06)

Inpatient services in TEFRA hospitals (i.e., hospitals excluded from inpatient prospective payment system (PPS), cancer and children's hospitals) and SNFs are billed:

- Upon discharge of the beneficiary;
- When the beneficiary' benefits are exhausted;
- When the beneficiary's need for care changes; or
- On a monthly basis.

Hospitals in Maryland that are under the jurisdiction of the Health Services Cost Review Commission are subject to monthly billing cycles.

Providers shall submit a bill to the FI when a beneficiary in a SNF ceases to need active care (occurrence code 22), or a beneficiary in one of these hospitals ceases to need hospital level care (occurrence code 22). FIs shall not separate the occurrence code 31 and occurrence span code 76 on two different bills. Each bill must include all applicable diagnoses and procedures. However, interim bills are not to include charges billed on an earlier claim since the "From" date on the bill must be the day after the "Thru" date on the earlier bill.

SNF providers shall follow the billing instructions provided in Chapter 6 (SNF Inpatient Part A Billing), Section 40.8 (Billing in Benefits Exhaust and No-Payment Situations) for proper billing in benefits exhaust and no-payment situations.

Inpatient acute-care PPS hospitals, inpatient rehabilitation facilities (IRFs), long term care hospitals (LTCHs) and inpatient psychiatric facilities (IPFs) may interim bill in at least 60-day intervals. Subsequent bills must be in the adjustment bill format. Each bill must include all applicable diagnoses and procedures.

All inpatient providers will also submit a bill when the beneficiary's benefits exhaust. This permits them to bill a secondary insurer when Medicare ceases to make payment. Initial inpatient acute care PPS hospital, IRF, IPF and a LTCH interim claims must have a patient status code of 30 (still patient). When processing interim PPS hospital bills, providers use the bill designation of 112 (interim bill - first claim). Upon receipt of a subsequent bill, the FI must cancel the prior bill and replace it with one of the following bill designations:

- For subsequent interim bills, bill type 117 with a patient status of 30 (still patient); or
- For subsequent discharge bills, bill type 117 with a patient status of one of the following:
    - 01 - Discharged to home or self care;
    - 02 - Discharged/transferred to another short-term general hospital;
    - 03 - Discharged/transferred to SNF;

- 04 - Discharged/transferred to an ICF;
- 05 - Discharged/transferred to a non-Medicare PPS children's hospital or non-Medicare PPS cancer hospital for inpatient care;
- 06 - Discharged/transferred to home under care of an organized home health service organization;
- 07 - Left against medical advice;
- 08 - Discharged/transferred to home under care of a home IV drug therapy provider;
- 09 - Admitted as an inpatient to this hospital;
- 20 - Expired (or did not recover - Religious Non-Medical Healthcare Institution patient);
- 43 - Discharged/transferred to a Federal hospital (effective for discharges on and after October 1, 2003);
- 50 - Discharged/transferred to Hospice - home
- 51 - Discharged/transferred to Hospice - medical facility
- 61 - Discharged/transferred within this institution to a hospital-based Medicare approved swing bed.
- 62 - Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital
- 63 - Discharged/transferred to long term care hospitals
- 64 - Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
- 65 - Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital (effective April 1, 2004)
- 71 - Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (deleted October 1, 2003)
- 72 - Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (deleted October 1, 2003)

All inpatient providers must submit bills when any of the following occur, regardless of the date of the prior bill (if any):

- Benefits are exhausted;
- The beneficiary ceases to need a hospital level of care (all hospitals);
- The beneficiary falls below a skilled level of care (SNFs and hospital swing beds; or
- The beneficiary is discharged.

These instructions for hospitals and SNFs apply to all providers, including those receiving Periodic Interim Payments (PIP). Providers should continue to submit no-pay bills until discharge.

Medicare Claims Processing Manual

Chapter 6 - SNF Inpatient Part A Billing

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40.6 - Total and Noncovered Charges

(Rev. 930, Issued: 04-28-06, Effective: 10-01-06, Implementation: 10-02-06)

SNF-517.9

For each cost center for which a separate charge is billed (type of accommodation or ancillary), a revenue code is assigned. The appropriate numeric revenue code is entered in FL 42 to explain each charge in FL 47.

Additionally, there is no fixed "Total" line in the charge area. Instead, revenue code "0001" is always entered last in FL 42. Thus, the adjacent charge entry, in FL 47, is the sum of charges billed. This is also the same line on which noncovered charges, if any, in FL 48, are summed.

The total charge for all services, covered and noncovered, will generally be shown. See §40.6.1 below, for certain exceptions. In the "Noncovered Charges" column (FL48) enter the amount of any noncovered charge except where:

- The FI has notified the SNF that payment can be made under the limitation of liability provisions; and
- A payer primary to Medicare is involved. (See the Medicare Secondary Payer [MSP] Manual, Chapter 3, "MSP Provider Billing Requirements," and Chapter 4, "Contractor Prepayment Processing Requirements.")

Where a bill is submitted for a period including both covered and noncovered days *(e.g., days submitted for noncovered level of care)*, the SNF must list the charges for noncovered days under noncovered charges.

Refer to the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-92 (CMS-1450) Data Set," for further information about billing, as it contains UB-92 data elements and the corresponding fields in the electronic record.

40.7 - Ending a Benefit Period

(Rev. 930, Issued: 04-28-06, Effective: 10-01-06, Implementation: 10-02-06)

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

When the SNF resident's health has improved to the point where he or 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 the resident that leaves the Medicare-certified SNF or DPU:

    a. Submit a final discharge bill, and

    b. Any services rendered after the discharge and billed by the SNF should be submitted on a 23x.

2. For the resident that remains in the Medicare-certified SNF or DPU after the skilled level of care has ended:

a. Submit the last skilled care claim with an occurrence code 22 to indicate the date active care ended. *i.e., date covered SNF level of care ended, and patient status code 30 to indicate the patient is still a resident in the Medicare-certified SNF or DPU;*

b. Any *Part B covered* services rendered and billed by the SNF after the skilled care ended should be submitted on a 22x; and

c. 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, §10.4.2.

40.8 – *Billing in Benefits Exhaust and No-Payment Situations*

(Rev. 930, Issued: 04-28-06, Effective: 10-01-06, Implementation: 10-02-06)

An SNF is required to submit a bill for a beneficiary that has started a spell of illness under the SNF Part A benefit for every month of the related stay even though no benefits may be payable. CMS maintains a record of all inpatient services for each beneficiary, whether covered or not. The related information is used for national healthcare planning and also enables CMS to keep track of the beneficiary's benefit period. These bills have been required in two situations: 1) when the beneficiary has exhausted his/her 100 covered days under the Medicare SNF benefit (referred to below as benefits exhaust bills) and 2) when the beneficiary no longer needs a Medicare covered level of care (referred to below as no-payment bills).

An SNF must submit a benefits exhaust bill monthly for those patients that continue to receive skilled care and also when there is a change in the level of care regardless of whether the benefits exhaust bill will be paid by Medicaid, a supplemental insure, or private payer. There are two types of benefits exhaust claims: 1) Full benefits exhaust claims: no benefit days remain in the beneficiary's applicable benefit period for the submitted statement covers from/through date of the claim and 2) Partial benefits exhaust claims: only one or some benefit days, in the beneficiary's applicable benefit period, remain for the submitted statement covers from/through date of the claim. These bills are required in order to extend the beneficiary's applicable benefit period posted in the Common Working File (CWF). Furthermore, when a change in level of care occurs after exhaustion of a beneficiary's covered days of care, the provider must submit the benefits exhaust bill in the next billing cycle indicating that active care has ended for the beneficiary.

In addition, SNF providers must submit no-payment bills for beneficiaries that have previously received Medicare-covered care and subsequently dropped to a non-covered level of care but continue to reside in a Medicare-certified area of the facility. Consolidated Billing (CB) legislation indicates that physical therapy, occupational therapy, and speech language pathology services furnished to SNF residents are always subject to SNF CB. This applies even when a resident receives the therapy during a non-covered stay in which the beneficiary who is not eligible for Part A extended care benefit still resides in an institution (or part thereof) that is Medicare-certified as a SNF. SNF CB edits require the SNF to bill for these services on a 22x (inpatient part B) bill type.

SNF providers and FIs shall follow the billing guidance provided below for the proper billing of benefits exhaust bills and no-payment bills.

1) *SNF providers shall submit benefits exhaust claims for those beneficiaries that continue to receive skilled services as follows:*

   a) Full or partial benefits exhaust claim.

   *i) Bill Type = Use appropriate covered bill type (i.e., 211, 212, 213 or 214 for SNF and 181, 182, 183 or 184 for Swing Bed (SB). **NOTE:** Bill types 210 or 180 should not be used for benefits exhaust claims submission).*

   ii) Covered Days and Charges = Submit all covered days and charges as if beneficiary had days available.

   iii) Value Code 09 (First year coinsurance amount) or Value Code 11 (Second year coinsurance amount) = 1.00 (If applicable, the FISS will assign the correct coinsurance amount based off the CWF response).

   iv) Patient Status Code = Use appropriate code.

   b) Benefits exhaust claim with a drop in level of care within the month; Patient remains in the Medicare-certified area of the facility after the drop in level of care.

   *v) Bill Type = Use appropriate bill type (i.e., 212 or 213 for SNF and 182 or 183 for SB. **NOTE:** Bill types 210 or 180 should not be used for benefits exhaust claims submission).*

   vi) Occurrence Code 22 (date active care ended, i.e., date covered SNF level of care ended) = include the date active care ended; this should match the statement covers through date on the claim.

   vii) Covered Days and Charges = Submit all covered days and charges as if the beneficiary had days available up until the date active care ended.

   viii) Value Code 09 (First year coinsurance amount) or Value Code 11 (Second year coinsurance amount) = 1.00 (If applicable, the FISS will assign the correct coinsurance amount based off the CWF response).

   ix) Patient Status Code = 30 (still patient).

   c) Benefits exhaust claim with a patient discharge.

   *i) Bill Type = 211 or 214 for SNF and 181 or 184 for SB (**NOTE:** Bill types 210 or 180 should not be used for benefits exhaust claims submission).*

   ii) Covered Days and Charges = Submit all covered days and charges as if beneficiary had days available up until the date active care ended.

   iii) Value Code 09 (First year coinsurance amount) or Value Code 11 (Second year coinsurance amount) = 1.00 (If applicable, the FISS will assign the correct coinsurance amount based off the CWF response).

   iv) Patient Status Code = Use appropriate code other than patient status code 30 (still patient).

NOTE: *Billing all covered days and charges allow the Common Working File (CWF) to assign the correct benefits exhaust denial to the claim and appropriately post the claim to the patient's benefit period. Benefits exhaust bills must be submitted monthly.*

2) SNF providers shall submit no-payment claims for beneficiaries that previously dropped to non-skilled care and continue to reside in the Medicare-certified area of the facility using the following options.

a) Patient previously dropped to non-skilled care. Provider needs Medicare denial notice for other insurers.

i) Bill Type = 210 (SNF no-payment bill type).

ii) Statement Covers From and Through Dates = days provider is billing, which may be submitted as frequently as monthly, in order to receive a denial for other insurer purposes. No-payment billing shall start the day following the date active care ended.

iii) Days and Charges = Non-covered days and charges beginning with the day after active care ended.

iv) Condition Code 21 (billing for denial).

v) Patient Status Code = Use appropriate code.

b) Patient previously dropped to non-skilled care. In these cases, the provider must only submit the final discharge bill that may span multiple months.

vi) Bill Type = 210 (SNF no-payment bill type).

vii) Statement Covers From and Through Dates = days billed by the provider, which may span multiple months, in order to show final discharge of the patient. No-payment billing shall start the day following the date active care ended.

viii) Days and Charges = Non-covered days and charges beginning with the day after active care ended.

ix) Condition Code 21 (billing for denial).

x) Patient Status Code = Use appropriate code other than patient status code 30 (still patient).

Refer to the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-92 (CMS-1450) Data Set" for further information about billing, as it contains UB-92 data elements and the corresponding fields in the electronic record.

40.9 – Other Billing Situations

(Rev. 930, Issued: 04-28-06, Effective: 10-01-06, Implementation: 10-02-06)

A. Demand Bills

Where the SNF believes that a covered level of care has ended but the beneficiary disagrees, they report occurrence code 21 (UR notice received) or 22 (date active care

ended) as applicable and condition code 20 indicating the beneficiary believes the services are covered beyond the occurrence date.

See the Medicare Claims Processing Manual, Chapter 1, "General Billing Requirements," §60.3, for instructions on advance beneficiary notices and demand bills.

Refer to the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-92 (CMS-1450) Data Set," for further information about billing, as it contains UB-92 data elements and the corresponding fields in the electronic record.

B. Request for Denial Notice for Other Insurer

The SNFs complete a noncovered bill and enter condition code 21 to indicate a request for a Medicare denial notice. Refer to Chapter 25, "Completing and Processing the UB-92 (CMS-1450) Data Set," for further information about billing, as it contains UB-92 data elements and the corresponding fields in the electronic record.

C. Another Insurer is Primary to Medicare

See the Medicare Secondary Payer (MSP) Manual, Chapter 3, "MSP Provider Billing Requirements" and Chapter 5, "Contractor Prepayment Processing Requirements," for submitting claims for secondary benefits to Medicare. Refer to the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-92 Data Set," for further information about billing, as it contains UB-92 data elements and the corresponding fields in the electronic record.

D. Special MSN Messages

The Medicare Prescription Drug Improvement and Modernization Act of 2003 requires that Medicare Summary Notices (including SNF claims for post-hospital extended care services provided under Part A) report the number of covered days remaining in the given spell of illness. This requirement became effective July 6, 2004.