



Picture this scenario: Your skilled nursing facility (SNF) receives a referral from your local hospital for a potential admission. The referred resident has a feeding tube and was admitted to the hospital from another nursing home where he had spent the past year. You determine that the resident exhausted his SNF Medicare benefit many months ago, but the resident has received a skilled level of care since that time because of the feeding tube.

Your facility staff decide, based on their knowledge of Medicare benefit periods, that the resident would not be eligible for a new benefit period. However, in checking the Medicare Common Working File, you learn that the resident has another 100 days of SNF Medicare Part A benefit available.

Should you assume that the Common Working File is correct and cover the resident on Medicare Part A?

This situation happens all too frequently in long-term care facilities. It's also one that the government is attempting to fix, through the introduction of CMS' revised Benefits Exhaust and No-

Payment Billing Instructions. The instructions were released April 28, 2006, in *Transmittal 930* (CR4292).

Although no-pay bills have been required for many years, CMS recognized that bill submission in benefits exhaust and no-payment situations have varied across the fiscal intermediaries (FIs). In many cases, these resulted in noncompliance by SNFs that submitted these types of claims.

CMS issued *Transmittal 930* to provide a single consistent billing process for all contractors. *Transmittal 930* is effective as of this month—October 1, 2006—and only applies to residents who

are newly admitted or in a Medicare Part A stay on or after that effective date.

### How the claims work

Compliance with the SNF no-pay and benefits exhaust claims instructions will help CMS ensure its records accurately reflect all inpatient services the resident receives. The claims are also supposed to help maintain accurate benefit period information. The agency's goal is that the information supplied by the no-pay and benefits exhaust claims will assist in national healthcare planning and future policy making.

To understand the rationale behind no-pay and benefits exhaust claims, it's useful to review the concept of a benefit period, which is a period of consecutive days during which medical benefits for covered services, with certain specified maximum limitations, are available to the beneficiary.

## Submitting Benefits Exhaust claims

For submission of benefits exhaust claims, CMS has outlined the following three different billing scenarios:

### 1. Full or partial benefits exhaust claims; resident continues to receive skilled services:

- Bill type: 211, 212, 213, or 214
- Covered days and charges: Business office staff should submit all covered days and charges as if the beneficiary had days available
- Patient status code: Use appropriate code

### 2. Benefits exhaust claim with a drop in level of care within the month, and resident remains in a certified part of the nursing facility:

- Bill type: 212 or 213
- Occurrence code 22 (the date active care ended) should match the "statement covers through" date on the claim

- Covered days and charges: Business office staff should submit all covered days and charges as if the beneficiary had days available up until the date active care ended
- Patient status code = 30 (still a patient)

### 3. Benefits exhaust claim with a patient discharge:

- Bill type: 211 or 214
- Covered days and charges: Business office staff should submit all covered days and charges as if the beneficiary had days available up until the date of discharge
- Patient status code: Use appropriate code other than patient status code 30

Note: Bill type 210 should not be used for benefits exhaust claims submission.

— Ronald Orth

A beneficiary who has hospital insurance coverage (Medicare Part A) is entitled to payment made on his or her behalf for up to 100 days of covered inpatient extended care services, i.e., SNF days, during each benefit period.

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. A beneficiary is considered an inpatient of a SNF only if he or she requires and receives skilled services on a daily basis that could, as a practical matter, only have been provided in a SNF on an inpatient basis.

A SNF must submit a benefits exhaust bill every month for those residents who continue to receive a skilled level of care, and also when there is a change in the level of care.

CMS has identified two different types of benefits exhaust claims:

**1. Full benefits exhaust claims** in which no benefit days remain for the submit-

ted from/through date on the submitted claims.

**2. Partial benefits exhaust claims** in which one or more benefit days in the beneficiary's applicable benefit period remain for the submitted from/through date on the submitted claims.

CMS requires nursing homes to submit both of these types of bills in order to extend the beneficiary's applicable benefit period posted in the Common Working File.

CMS also requires that all days be billed as covered days and charges to allow the Common Working File to assign the correct benefits exhaust denial to the claim and appropriately post the claim to the resident's benefit period.

### New time frame

SNF providers must submit no-payment bills for beneficiaries who have previously received Medicare-covered care and subsequently dropped to a non-covered level of care, but they continue to

reside in a Medicare-certified facility.

The date active care ended (occurrence code 22) will determine the date your facility should begin billing no-pay bills.

You will no longer need to submit SNF no-pay bills on a monthly basis, CMS instructs. Facilities may still choose to submit them monthly or they may send one final discharge bill spanning a longer period of time. CMS recommends you submit no-pay bills at least once per year.

Regardless of the timeframe of the final discharge claim, CMS does require the claim to report all days and charges for the time being billed, starting with the date active care ended. **cltc**



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