POLARIS PULSE®

A Bi-monthly Informational Bulletin Brought To You By Polaris Group

CMS Issues Guidance for Benefits Exhaust and No-Payment Bills

A Skilled Nursing Facility (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. These bills are required in two situations: 1) when the beneficiary has exhausted his/her 100 covered days under the Medicare SNF benefit (referred to as benefits exhaust bills) and 2) when the beneficiary no longer needs a Medicare covered level of care (referred to as no-payment bills).

Center for Medicare and Medicaid Services (CMS) recognized that bill submission in benefits exhaust and no-payment situations have varied across Fiscal Intermediaries. In response, CMS has issued instructions to provide a single consistent billing process for all contractors. These instructions will apply to residents who are in a Part A stay on or after October 1, 2006.

During the June SNF Open Door Forum call, CMS confirmed that facilities will not be required to process bills for services prior to that date. CMS realized asking facilities to go back years to "catch up" may be burdensome. The process applies to beneficiaries admitted to a Part A stay on or after October 1, 2006 and beneficiaries in a current Part A stay on October 1, 2006.

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.

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.

CMS provided the below billing guidance for providers to follow 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 (ie. 211, 212, 213 or 214 for SNF and 181, 182, 183 or 184 for Swing Bed (SB).

For more information, please contact your Polaris Group representative.

© POLARIS GROUP, 2006, 5431 Nellie Davis Lane, Tampa, FL 33634 813-886-6500, www.polaris-group.com

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

© POLARIS GROUP, 2006, 5431 Nellie Davis Lane, Tampa, FL 33634 813-886-6500, www.polaris-group.com

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).

PROVIDER REVALIDATION

On June 20, 2006, CMS will implement a Provider Revalidation rule. Beginning the summer of 2007 all current providers will be required to complete provider revalidation information every 5 years. CMS will mail a pre-completed Form 855 to one fifth of the provider population annually. The form will include the information currently available in the CMS database. The provider will be allowed 60 days to review the information, correct errors / outdated information, complete any missing information, sign and return the form to CMS.

New providers within the last year will likely be the last group to receive a revalidation request (2011). Current providers for whom CMS has missing information will likely be in the first group to receive revalidation requests (2007). Effective May 15, 2006, new provider enrollment applications (Form 855) must include a National Provider Identifier number (NPI). Current providers must have an NPI no later than May 23, 2007. CMS encourages current providers to obtain their NPI as early as possible.

SOLUTION CENTER Q&A

"Where No Question Goes Unanswered"

Q: Does Restorative Nursing qualify as a Medicare Part A skilled service?

A: Chapter 8, Section 30.6 of the Medicare Benefit Policy manual states: "In instances when a patient requires a skilled restorative nursing program to positively impact his functional well-being, the expectation is that the program be rendered at least 6 days q week. (Note that when a patient's skilled status is based on a restorative program, medical evidence must exist to justify the services. In most instances, it is expected that duration of a skilled restorative program last only a couple of weeks.)" Restorative may be a qualifying skilled service if these requirements are met.

TELECONFERENCE TRAININGS

Polaris Group is pleased to present the following ***CEU approved*** teleconference trainings

Live Teleconference Trainings

Topic	Date
Medicare Billing Practicum	6/13
Quality Indicator/Measure Report	6/15
Consolidated Billing	6/20
Behavior Assessments and Care Planning	6/21
Super Supervisor	6/22
New Activity Protocol and Psychosocial	6/28
Falls Management	7/6
Medicare Skilled Nursing Documentation	7/11
Event Management	7/12
Pressure Ulcer Management	7/13
Section I, J, O, and W	7/18
Med. Director and QAA Protocol	7/19
Urinary Incontinence	7/20
Part B Cap and Billing	7/25
How to have a successful FI Review or Appeals	7/25
QA Audits: What To Do When	7/26
Pain Management	7/27
Managing New Adm. & Acute Episodics	7/27

Please join us in our Teleconferences .
For further information regarding these seminars, please contact the
Seminar Department at: 800-275-6252 ext. 233
Or register at: www.polaris-group.com

POLARIS GROUP
Strategic solutions for health care

POLARIS PULSE is a bi-monthly, informational newsletter distributed to **POLARIS GROUP** clients. For further information regarding services or information contained in this publication, please contact **POLARIS GROUP** corporate headquarters at 800-275-6252.

Contributors:
Gayle Atherton
Victor Kintz
Marty Pachciarz

Editor:
Chuck Cave

Production Manager
Cindy Hernandez

For more information, please contact your Polaris Group representative.