

Neighborhood Health Plan of Rhode Island

Skilled Nursing Facility Reference Guide

Providers must ensure claims are submitted in accordance with the applicable requirements in the [Medicare Claims Processing Manual](#).

Skilled Nursing Facility Stays

- Medicare Part A covers Medicare-certified skilled nursing facility (SNF) skilled care. Skilled care is nursing or other rehabilitative services, provided according to physician orders that require skills of qualified technical or professional health personnel, like:
 - Registered nurses
 - Licensed practical or vocational nurses
 - Physical therapists
 - Occupational therapists
 - Speech-language pathologists or audiologists
- Skilled nursing or skilled rehabilitation personnel, or others under their general supervision, provide:
 - Supervision requiring initial direction and periodic inspection of the actual activity
 - Services that an assistant performs when a supervisor isn't always physically present or at the location
- A service is considered skilled if, because of its complexity, you can only perform it safely and effectively by, or under the supervision of, skilled nursing or skilled rehabilitation personnel.

Coverage Guidelines – Part A

Enrollees must meet these conditions to qualify for Part A-covered SNF services:

1. Patient was a hospital inpatient for a medically necessary stay of at least 3 consecutive calendar days. Time spent in observation or in an emergency department **doesn't** count toward a medically necessary 3-day qualifying inpatient hospital stay
2. Patient transfers to a Medicare-certified SNF within 30 days after discharge, unless both are true:
 - Patient's condition is medically inappropriate for starting active treatment in a SNF immediately after discharge
 - It's medically predictable at the patient's hospital discharge that they'll need covered SNF care within a predetermined period, and they meet that prediction
3. Patient needs daily skilled nursing or rehabilitation services

Coverage Guidelines – Part A (continued)

Daily skilled services happen **only** in a SNF on an inpatient basis if:

- They aren't available on an outpatient basis in the patient's location
- Compared to an inpatient setting, transportation to a facility is:
 - An excessive physical hardship
 - Less economical
 - Less efficient or effective
- Services are reasonable and necessary for diagnosing or treating a patient's qualifying condition and of reasonable duration and quantity

Benefit Period

- SNF coverage is based in benefit periods, sometimes called “spells of illness.” It starts the day a hospital or SNF admits a patient as an inpatient.
- A benefit period ends after a patient isn’t an inpatient of a hospital or SNF for 60 consecutive days. Once a benefit period ends, a new benefit period starts when a hospital or SNF admits a patient. New benefit periods don’t start with a change in diagnosis, condition, or CY.
- SNFs need to understand benefit periods because sometimes they must submit claims even when they don’t expect payment. This ensures proper tracking used to verify SNF benefit periods and patient information.

Consolidated Billing

In the Balanced Budget Act of 1997, Congress mandated that payment for the majority of services provided to beneficiaries in a Medicare covered SNF stay be included in a bundled prospective payment made through Part A to the SNF.

These bundled services are billed by the SNF in a consolidated bill. Medicare beneficiaries can either be:

- in a Part A covered SNF stay which includes medical services as well as room and board, or
- in a Part B non-covered SNF stay in which the Part A benefits are exhausted, but certain medical services are still covered though room and board is not.

The Consolidated Billing requirement confers on the SNF the billing responsibility for the entire package of care that residents receive during a covered Part A SNF stay and physical, occupational, and speech therapy services received during a non-covered stay.

Separately Payable Services

There are a limited number of services specifically excluded from consolidated billing, and therefore, separately payable.

For Medicare beneficiaries in a covered Part A stay, these separately payable services include:

- **physician's professional services;**
- certain **dialysis-related services**, including covered ambulance transportation to obtain dialysis
- certain **ambulance services**, including ambulance services that transport the beneficiary to the SNF initially, ambulance services that transport the beneficiary from the SNF at the end of the stay (other than transfer to another SNF), and roundtrip services furnished during the stay that transport the beneficiary temporarily to receive dialysis, or to receive certain types of intensive or emergency outpatient services;
- **erythropoietin** for certain dialysis patients;
- certain **chemotherapy drugs;**
- certain **chemotherapy administration** services;
- **radioisotope services;** and
- **customized prosthetic devices.**

Claim Submission

SNFs bill Part A using the [Medicare Uniform Institutional Provider Bill \(CMS-1450\)](#), also called UB-04, or its electronic equivalent. Send claims monthly, in order, and when the patient:

- Drops from skilled care
- Discharges
- Exhausts their benefit period

[Medicare Claims Processing Manual, Chapter 25](#) has CMS-1450 general billing information for all data elements required

Billing SNF PPS

In addition to the required fields identified in Chapter 25, SNFs must also:

- Report occurrence span code “70” to indicate the dates of a qualifying hospital stay of at least three consecutive days which qualifies the beneficiary for SNF services.
- Separate bills are required for each Federal fiscal year for admissions that span the annual update effective date (October 1).
- Use Type of Bill 21X for SNF inpatient services
- Revenue Code 0022. This code indicates that this claim is being paid under the SNF PPS. This revenue code can appear on a claim as often as necessary to indicate different HIPPS Rate Code(s) and assessment periods.
- Claims must have an occurrence code 50 (assessment date) for each assessment period represented on the claim with revenue code 0022.
- HCPCS/Rates field must contain a 5-digit “HIPPS Code”. The first three positions of the code contain the RUG group and the last two positions of the code contain a 2-digit assessment indicator

Billing SNF PPS (continued)

- SNF providers must bill the HIPPS codes on the claim form in the order in which the beneficiary received that level of care.
- Service Units must contain the number of covered days for each HIPPS rate code.
- Total Charges should be zero for revenue code 0022.
- When a HIPPS rate code of RUAxx, RUBxx, RUCxx, RULxx and/or RUXxx is present, a minimum of two rehabilitation therapy ancillary codes are required (revenue code 042x and/or, 043x and/or, 044x). When a HIPPS rate code of RHAxx, RHBxx, RHCxx, RHLxx, RHXxx, RLAxx, RLBxx, RLXxx, RMAxx, RMBxx, RMCxx, RMLxx, RMXxx, RVAxx, RVBxx, RVCxx, RVLxx, and/or RVXxx is present, a minimum of one rehabilitation therapy ancillary revenue code is required (revenue code 042x, 043x, or 044x). Bills that are missing required rehabilitation therapy ancillary revenue codes will be denied.

Skilled Nursing Billing Requirements



At a minimum, providers must ensure claims are submitted in accordance with the applicable requirements in the [Medicare Claims Processing Manual](#).

| UB-04 Field | Report |
|---|---|
| Form Locator (FL) 04 Type of Bill (TOB) | 21X for SNF inpatient services 18X for hospital swing bed services |
| FL 06 Statement Covers Period | From date must be admission date or, for a continuing stay bill, the day after the previous bill date. Through date is the last day of the billing period. |
| FL 31–FL 34 Occurrence Code and Date | 50 with the assessment reference date for each assessment period on claims with revenue code 0022. 70 with dates of the 3-day qualifying stay when applicable. |
| FL 42 Revenue Code | 0022 to show submission of the SNF PPS claim. |

Skilled Nursing Billing Requirements



At a minimum, providers must ensure claims are submitted in accordance with the applicable requirements in the [Medicare Claims Processing Manual](#).

| UB-04 Field | Report |
|-------------------------------------|--|
| FL 44 HCPCS/Rate/HIPPS Rate Code | HIPPS rate code. Codes must be in the same order the patient received that level of care. |
| FL 46 Units of Service | Number of covered days for each HIPPS rate code. |
| FL 47 Total Charges | Zero for 0022 revenue code lines. |
| FL 67 Principal Diagnosis Code | ICD-10-CM code for the principal diagnosis. |
| FL 67A–FL 67Q Other Diagnosis Codes | ICD-10-CM codes for up to 8 other conditions. |

Ending a 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. 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:
 - Submit a final discharge bill, and
 - 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 has ended:
 - 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;
 - Any Part B covered services rendered and billed by the SNF after the skilled care ended should be submitted on a 22x; and
 - 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

Benefits Exhausted

When benefits exhaust, continue submitting monthly bills if the patient stays in a Medicare-certified area of the facility. Benefits can exhaust:

- **Fully** — Patient had no benefit days available between the **From** and **Through** dates on the claim
- **Partially** — Patient had benefit days available between the **From** and **Through** dates on the claim

There are different types of benefit exhausts situations. Medicare provides the following guidance in their Medicare Learning Document entitled “**Skilled Nursing Facility Billing Reference**”.

Benefits Exhausted

| If.... | Then... |
|---|--|
| Patient moves to a non-Medicare-certified area of the institution | <p>Discharge them using the correct discharge status code.</p> <p>If appropriate, the claims processing system applies an A3 occurrence code with the last day the patient had benefits.</p> <p>Report:</p> <ul style="list-style-type: none">• Covered TOB except for 210 or 180• HIPPS ZZZZZ• Occurrence span code 70 with qualifying hospital stay dates• Covered days and charges as if the patient had days available• Value code 09 (first year coinsurance amount) = \$1• Patient status code <p>Don't submit Part B services with TOB 22X until the benefits exhaust claim processes. Submit Part B services delivered after skilled care ended, including therapy, on a TOB 22X.</p> |

Benefits Exhausted

| If.... | Then... |
|---|--|
| Patient drops to a non-skilled level of care while benefits exhaust and stays in a Medicare-certified area of the institution | <p>Report:</p> <ul style="list-style-type: none">• TOB 212 or 213 for SNF and 182 or 183 for swing bed; don't report TOBs 210 or 180• Occurrence span code 70 with qualifying hospital stay dates• Occurrence code 22 with date covered SNF care ended• Covered days and charges as if the patient had days available• Value code 09 (first year coinsurance amount) = \$1• Patient status code 30 (still patient) <p>Submit Part B services delivered after skilled care ended, including therapy, on a TOB 22X.</p> |

Benefits Exhausted

| If.... | Then... |
|--|--|
| <p>Patient drops to a non-skilled level of care while benefits exhaust and moves to a non-Medicare-certified area of the institution or otherwise discharges</p> | <p>Report:</p> <ul style="list-style-type: none"> • TOB 211 or 214 for SNF and 181 or 184 for swing bed; don't report TOBs 210 or 180 • Covered days and charges as if the patient had days available • Value code 09 (first year coinsurance amount) = \$1 • Patient status code, use appropriate code other than patient status code 30 <p>Submit Part B services delivered after skilled care ended, including therapy, on a TOB 23X.</p> |

Custodial Claims

Claims are reimbursed for custodial nursing facility services in accordance with patient-driven payment model (PDPM) state fee-for-service rates.

- 837 Institutional file format (UB-04)
- Type of bill 26X
- Revenue code 0100 with the corresponding PDPM-HIPPS code for the member
- Billing guidelines require the 5-digit HIPPS code

PDPM 5 Character HIPPS Code Breakdown

- Character 1: PT/OT Payment Group
- Character 2: SLP Payment Group
- Character 3: Nursing Payment Group
- Character 4: NTA Payment Group (Non-therapy Ancillary) based on comorbidities
- Character 5: Assessment Indicator (e.g. “1” for 5-day assessment, “0” for IPA (Interim Payment Assessment))

Coverage Guidelines – Part B

When a patient's SNF Part A coverage is disqualified, Consolidated Billing rules don't apply. The following situations are reasons for disqualification:

- Part A benefits exhaust
- No qualifying 3-day hospital stay
- Level-of-care requirement not met

There's no comprehensive institutional coverage as under Part A for a non-covered Part B stay. The patient may qualify for Part B medical coverage and other individual services:

- Outpatient hospital services to patients who aren't SNF inpatients:
 - Diagnostic tests like diagnostic X-rays or lab tests
 - Physical therapy, occupational therapy, or speech-language pathology services
 - Physician and surgeon services
- Services excluded from SNF PPS and SNF CB
- Certain medical and other health services to patients residing in a SNF whose Part A benefits exhausted or who aren't otherwise entitled to Part A payment
- Therapy services edited as inclusions, rather than exclusions, to consolidated billing.

Resources

Neighborhood Health Plan of RI

- [Skilled Nursing Facility Payment Policy](#)

Center for Medicare and Medicaid Services (CMS.Gov)

- [SNF Consolidated Billing](#)
- [SNF Consolidated Billing web-based training](#)
- [Medicare claims Processing Manual, Chapter 25](#) (CMS-1450 general billing information on how to complete the data sets for this form type)
- [Medicare Claims Processing Manual, Chapter 6](#)
- [Medicare Benefit Policy Manual, Chapter 8](#)
- [Medicare Claims Processing Manual, Chapter 7](#)