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SNF BENEFITS EXHAUST AND NO PAYMENT BILLING

Computer Based Training



Agenda

- Background
- Benefits Exhaust Billing Situations
 - claim examples
- No-Payment Billing Situations
 - claim examples
- Resources

During this presentation, I will give a brief overview of SNF Benefits Exhaust and No-payment billing background, followed by the corresponding claim examples.

Objective

- *To Better Understand:*
 - How to bill when benefits exhaust
 - How to bill when the level of care changes
 - What constitutes a “no-payment” bill

At the conclusion of this training session you should be able to understand how to correctly send bills to Medicare when a resident's Medicare benefits exhaust and when their level of care changes.

Background

- Since 01/01/05, CMS has required SNFs to submit a *monthly* bill for a beneficiary who:
 - Started a spell of illness under the SNF Part A benefit, even though no benefits may be payable
- CMS maintains a record of all inpatient services for each beneficiary, whether covered or not
 - The information is used for national healthcare planning, and
 - To track the benefit period

Background Continued

- Prior to this requirement, providers were allowed to submit one “No Payment Bill” from the first non-covered day through the date of discharge.
- After some investigation, CMS had found that providers were seldom, if ever, submitting the final discharge claims.
- The reinforcement of this requirement is to:
 - Gather information for national healthcare planning
 - Help track benefit periods, and
 - Allow providers to collect from secondary payers or other insurers without having to wait until the discharge claim is submitted.

New Requirement Effective 10/01/06

Per Change Request (CR) 4292:

- When benefits exhaust and the patient remains at a skilled level of care:
 - a *monthly covered claim* is submitted through discharge, or until there is a level of care change *after* the benefits are exhausted
- After a level of care change, providers submit “no-pay” claims in one of two ways:
 - *Monthly* if denial for another insurer is needed, or
 - *One* “no-pay discharge claim” from day after level of care change through discharge if denial for another insurer is not needed

Benefits Exhaust Billing

Benefits Exhaust and the Patient is Still Skilled

- SNF providers must submit *monthly covered* "benefits exhaust claims" for beneficiaries who continue to receive skilled services
- There are two types of benefits exhaust:
 - Full benefits exhaust - when no days remain in the billing period
 - Partial benefits exhaust - when the beneficiary has one or more days left in their benefit period and the facility will bill for the remaining days

What Coding is Needed on Partial or Full Exhaust Claim?

- Type of bill must be a covered bill type
 - 211, 212, 213 or 214
- Days and charges billed as covered, as if patient had days available:
 - No "A3" date
 - No split billing
- Coinsurance days
- Value code 09 or value code 11 with 1.00 in the amount field
- Appropriate patient status code

Partial Benefits Exhaust

- This claim example demonstrates how a benefits exhaust claim would be billed when the resident's benefits are partially exhausted (i.e., some of the days in the billing period are covered and some are not).

Claim Example #1

Partial Exhaust

- Screen 1

```

SC          UB92 CLAIM ENTRY          SV
HC 99999999A  T08 212  SLOC 8 B0100  PROVIDER 999999  UB-FORM
TRANSFERRING RESPIRE PROVIDER        PROCESS NEW HC
PATIENT CONTROL NBR 88888888M        FED TAX NO      TAX SUB
STMT DATES FROM 100106 TO 103106     DAYS COV 31     CO 20  LTR
LAST NAME        FIRST NAME          ME            D-OB 08211908
ADDR:            1 5500 MAIN STREET    2 APT. #94
                3 ORANGEVALE, CA      4
                5                        6
ZIP 95662  SEX M  MS W  ADMIT DATE 100106  HE  TYPE 3 SRC 1  D HM  STAT 30
COND CODES 01 02 03 04 05 06 07 08 09 10
OCCUR DATE 01 02 03 04 05 06 07 08 09 10
                06 07 08 09
SPAN CODES DATES 01 70 092006 100106      02
04 05 06 07 08 09 10
DCN
                VALUE CODES - AMOUNTS - ANSI  MSP APP END
01 09 1.00      02 03 04 05 06 07 08 09
PLEASE ENTER DATA
PRESS PF3-EXIT PF5-SCROLL BEWD PF6-SCROLL FWD PF7-PREV PF8-NEXT
    
```


Benefits Exhaust and the Level of Care Changes Within the Month

- We will now review how to submit a benefits exhaust claim when the patient's level of care changes within the month.

Claim Example #3

- This example demonstrates how you would bill for a patient who had exhausted their benefits, and the level of care changed within the same month. In this example the patient's active care ended on 11/15/06, as indicated by Occurrence Code 22.
- The type of bill is a 213.
- The covered days are 15 days because the from and through dates are 11/01/06 through 11/15/06.
- Coinsurance days would be 15 days. NOTE: CWF will look to see how many days are remaining in the Benefit Period. If no days remain, CWF will respond that no days remain, and a Benefits Exhaust denial will be given.
- Patient status is 30.
- Value code 09 is coded with \$1.00 in the amount field. Common Working File (CWF) will assign the correct coinsurance amount based off the CWF response).

Benefits Exhaust and Level of Care Changed Within the Month

- FISS Screen 1

```

SC          UB92 CLAIM ENTRY          SV
HC 999999999A  TOB 213  SLOC $ 10100  PROVIDER 999999  UB-FORM
TRANSFER/DG HOSPICE PROVIDER          PROCESS NEW HC
PATIENT CONTROL NBR 888888888M          FED TAX NO          TAX SUB
SITE DATES FROM 110106 TO 111506          DAYS COV 15  N-C          CO 15  LTR
LAST BAKER          FIRST ROMNEY          MI          DOB 08111908
ADDR 1 5600 MAIN STREET          2 APT. #94
      2 ORANGEVALE, CA          4
      5
ZIP 95662  SEX M          MS W          ADMIT DATE 100106  HR TYPE3 SRC 1  D HM          STAT 30
CORD CODES 01 02 03 04 05 06 07 08 09 10
OCC CODE DATE 012 111506
05
SPAN CODES DATES 01 70 092006 100106          02          09          10
03
04          05          06          07
08          09          10
DCN
01 09 1.00          VALUE CODES - AMOUNTS - ANSI          MSP APP IND
04          05          06          07
07
PLEASE ENTER DATA
PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD PF7-PREV PF8-NEXT
    
```

Benefits Exhaust and Level of Care Changed Within the Month

- FISS Screen 2

```

SC          UB92 CLAIM ENTRY          KEY CD PAGE 01
HC 999999999A  TOB 213  SLOC $ 10100  PROVIDER 999999
CL REV  HCFC MODIF5  RATE  TOT  COV  TOT CHARGE  NOOV CHARGE  SERV DT
1 0022  AA00          00015  00015  7750.00
2 0110          250.00  00015  00015  7750.00
3 0001
PROCESS COMPLETED --- PLEASE CONTINUE
PRESS PF2-171D PF3-EXIT PF5-UP PF6-DOWN PF7-PREV PF8-NEXT PF9-UP/DN PF11-830RT
    
```

How Do We Bill When Benefits Exhaust With a Patient Discharge?

- Provider should bill through the date that the patient discharged
 - Type of bill should be a 211 or 214
 - Days and charges are billed as covered, as if the patient had days available
 - Date of discharge is not counted as a day
 - Coinsurance days
 - Value code 09 or value code 11 with 1.00 in the amount field
 - Appropriate patient status code, other than 30

Benefits Exhaust With a Patient Discharge

- We will now review how to submit a benefits exhaust claim when a patient discharges.

Test Your Knowledge

When a patient exhausts benefits but still resides in a Medicare bed at a skilled level of care, the provider would "split bill" the claim for that month.

- A. TRUE
- B. FALSE

This is false. When a patient exhausts benefits and remains at a skilled level of care, the provider must bill a covered claim for the entire billing period and every month thereafter until discharge or until the level of care changes (see slide #8).

After the first benefits exhaust claim has processed, you may submit one claim when the patient discharges.

- A. TRUE
- B. FALSE

This is false. When benefits exhaust, providers must submit a *monthly covered claim* until discharge or until the level of care changes (see slide #5, 7 and 9).

Benefits Exhaust claims should be submitted on a covered bill type (211, 212, or 213).

- A. TRUE
- B. FALSE

This is true. Benefits Exhaust claims must be submitted as a covered claim (see slide #8).

When a resident's level of care changes during the month, the claim must be billed through the entire month, with covered and non-covered charges on the claim.

- A. TRUE
- B. FALSE

This is false. When a resident's level of care changes during the month, the provider must bill only through the last covered day and then begin the no-payment claims the day after the level of care changes (see slide # 23).

Test Your Knowledge

The reinforcement of this requirement will help track benefit periods as well as allow providers to

collect from secondary payers or other insurers without having to wait until the discharge claim is

submitted.

- A. TRUE
- B. FALSE

This is true. Following the requirements of CR 4292 allows CMS to track benefit periods and it allows providers to collect from other insurers (see slide #4).

Prior to this new requirement providers were not required to submit no-pay bills.

- A. TRUE
- B. FALSE

This is false. Providers have always been required to submit no-pay bills. CR 4292 simply clarifies when and how they must be submitted.