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**Medicare Billing and MDS 3.0**

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**Q: When going from a 214 to a 210 (no payment claim), what do you use as patient status on the 214 and what special codes do you use on the 210?**

**A:** A 214 Type of bill is a discharge claim and would not require a 210 if the resident was no longer in house at the end of the Medicare Part A stay. You would use a 213 Type of Bill with a 30 day status and a 22 occurrence code to identify the last covered day.

**Q: We have a resident that was admitted 4/20/10. The resident went to the hospital 4/17 and admitted but was in the ER until 4/18. Does that cover the 3-day hospital stay?**

**A:** No. Those days spent in the ER are not considered inpatient status. Only three consecutive INPATIENT days meet the technical requirements.

**Q: How do the overnight observation admissions into a hospital affect the benefit period?**

**A:** The key word is admission. If a patient is admitted to an inpatient facility this breaks the period that can be counted towards rejuvenating the patients benefit period. Upon discharge we would began counting at day one towards the 60 day period of non skilled care.

Observation stays do not meet the three day qualifying stay criteria and would not be considered an "admission" on the SNF stay claim. Be careful when checking your hospital admission dates. A patient may have been in "observation" for long periods of time. We have heard of hospitals keeping patients in "observation" without admission for up to 13 days. You can no longer assume that patients with long hospital stays were actually admitted. Your Admission Department should be alert to this.

**Q: How do you access the CWF?**

**A:** Via a secure platform such as Vision Share or IVANs.

**Q: If the Resident is transferred to a LTC (NF) unit, can they re-up their days if they stay in the NF for 60 days?**

**A:** Yes, as long as the resident remains at a NON-skilled level of care (LOC) and does not return to the hospital. 210 claims need to be filed during the NON-skilled stay.

**Q: Do I still need to submit a no pay claim when the patient is not skilled anymore? All our beds are skilled even if a patient is not.**

**A:** Yes, a NO pay bill is to report NON-skilled days after a skilled stay regardless of bed certification.

**Q: Can you please explain the SNF requirement submit claims for beneficiaries even though no benefits may be payable?**

**A:** The requirement stems from the Medicare program's attempt to track the benefit period of each Medicare beneficiary. No pay and benefit exhaust claims provide information to the intermediaries/MAC to determine the days used in a benefit period and when the beneficiary can start to renew their days.

No pay bills and exhaust claims are required as follows:

- **NO PAY**-After a skilled stay when a resident is not at a skilled LOC. Submit 210 claims until discharge.
- **EXHAUST**-After 100 days are exhausted and the resident remains in the facility at a skilled LOC, submit 213 claims until discharge or until the resident is not at a skilled LOC. Then, file NO PAY claims until discharge.

**Q: For MA plans who are contracted with an entity so that our billing goes through that entity rather than directly to the MA, who is responsible for billing exhaust claims to Medicare? Who is responsible for submitting the informational claims to Medicare, the contracted entity or the SNF?**

**A:** Ultimately the facility is required to submit the claims. Look at your contract...but if you do not have access to Medicare for claims submission, you could bill through the third party administrator (TPA).

**Q: Are the Managed care benefits exhaust claims being sent to Medicare or to the Managed care itself?**

**A:** Medicare requires MA notification claims while the resident is skilled. You are not required to submit NO PAY claims after Managed Care skilled care benefit ends.

**Q: Are you saying that if a resident has, for example Pacificare that has replaced Medicare Part A, that we have to submit BE bills from the day of admit?**

**A:** Yes- MA notification claims are required to report the skilled days for Medicare Advantage beneficiaries.

**Q: If all of your beds in the facility are certified skilled under Medicare and a self pay resident is in a certified bed and if they go to the hospital for 3 days then are they eligible for Part A benefits?**

**A:** If they have Medicare Part A entitlement, have a 60 day break in skilled care prior to the hospitalization and the hospital stay is three consecutive midnights as an INPATIENT then, yes they are eligible for Part A benefits.

**Q: When a person uses the full 100 days and remains skilled, do they have to remain in a Medicare certified bed?**

**A:** Not necessarily, but if they remain at a skilled LOC then you must file Benefit Exhaust claims to Medicare.

**Q: Are you saying that a resident cannot change to Part B from a Part A stay if the Part A has not been exhausted?**

**A:** No, but you cannot bill Part B for services during a Part A stay.

**Q: A benefits exhaust claim is a one- time submission after benefits are exhausted but then the following month you need to submit a NO Pay claim on that person every month until they leave the facility, correct? Can the benefit exhaust claim be submitted on two different claims if the benefits exhaust in the same month or does it have to be submitted on one claim for the month?**

**A:** Two issues:

- A benefit exhaust claim is a “covered” claim and must be submitted monthly until the resident is no longer at a skilled LOC. Once the LOC changes, the facility MUST submit monthly NO PAY claims until discharge.
- Usually, Benefit exhaust claims are combined with the final claim.

**Q: Could you clarify: If a resident enters the SNF covered by Medicare and uses 15 days, then when coverable services end, changes over to Medicaid for 60 days, but then falls and fractures a hip resulting in a 3+ day hosp stay for repair - are they eligible for Medicare Part A coverage on readmission, Medicare Part B or other?**

**A:** In this scenario, the resident is eligible for a new 100 day benefit period (since they met the requirement of having a 60 day break after skilled care ended).

**Q: Is there anywhere I can find a list of what is considered “Skilled Care”?**

**A:** This is a clinical decision upon admission and requires a physician certification.

**Q: What is the billing code for the Med A Benefit Exhaust claim?**

**A:** 213 Type of Bill/ 30 status code. Revenue Code 022 with AAA00 RUGS/HIPPS. Revenue Code 120 with covered days and charges.

**Q: If a resident goes to the hospital, do you have to do a new MSP for all readmissions or just Medicare A and B readmissions?**

**A:** Yes, Medicare Part A and Part B admissions/re-admissions require a new MSP questionnaire.

**Q: Can you tell me where I could find the forms to determine if the beneficiary had black lung etc.**

**A:** Entitlement to MSP programs can be found in the CWF record for the beneficiary. The MSP questionnaire helps to determine this also.

**Q: Is there a good MSP questionnaire that you could recommend and/or make available to us?**

**A:** Check your Fiscal Intermediary (FI) website for MSP questionnaire examples.

**Q: Is there a specific bill type when billing for conditional payment or would you use the original bill type?**

**A:** Original Type of Bill. Conditional Claims require a condition code to describe why the primary insurance has not paid.

**Q: Is there a maximum number of days that a hospital can classify a patient as an "observation stay"? We have seen as many as 8 days listed as observation on some of our admissions from the hospital.**

**A:** At this time there is no limit however providers are raising this as an issue with CMS. Your Admissions department should be alerted to check that a hospital stay was in fact an admission and not just observation. An observation stay of more than three days does not meet the criteria for a "qualifying three day hospital stay".

**Q: Are they planning on getting rid of the grace days along with the look back period?**

**A:** No.

**Q: Please explain the recalibration of concurrent therapy minutes and limiting treatment to two patients.**

**A:** The total minutes are documented for each resident on the MDS in concurrent therapy the minutes are divided in  $\frac{1}{2}$ . This is because the therapist is working with 2 patients at the same time. (See page 0-18 MDS RA13.0)

**Q: All of our beds are Medicare certified. Does that mean that if any of our residents drop to a non-covered level of care in mid month we must bill no pay for the remainder of that month?**

**A:** Yes, and every month thereafter until the resident discharges from your facility.

**Q: If someone is on observation in the hospital, does this affect benefit period?**

**A:** Observation days do not meet the three day qualifying stay technical requirement because these are not in-patient days. You cannot use the observation days for a SNF Part A claim.

**Q: How do you determine when to stop the no pay claims? If you don't have a different section for skilled or non-skilled, do you stop the no pay claims when the patient is no longer receiving skilled care based on MCR guidelines?**

**A:** NO-Pay claims are to be submitted to Medicare until the resident discharges from the facility.

**Q: It was mentioned that there is no more look back dates for Medicare assessments. Does that mean that only care provided in the facility will be included in the MDS assessment?**

**A:** Yes.

**Q: A resident with a new PEG, are they only allowed 1 benefit period of a 100 days and never again qualify for a new benefit period?**

**A:** Yes. They cannot be re-skilled as the PEG tube requires continuous skilled LOC even after Medicare exhausts. (If the PEG tube is removed, the resident can qualify after a 60 days break in skilled care).

**Q: Is there any recourse for a SNF if more than a week after the admission, the hospital comes back and changes the 3 day stay to observation?**

**A:** No, the SNF cannot bill Medicare without a Qualifying Hospital Stay.

**Q: Assume a patient had more than 1 hospital stay in the past 60 days prior to be admitted to SNF. Do these prior stays affect Medicare A benefits?**

**A:** If there is no 60 day break, then the resident does not qualify for a new benefit period.

**Q: Where can we obtain a listing of new RUG groupings and reimbursement rates?**

**A:** The CMS website has the new RUGS info. The Federal Register has the calculation for the reimbursement. You must know your wage index in order to calculate.

**Q: CMI and Medicaid is it better to have a lower average CMI in the start and then show upgrade or higher CMI?**

**A:** The CMI reflects the relative resources to provide care to a resident. The higher the case mix weight the greater the resource requirement for the resident. Payment is linked to the intensity of resource used. (MDS3.0 RAI appendix A-6) I do not know of any regulation for this.

**Q: What does "limit to two patients" mean when recalibrating concurrent therapy minutes?**

**A:** The total minutes are documented for each resident, but because they are working with a 2 people they will receive ½ of the minutes when calibrating concurrent therapy (MDS RAI 3.0 page 6-18 &19)

**Q: If I have a patient that has insurance but does not have SNF coverage, can I file a MSP claim?**

**A:** No, MSP is a Medicare program. The Resident must have Medicare entitlement to be considered under MSP.

**Q: If a person is an observation status for 36 hours and then rolls over to inpatient, what is the real date of admission?**

**A:** The date when the patient was actually admitted to the hospital and became INPATIENT. The hospital billing office can provide this information.

**Q: Are we required to send exhaust and no-pay claims on Medicare Advantage residents to both Medicare and the Medicare Advantage Plan (Medicare Plus Blue for example)?**

**A:** You are not required to send NO Pay claims for Medicare Advantage beneficiaries, however while the resident is on a skilled stay under a Medicare Advantage plan, you must submit notification claims to Medicare to report skilled days.

**Q: If you are billing a Medicare replacement policy, do you submit anything to Medicare?**

**A:** You are not required to send NO Pay claims for Medicare Advantage beneficiaries, however while the resident is on a skilled stay under a Medicare Advantage plan, you must submit notification claims to Medicare to report skilled days.

**Q: If patient admits as ICF not billable to Medicare, do we need to send no pay bills? SNF beds are all Medicare/Medicaid dual.**

**A:** No. Not if the resident did not use Medicare Part A days in the SNF.

**Q: So there is no need to submit a no-pay bill as long as the level of care has ended?**

**A:** Benefit exhaust claims are submitted to Medicare if the LOC is skilled after the patient exhausts the 100 day benefit. When the patient is changed to a Non-skilled LOC, then NO Pay bills are to be submitted until discharge.

**Q: What do you mean when you say we need to submit no pay bills until "level of care" has changed? Could this be the duration of their lives in the SNF?**

**A:** Yes it can. NO Pay bills must be submitted until the resident discharges from the facility. This could be a long time, the duration of their life.

**Q: Please explain again about the 60 day no HOSPITAL and no SNF then they receive a new benefit period. If they leave a SNF, go home for over 60 days but had a hospital admission during that period, do they still get a new 100 days? Or do they not because the skilled service was the hospital stay?**

**A:** A 60 day break means **NO** hospitalization and **NO** SNF Part A stay. It is a 60 day break in illness.

**Q: Is a resident who has used 100 days with a g-tube, and then goes out to the hospital for 4 days with pneumonia, eligible for new entitlement due to IV meds?**

**A:** No, the G tube kept the resident at a skilled LOC, therefore there is NO 60 day break in illness and the resident cannot qualify for a new benefit period.

**Q: If a tube feeder's tube has been removed and they had previously used all of their 100 days, can they now get a new 100 days since the tube is out and they are not getting skilled services?**

**A:** Yes, as long as there is a 60 day break in skilled care prior to the new hospitalization (and all NO Pay/Benefit Exhaust claims have been filed).

**Q: In a SNF, if they remain on the Skilled unit, but are on a lower level of care, can they rebuild their benefit days up while in the Skilled section?**

**A:** If they are not at a skilled LOC and have **NO** hospitalizations for 60 days they can regenerate the 100 day benefit period provided that all NO Pay/Benefit Exhaust claims have been filed.

**Q: Who pays when a facility cares for a Medicare resident based on the CWF and then finds out that they cared for residents after benefits exhausted because the CWF was not current?**

**A:** Beneficiaries are ultimately responsible to count their own benefit days. A facility can bill the resident upon exhaust. The facility question the beneficiary upon admission about prior SNF stays to determine if all days are available. Even if the CWF was not current, asking the beneficiary (resident) or family members on admission about prior stays is an added opportunity to catch this.

**Q: The regs say something about having to have a distinct part for your Medicare skilled services. Our facility has all of our beds certified for the entire building. Does that mean we have to send no-pay claims for every bed?**

**A:** NO pay claims are required for all residents who have a Part A stay and remain in the facility at a non-skilled LOC until the resident discharges. This is regardless of bed certification.

**Q: do you have any guidelines to determine if a patient is no longer receiving skilled care Has the therapy part B caps been extended?**

**A:** Guidelines to determine if a patient is no longer receiving skilled care is a clinical decision. The exceptions to the therapy caps have been extended until 12.31.10.

**Q: For MSP, if you have a spouse working aged resident, and you did not accept a contracted amount from the primary insurance company, how do you process the claim to get the remaining balance due amount from MSP?**

**A:** Submit the claim to Medicare with Medicare as secondary. You need to indicate on the claim the amount paid by the insurance carrier. Medicare will only pay up to the amount that they would have paid if Medicare was primary.

**Q:** Resident has had feeding tube in during 100 days of skilled; dropped below level; still has tube now for over one year. Resident went to hospital for 3-night stay; returned but cannot be skilled again because medical condition did not change. What is rule of thumb for sending no pay claim?

**A:** The feeding tube would keep the resident at a skilled LOC after Medicare benefits exhausted. The facility would be filing Benefit Exhaust claims for this resident monthly and therefore the 100 days benefit period would not regenerate.

(NO Pay claims are submitted when a resident is at a Non-skilled LOC so in this scenario there would not be NO Pay claims submitted, but Exhaust claims are required until discharge)