Healthcare
SNF Compliance Claims

No Pay

Definition: CMS requires skilled nursing facilities (SNFs) to submit No Pay bills for residents who received Part A care and dropped to a non-covered level of care, *i.e.*, Medicaid or private, but continued to stay in a Medicare-certified portion of the facility.

Billing Requirements:

- Can be submitted monthly or as one claim spanning the entire No Pay time frame at discharge
- Unlike regular claims, No Pay bills can span both the provider and Medicare's fiscal year-ends
- Considered non-covered:
  - Type of bill 210
  - Condition code 21
  - Non-covered days (value code 81)
  - Non-covered charges for room and board
  - HIPPS code ZZZZZ
  - Resident status on the final claim billed at discharge should accurately reflect the correct status location

Purpose: No Pay claims are billed to allow CMS to track the location of residents. Keep in mind when billing the last Medicare claim for a resident who remains in the facility that the status code reflects there is still a resident (status code 30). Until Medicare receives a final claim with the discharge status code, it shows the resident is still in the facility. Not filing No Pay bills timely can lead to overlap issues with other providers. No Pay claims reflect non-skilled levels of care and will not impact a resident's benefit period or prevent them from receiving a new Medicare A benefit period.

Note: No Pay bills are not required for residents who are discharged off Part A to a non-Medicare certified section of the facility.

Benefits Exhaust

Definition: CMS requires Benefits Exhaust claims when a resident exhausts their 100 Part A covered days but remains at a Medicare-covered level of care.

There are two types of benefits exhaust claims:

- Full exhaust where no benefit days remain, and the entire claim is considered benefits exhausted
- Partial benefits exhaust where some days remain, and the remaining days will be exhausted

Billing Requirements:

- Must submit monthly regardless of who the primary payor is
- Covered bill type
- Covered days
- Covered room and board charges
- HIPPS code (ZZZZZ can be used if no other HIPPS code exists)

Purpose: Benefits exhaust claims will prevent the resident from resetting to a new benefit period.

Note: Once the resident drops to a non-skilled level of care, the final benefits exhaust claim should reflect occurrence code 22 and the last skilled care date. If the resident remains in a Medicare certified portion of the facility, then No Pay billing requirements would come into effect.

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Medicare Advantage (MA) Informative

Definition: CMS requires MA skilled claims to be sent to original Medicare to reduce the days for skilled care from the resident's benefit period.

Billing Requirements:

- Must be sent on a monthly basis
- Billed with a covered bill type (21X)
- Condition code 04
- Covered days (value code 80)
- Covered room and board charges
- HIPPS code ZZZZZ

Purpose: MA Informative claims are required to keep the resident's benefit period accurately updated to reflect skilled days minus those paid by the MA plan. If the resident discharges from the MA plan back to traditional Medicare, they will only have what remains of their 100-day benefit period.

Note: If the resident discharges from skilled care, the final claim can show a status code 04 (versus 30) as No Pay claims are not required following an MA stay.

Skilled No Stay

Definition: CMS requires SNFs to submit claims to Medicare for beneficiaries that receive a skilled level of care, including those residents who did not qualify for a Part A stay due to not meeting the qualifying stay or transfer criteria.

Billing Requirements:

- Submitted monthly
- Billed with:
  - Covered bill type (21X)
  - Covered days (value code 80)
  - Covered room and board charges
- Since residents would not have a qualifying hospital stay, there will be no occurrence span code 70 on the bill.

Purpose: Skilled No Stay claims are required so that Medicare can accurately track the resident's spell of illness. If the resident had days remaining in their benefit period, those days would not be deducted; however, it would prevent the resident from receiving a new 100-day benefit period if 60 days of wellness were not met.

Compliance Claim Type	Type Of Bill	Condition Code	Charges	Level Of Care	Billing Frequency
No Pay	210	21	Non-Covered	Non-Skilled	Monthly Or @Discharge
Benefits Exhaust	21x	N/A	Covered	Skilled	Monthly
MA Informative	21x	04	Covered	Skilled	Monthly
Skilled No Stay	21x	N/A	Covered	Skilled	Monthly

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