DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®

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Skilled Nursing Facility (SNF) Billing Reference

Please note:
The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

Table of Contents

Medicare Part A covers skilled nursing and rehabilitation care in a Skilled Nursing Facility (SNF) under certain conditions for a limited time. This billing reference provides information for SNF providers about:

- SNF coverage;
- SNF payment;
- SNF billing; and
- Resources for more detailed information.

SNF Coverage

Coverage Requirements

To qualify for Medicare Part A coverage of SNF services, the following conditions must be met:

- The beneficiary was an inpatient of a hospital for a medically necessary stay of at least 3 consecutive days;
- The beneficiary transferred to a participating SNF within 30 days after discharge from the hospital (unless the beneficiary's condition makes it medically inappropriate to begin an active course of treatment in a SNF immediately after discharge and it is medically predictable at the time of the hospital discharge the beneficiary will require covered care within a predictable time period);
- The beneficiary requires skilled nursing services or skilled rehabilitation services on a daily basis. Skilled services must be:
  - Performed by or under the supervision of professional or technical personnel;
  - Ordered by a physician; and
  - Rendered for an ongoing condition for which the beneficiary had also received inpatient hospital services or for a new condition that arose during the SNF care for that ongoing condition;
- As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF; and
- The services delivered are reasonable and necessary for the treatment of the beneficiary's inpatient illness or injury and are reasonable in terms of duration and quantity.

Skilled Services

Skilled nursing and skilled rehabilitation services are those services furnished pursuant to physician orders that:

- Require the skills of qualified technical or professional health personnel, such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, and speech-language pathologists or audiologists; and
- Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the beneficiary and to achieve the medically desired result.

NOTE: For more information, refer to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLN MattersArticles/Downloads/ MM8458.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

Benefit Period

Coverage for care in SNFs is measured in "**benefit periods**" (sometimes called a "spell of illness"). In each benefit period, Medicare Part A covers up to 20 days in full. After that, Medicare Part A covers an additional 80 days with the beneficiary paying coinsurance for each day. After 100 days, the SNF coverage available during that benefit period is "exhausted," and the beneficiary pays for all care, except for certain Medicare Part B services.

A benefit period begins the day the Medicare beneficiary is admitted to a hospital or SNF as an inpatient and ends after the beneficiary has not been in a hospital (or received skilled care in a SNF) for 60 consecutive days. Once the benefit period ends, a new benefit period begins when the beneficiary has an inpatient admission to a hospital or SNF. New benefit periods do not begin due to a change in diagnosis, condition, or calendar year.

Understanding the benefit period is important because SNFs must sometimes submit claims for which they do not expect to receive payment to ensure the benefit period is properly tracked in the Common Working File (CWF).
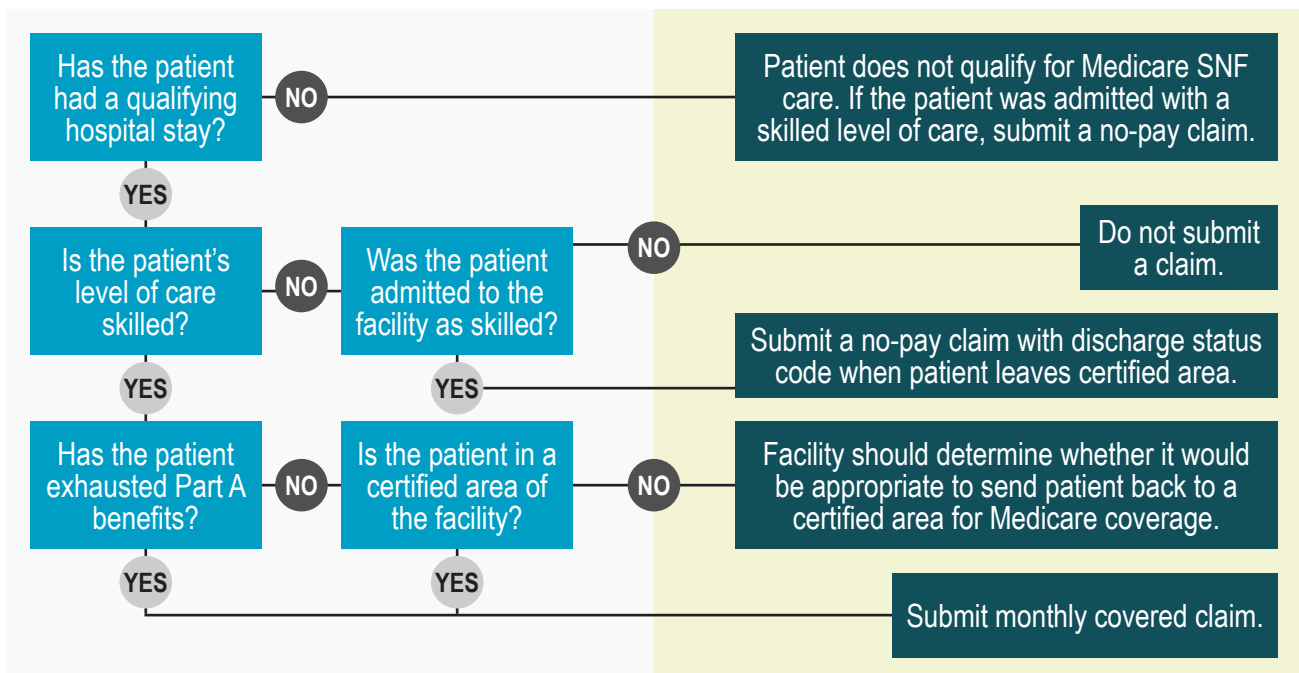
Common Working File (CWF)

The CWF contains information about Medicare beneficiaries that Medicare Administrative Contractor (MAC) claims processing systems access to ensure proper payment of claims. The CWF tracks the SNF benefit period.

Figure 1 helps you understand the relationships between coverage, skilled care, the benefit period, and whether you submit a claim to Medicare.

Figure 1. Summary of SNF Coverage and Billing

Has the patient had a qualifying hospital stay? — NO → Patient does not qualify for Medicare SNF care. If the patient was admitted with a skilled level of care, submit a no-pay claim.

YES

Is the patient's level of care skilled? — NO → Was the patient admitted to the facility as skilled? — NO → Do not submit a claim.

YES — Was the patient admitted to the facility as skilled? — YES → Submit a no-pay claim with discharge status code when patient leaves certified area.

Has the patient exhausted Part A benefits? — NO → Is the patient in a certified area of the facility? — NO → Facility should determine whether it would be appropriate to send patient back to a certified area for Medicare coverage.

YES — YES → Submit monthly covered claim.

SNF Payment

Medicare Part A

The SNF Prospective Payment System (PPS) pays for all SNF Part A inpatient services. Part A payment is primarily based on the Resource Utilization Group (RUG) assigned to the beneficiary following required Minimum Data Set (MDS) 3.0 assessments. As a part of the Resident Assessment Instrument (RAI), the MDS 3.0 is a data collection tool that classifies beneficiaries into groups based on the average resources needed to care for someone with similar needs. The MDS 3.0 provides a core set of screening, clinical, and functional status elements, including common definitions and coding categories. It standardizes communication about resident problems and conditions.

Consolidated Billing

Under the consolidated billing provision, SNF Part A inpatient services include all Medicare Part A services considered within the scope or capability of SNFs. In some cases, the SNF must obtain some services it does not provide directly. For these services, the SNF must make arrangements to pay for the services and must not bill Medicare separately for those services.

Medicare Part B

Medicare Part B may pay for:

- Some services provided to beneficiaries residing in a SNF whose benefit period exhausted or who are not otherwise entitled to payment under Part A;
- Outpatient services rendered to beneficiaries who are not inpatients of a SNF; and
- Services excluded from SNF PPS and SNF consolidated billing.

General Payment Tips

- Medicare will not pay under the SNF PPS unless you bill a covered day.
- Ancillary charges are only allowed for covered days and are included in the PPS rate.

Consolidated Billing Resources

For more information, visit http://go.cms.gov/MLNGenInfo on the CMS website and refer to the Web-Based Training courses section to learn more about SNF consolidated billing. To help you determine how consolidated billing applies to specific services, refer to the flow charts in the "Skilled Nursing Facility Prospective Payment System" fact sheet at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243671.html on the CMS website.

SNF Part B Billing

Some services must be billed to Part B. Bill repetitive services monthly or at the conclusion of treatment. Bill one-time services on completion of the service.

For more information on SNF Part B billing, refer to the "Medicare Claims Processing Manual," Chapter 7, at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c07.pdf on the CMS website.

SNF Billing Requirements

SNFs bill Medicare Part A using Form CMS-1450 (also called the UB-04) or its electronic equivalent. Send claims sequentially, monthly, and upon:

- Decrease to less than skilled care;
- Discharge; or
- Benefit period exhaustion.

NOTE: When a benefit period exhausts, continue to submit monthly noncovered claims to ensure the claims processing system accurately tracks the benefit period.

For general information on billing, refer to the "Medicare Claims Processing Manual," Chapter 25 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c25.pdf on the CMS website. In addition to the fields required for all claims, SNFs must populate the elements in Table 1 for Part A claims.

Bill in Sequence

MACs return a continuing stay bill if the prior bill has not processed. If you previously submitted the prior bill, hold the returned continuing stay bill until you receive the Remittance Advice (RA) for the prior bill.

Table 1. SNF Billing Requirements

UB-04 Field	Report
FL 04 Type of Bill (TOB)	21X for SNF inpatient services. 18X for swing bed services.
FL 06 Statement Covers Period – From/Through	The "from" date must be the admission date or, for a continuing stay bill, the day after the "through" date on the prior bill. The "through" date is the last day of billing for the period.
FL 31 – FL 34 Occurrence Code/Date	50 with the Assessment Reference Date (ARD) for each assessment period represented on the claim with revenue code 0022 (not required for the default Health Insurance Prospective Payment System [HIPPS] code).
FL 35 & FL 36 Occurrence Span Code – From/Through	70 with the dates of the 3-day qualifying stay.
FL 42 Revenue Code	0022 to indicate you are submitting the claim under the SNF PPS. You can use this revenue code as often as necessary to indicate different rate codes and periods.

Table 1. SNF Billing Requirements (cont.)

UB-04 Field	Report
FL 44 Healthcare Common Procedure Coding System (HCPCS)/ Rate/HIPPS code	HIPPS rate code (a five-digit code consisting of a three-digit RUG code and a two-digit Assessment Indicator [AI] code*). Must be in the order in which the beneficiary received that level of care. Certain HIPPS rate codes require additional rehabilitation therapy ancillary revenue codes. The MAC returns claims for resubmission when these corresponding codes are missing.
FL 46 Units of Service	The number of covered days for each HIPPS rate code.
FL 47 Total Charges	Zero for 0022 revenue code lines.
FL 67 Principal Diagnosis Code	International Classification of Diseases, Clinical Modification (ICD-CM) code for the principal diagnosis.
FL 67a – FL67q Other Diagnoses	ICD-CM codes for up to eight additional conditions.

* The AI code describes the assessment that determined the RUG code. For a full explanation of the assessments required, refer to the "Medicare Claims Processing Manual," Chapter 6, Section 30 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf on the CMS website.

Billing Tips

▫ Generally, the day of discharge, death, or a day on which a patient begins a leave of absence (LOA) is not counted as a utilization day.

▫ If a beneficiary is discharged and returns before midnight on the same day, Medicare does not count this as a discharge.

▫ The HIPPS rate code that appears on the claim must match the assessment that was transmitted and accepted by the state in which the facility operates. For additional HIPPS information, visit http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Prosp MedicareFeeSvcPmtGen/HIPPSCodes.html on the CMS website.

Special Billing Situations

Certain situations require variations from the billing practices just described. In some cases, Medicare requires submission of a claim even though you do not expect payment. Tables 2 – 7 provide additional information to help you decide how to bill Part A for various situations. Remember that you must be able to support the information reported on claims with adequate documentation.

Readmission Within 30 Days

Readmission occurs when the beneficiary is discharged and then readmitted to the SNF as skilled within 30 days of discharge.

Specific Billing Questions

For assistance with billing situations not described, contact your MAC for additional information. For MAC contact information, visit http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map on the CMS website.

Table 2. Readmission Within 30 Days

If…	Then…
You sent a discharge claim **prior to readmission**.	Report: ◘ The admission date as the admission day for the current stay; ◘ Condition code 57; and ◘ Occurrence span code 70 with the dates of the qualifying hospital stay.
The beneficiary is **readmitted before you send a discharge claim**.	Report: ◘ The admission date as the admission day for the current stay; ◘ Condition code 57; ◘ Occurrence span code 70 with the dates of the qualifying hospital stay; and ◘ Occurrence span code 74 showing from and through dates for the LOA and the number of noncovered days.

Benefits Exhaust

When the benefit period exhausts (fully or partially), continue to submit monthly bills as long as the beneficiary remains in a Medicare-certified area of the facility.

Table 3. Benefits Exhaust

If…	Then…
The beneficiary moves to a non-Medicare-certified area of the facility.	Discharge the beneficiary. Do not submit Part B services on a 22X until the benefits exhaust claim processes. If applicable, the claims processing system will apply an A3 occurrence code with last day for which benefits were available. Report: ◘ Appropriate covered TOB (not 210); ◘ HIPPS AAA00; ◘ All days and charges as covered; ◘ Occurrence span code 70 with date of qualifying hospital stay; ◘ Value code 09 with $1.00; and ◘ Appropriate patient status code. Submit any Part B services provided after skilled care ended on a 22X. Bill therapy on a 22X.
The beneficiary **drops to a nonskilled level of care** while benefits are exhausted **and remains in a Medicare-certified area** of the facility.	Report: ◘ Occurrence code 22 with date covered SNF care ended; and ◘ Patient status code 30. Submit any Part B services provided after skilled care ended on a 22X. Bill therapy on a 22X.
The beneficiary **drops to a nonskilled level of care** while benefits are exhausted and **moves to a non-Medicare-certified area of the facility** or otherwise discharges.	Report: ◘ TOB 211 or 214 for SNFs and 181 or 184 for swing beds; and ◘ Appropriate patient status code (other than 30). Submit any Part B services provided after skilled care ended on a 22X. Bill therapy on a 22X.

No Payment Billing

For no payment billing, the beneficiary drops to a nonskilled level of care and remains in a Medicare-certified area of the facility.

Table 4. No Payment Billing

If…	Then…
If you **need a denial notice** so another insurer will pay, send the initial no payment claim with the from date as the date SNF care ended. Then, continue to send claims as often as monthly.	Report: ◘ All days and charges as noncovered, beginning the day following the day SNF care ended; ◘ Condition code 21; ◘ Appropriate patient status code; ◘ TOB 210 for SNFs or 180 for swing beds; and ◘ HIPPS AAA00. Submit any Part B services provided after skilled care ended on a 22X. Bill therapy on a 22X.
If you **do not need a denial notice**, you only need to send one final discharge claim. The claim may span both the SNF and Medicare Fiscal Year end dates.	Report: ◘ From date as the day SNF care ended; ◘ Through date as the date of discharge; ◘ All days and charges as noncovered, beginning the day following the day SNF care ended; ◘ Condition code 21; ◘ Appropriate patient status code; ◘ TOB 210 for SNFs or 180 for swing beds; and ◘ HIPPS AAA00. Submit any Part B services provided after skilled care ended on a 22X. Bill therapy on a 22X.

Expedited Review Results

For SNFs, provider-initiated discharges for coverage reasons associated with inpatient claims require an expedited determination notice. You must report the outcomes of expedited determinations on the claim.

Table 5. Expedited Review Results

If…	Then…

The Quality Improvement Organization (QIO)/Qualified Independent Contractor (QIC) **upholds the discharge decision**.	Report:
	◘ A discharge for the billing period that precedes the determination;
	◘ Condition code C4; and
	◘ If the beneficiary is liable for any care days, report:
	  ■ Occurrence span code 76 with the days beneficiary incurred liability;
	  ■ Zero charges for the beneficiary-liable days; and
	  ■ Modifier TS for any HCPCS codes for those days.

The QIO/QIC **authorizes continued coverage with no specific end date**.	Report: ◘ A continuing claim for the current billing or certification period; and ◘ Condition code C7.
The QIO/QIC **authorizes continued coverage only for a limited period of time**, and **the time extends beyond the end of the normal billing or certification period.**	Report: ◘ A continuing claim for the current billing or certification period; ◘ Condition code C3; and ◘ Occurrence span code M0 with the beginning date of QIO/QIC-approved coverage and the claim through date.
The QIO/QIC **authorizes continued coverage only for a limited period of time**, and **the time does not extend beyond the end of the normal billing or certification period**.	Report: ◘ A discharge; ◘ Condition code C3; and ◘ Occurrence span code M0 with the beginning and end dates of QIO/QIC-approved coverage.
The provider is liable due to failure to give information to the QIO/QIC timely or to provide valid notice to the beneficiary.	Report services as noncovered with modifier GZ.

Noncovered Days

The patient does not meet Medicare SNF coverage requirements.

Table 6. Noncovered Days

If…	Then…
The **beneficiary is liable**.	Report occurrence span code 76. Submit the claim as covered if the beneficiary is skilled.
The **SNF is liable**.	Report occurrence span code 77. Submit the claim as covered if the beneficiary is skilled.

Other SNF Billing Situations

Table 7. Other SNF Billing Situations

Situation	If…	Then…
No Qualifying Hospital Stay	The beneficiary is admitted as skilled but does not have a qualifying hospital stay. This includes beneficiaries who were initially admitted as skilled, following a qualifying hospital stay, dropped to a nonskilled level of care for more than 30 days (thus ending their connection to the original qualifying hospital stay), and then become skilled again but do not have a new qualifying hospital stay.	Bill as you would otherwise, but do not report occurrence span code 70.
Same Day Transfer	The beneficiary is admitted to the SNF and is expected to remain overnight, but transfers before midnight on the same day to a Medicare-participating facility.	Report: ▫ The admission date, from date, and through date with the same date; ▫ Zero covered days; and ▫ Condition code 40.
LOA	The beneficiary leaves the SNF but is not admitted as an inpatient to any other facility.	Report: ▫ Revenue code 018X; ▫ Number of LOA days; ▫ Zero charges; and ▫ Occurrence span code 74 showing from and through dates for the LOA and the number of noncovered days.

Table 7. Other SNF Billing Situations (cont.)

Situation	If…	Then…
Forced Discharge	The beneficiary leaves the SNF and is admitted as an inpatient to another facility.	Bill as a discharge. If the beneficiary is readmitted to the SNF within 30 days, follow the instructions for "Readmission Within 30 Days" in Table 2.
Nonskilled Discharge	The beneficiary drops to a nonskilled level of care and moves to a non-Medicare-certified area of the facility.	Discharge the beneficiary on a final discharge claim. Submit services rendered after discharge on a 23X.
Demand Billing	The SNF believes covered skilled care is no longer medically necessary, and the beneficiary disagrees.	Report: ◘ Condition code 20; and ◘ Occurrence code 22 with the date SNF care ended or occurrence code 21 with the date the utilization review (UR) notice was received.
Medicare Advantage (MA) Plan Information Only Billing	The beneficiary is enrolled in an MA Plan.	Submit information only claims to Medicare so the CWF can track the benefit period. Report: ◘ Appropriate HIPPS code based on assessment or HIPPS AAA00; ◘ Days and charges as covered; and ◘ Condition code 04.
Disenroll from MA Plan	◘ The beneficiary disenrolls from an MA Plan (voluntarily or otherwise) and returns to Original Medicare coverage; ◘ The beneficiary meets the level of care criteria through the effective date of disenrollment, Medicare waives the requirement for a qualifying hospital stay; and ◘ The beneficiary is eligible for the number of days that remain out of the 100-day benefit period for that stay, minus the days that would have been covered by Original Medicare while the beneficiary was enrolled in the MA Plan.	Report: ◘ Condition code 58.

Resources

For more information for SNFs, visit http://www.cms.gov/Center/Provider-Type/Skilled-Nursing-Facility-Center.html on the CMS website, or scan the Quick Response (QR) code on the right with your mobile device. Table 8 provides additional resources about SNF services.

Table 8. Resources

Resource	Website
MDS 3.0	http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30.html
"Medicare Benefit Policy Manual," Chapter 8	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf
"Medicare Claims Processing Manual," Chapter 6	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf
"Medicare Claims Processing Manual," Chapter 7	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c07.pdf
Medicare Learning Network® (MLN) Guided Pathways (GPs)	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf
MLN Matters® Article MM8458, "Manual Updates to Clarify Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT) Coverage Pursuant to *Jimmo vs. Sebelius*"	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8458.pdf
Skilled Nursing Facility section of "Medicare Billing Information for Rural Providers and Suppliers"	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243515.html
SNF Consolidated Billing	http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/ConsolidatedBilling.html
SNF PPS	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243671.html
Swing Bed Services	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243409.html

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