CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 94 **Date: February 6, 2004**

CHANGE REQUEST 3098

I. SUMMARY OF CHANGES: Additional Information in Medicare Summary Notices (MSNs) to Beneficiaries about Skilled Nursing Facility (SNF) Benefits

NEW/REVISED MATERIAL - EFFECTIVE DATE: July 1, 2004
***IMPLEMENTATION DATE: July 6, 2004**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	6/40.7/Other Billing Situations
R	21/50.13/Skilled Nursing Facilities
R	21/50.20/Benefit Limits
R	21/90.13/Instalacion de Enferemeria Especializada
R	21/90.20/Limites En Los Beneficios

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

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SUBJECT: Additional Information in Medicare Summary Notices (MSNs) to Beneficiaries about Skilled Nursing Facility (SNF) Benefits

I. GENERAL INFORMATION

A. Background: Beneficiaries do not currently receive information on their MSNs on the number of days remaining under their SNF Part A benefit for a given spell of illness.

B. Policy: The Medicare Prescription Drug Improvement and Modernization Act of 2003 requires MSNs report on the number of days remaining in a Part A spell of illness for SNF beneficiaries.

C. Provider Education: A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article to their website, and include it in a listserv message if applicable, within one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

NOTE: This instruction does not have to be implemented by the APASS shared system, even if there is a delay in transitions from that system. The transition is currently scheduled to be completed by May 2004.

Requirement #	Requirements	Responsibility
3098.1	The shared system shall assure the new MSN message provided below will appear, in English or Spanish as indicated, on all MSNs, meeting the requirements specified below. The message shall be used when: • The MSN reports on a claim with type of bill (TOB) 18x or 21x for swing bed or SNF inpatient services; • The receipt of existing Common Working File (CWF) trailer 09, by adding the full and coinsurance days reported on	FISS

	that trailer, and reporting that sum as the number of SNF Part A days remaining in the message when there are still days available in the benefit period (i.e., the sum of full and coinsurance days reported on the trailer is less than 100). 13.11- You have ___ days(s) remaining of your total 100 days of skilled nursing facility benefits for this benefit period. Spanish: 13.11 - Sólo le quedan ___ de los 100 días por este período de beneficios de cuidado en un centro de enfermería especializada.	
3098.2	The shared system shall assure existing MSN message 20.1: "You have used all your benefit days for this period," ; "Usted ha utilizado todos sus días de beneficios por este periodo." will appear, in English or Spanish as indicated, on all MSNs when: • A claim is for either TOB 18x or 21x is included on the MSN; • The receipt of existing CWF trailer 09 indicates there are **no** days remaining in the benefit period (i.e., the sum of full and coinsurance days is equal to or greater than 100).	FISS
3098.3	The shared system shall revise existing MSN message 20.8 as specified below. The text revision to message 20.8 below must be implemented prior to applying it solely to MSNs for inpatient hospital claims (TOB 11x; note that previous wording of the message use to apply to both inpatient hospital and SNF claims): 20.8-Days are being subtracted from your total inpatient hospital benefits for this benefit	FISS

	period. Spanish: 20.8 - Algunos días han sido reducidos del total de sus días de beneficios como paciente interno para este período de beneficios.	

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
3098.1-.3	CMS will list the exact message text for each message, provide the Spanish language and numbering for the new and revised messages as is done in the establish process for MSN messages documented in Chapter 21 of the Medicare Claims Processing Manual

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: No new interfaces, though the shared system will have to interact with CWF.

D. Contractor Financial Reporting /Workload Impact: None.

E. Dependencies: None with other instructions.

F. Testing Considerations: None.

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: July 1, 2004 for MSNs generated on or after that date. **Implementation Date: July 6, 2004** **Pre-Implementation Contact(s): For MSN messages: Julie Day, 410-786-6342, Jday2@cms.hhs.gov; for business requirements: Elizabeth Carmody, 410-786-7533, ecarmody@cms.hhs.gov** **Post-Implementation Contact(s): Regional Office**	**These instructions shall be implemented within your current operating budget**

40.7 - Other Billing Situations

(Rev. 94, 2-6-04)

A3-3624, A3-3624.B, A3-3630.1, A3-3630.4, A3-3620, HO-411, SNF-517.3, SNF-526.3, SNF-527, SNF-527.1,

A - No Payment Bills

A hospital or SNF is required to submit a bill even though no benefits may be payable. CMS maintains a record of all inpatient services for each beneficiary, whether covered or not. The related information is used for national healthcare planning and also enables CMS to keep track of the beneficiary's benefit period. These bills are known as no-payment bills. A SNF must submit a no-payment bill every month and also when there is a change in the level of care regardless of whether the no-payment days will be paid by Medicaid or a supplemental insurer. When a change in level of care occurs after exhaustion of a beneficiary's covered days of care, the provider must submit the no-payment bill in the next billing cycle.

See the Medicare Claims Processing Manual, Chapter 3, "Inpatient Part A Hospital," §40.4.1, for billing instructions and situations requiring a no-payment bill. See §40.4.2 of the same chapter for FI processing instructions.

Refer to the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-92 (CMS-1450) Data Set" for further information about billing, as it contains UB-92 data elements and the corresponding fields in the electronic record. Where payment may be made for part of the services, one bill is prepared covering payable **and** nonpayable days and services.

A noncovered bill with condition code 21 indicates a request for a Medicare denial notice. The bill is submitted to obtain a denial notice for Medicaid or another insurer. Do not send a no-payment discharge bill where the patient has Part B entitlement only.

B - Demand Bills

SNF-526, SNF-526.1, A3-3630.1, SNF-526.2, A3-3630

Where the SNF believes that a covered level of care has ended but the beneficiary disagrees, they report occurrence code 21 (UR Notice Received) or 22 (active care ended) as applicable and condition code 20 indicating the beneficiary believes the services are covered beyond the occurrence date. The SNF reports the days and charges after the occurrence code 21 or 22 date as noncovered.

See the Medicare Claims Processing Manual, Chapter 1, "General Billing Requirements," §60, for additional instruction on advance beneficiary notices and demand bills.
Refer to the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-92 (CMS-1450) Data Set," for further information about billing, as it contains UB-92 data elements and the corresponding fields in the electronic record.

C - Request for Denial Notice for Other Insurer

SNFs complete a noncovered bill and enter condition code 21 to indicate a request for a Medicare denial notice. Refer to Chapter 25, " Completing and Processing the UB-92 (CMS-1450) Data Set," for further information about billing, as it contains UB-92 data elements and the corresponding fields in the electronic record.

D - Another Insurer is Primary to Medicare

See the Medicare Secondary Payer (MSP) Manual, Chapter 3, "MSP Provider Billing Requirements" and Chapter 5, "Contractor Prepayment Processing Requirements," for submitting claims for secondary benefits to Medicare. Refer to the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-92 Data Set," for further information about billing, as it contains UB-92 data elements and the corresponding fields in the electronic record.

E – Special MSN Messages

The Medicare Prescription Drug Improvement and Modernization Act of 2003 requires that Medicare Summary Notices (including SNF claims for post-hospital extended care services provided under Part A) report the number of covered days remaining in the given spell of illness. This requirement became effective July 6, 2004.

50.13 - Skilled Nursing Facility

(Rev. 94, 2-6-04)

PMs AB-01-169, B-00-67

13.1 - No qualifying hospital stay dates were shown for this skilled nursing facility stay.

13.2 - Skilled nursing facility benefits are only available after a hospital stay of at least 3 days.

13.3 - Information provided does not support the need for skilled nursing facility care.

13.4 - Information provided does not support the need for continued care in a skilled nursing facility.

13.5 - You were not admitted to the skilled nursing facility within 30 days of your hospital discharge.

13.6 - Rural primary care skilled nursing facility benefits are only available after a hospital stay of at least 2 days. (NOTE: This message is used only in connection with hospital stays that occurred prior to October 1, 1997).

13.7 - Normally, care is not covered when provided in a bed that is not certified by Medicare. However, since you received covered care, we have decided that you will not have to pay the facility for anything more than Medicare coinsurance and noncovered items.

13.8 - The skilled nursing facility should file a claim for Medicare benefits because you were an inpatient.

13.9 - Medicare Part B does not pay for this item or service since our records show that you were in a skilled nursing facility on this date.

13.11 - You have ___ days(s) remaining of your total 100 days of skilled nursing facility benefits for this benefit period

50.20 - Benefit Limits

(Rev. 94, 2-6-04)

AB-02-151

20.1 - You have used all of your benefit days for this period.

20.2 - You have reached your limit of 190 days of psychiatric hospital services.

20.3 - You have reached your limit of 60 lifetime reserve days.

20.4 - (___) of the Benefit Days Used were charged to your Lifetime Reserve Day benefit. (NOTE: Mandated message - This message must be printed claim level when all or a portion of the Benefit Days Used are charged to the Lifetime Reserve Day benefit.)

20.5 - These services cannot be paid because your benefits are exhausted at this time.

20.6 - Days used has been reduced by the primary group insurer's payment.

20.7 - You have (___) day(s) remaining of your 190-day psychiatric limit.

20.8 - Days are being subtracted from your total inpatient hospital benefits for this benefit period.

20.9 - Services after (mm/dd/yy) cannot be paid because your benefits were exhausted.

20.10 - This service was denied because Medicare only pays up to 10 hours of diabetes education training during the initial 12-month period. Our records show you have already obtained 10 hours of training.

20.11 - This service was denied because Medicare pays for two hours of follow up diabetes education training during a calendar year. Our records show you have already obtained two hours of training for this calendar year.

20.13 - This service was denied because Medicare only pays up to three hours of medical nutrition therapy during a calendar year. Our records show you have already received three hours of medical nutrition therapy.

20.14 - This service was denied because Medicare only pays two hours of follow-up for medical nutrition therapy during a calendar year. Our records show you have already received two hours of follow-up services for this calendar year.

90.13 - Instalación de Enferemería Especializada

(Rev. 94, 2-6-04)

AB-01-169, B-00-67

13.1 - No se demostraron fechas aprobadas de estadía en el hospital para una estadía en esta instalación de enfermería especializada.

13.2 - Los beneficios de una instalación de enfermería especializada son obtenibles solamente después de una estadía en el hospital de por lo menos 3 días.

13.3 - La información proporcionada no confirma la necesidad de una estadía en una instalación de enfermería especializada.

13.4 - La información proporcionada no confirma la necesidad de continuar los servicios de cuidado de una instalación de enfermería especializada.

13.5 - Usted no fue ingresado en una instalación de enfermería especializada dentro de los 30 días después de ser dado de alta en el hospital.

13.6 - Los beneficios de cuidado primario en una instalación de enfermería especializada rural son obtenibles después de una estadía de hospital de por lo menos 2 días.

13.7 - Normalmente, servicios de cuidado de salud no están cubiertos cuando son proporcionados en una cama que no está certificada por Medicare. Sin embargo, como usted recibió servicios de cuidado de salud que sí estaban cubiertos, decidimos que no tiene que pagarle a la institución nada más que el seguro complementario y los artículos y servicios que Medicare no cubre.

13.8 - La instalación de enfermería especializada (SNF, por sus siglas en inglés) debe archivar una reclamación para beneficios de Medicare porque usted estaba hospitalizado.

13.9 - Medicare Parte B no paga por este artículo o servicio ya que nuestros expedientes indican que usted estaba en una instalación de enfermería especializada (SNF, por sus siglas en inglés) en esta fecha. Su proveedor debe cobrarle este servicio a la instalación de enfermería especializada o a el intermediario fiscal.

13.11 - Sólo le quedan ___ de los 100 días por este período de beneficios de cuidado en un centro de enfermería especializada.

90.20 - Límites En Los Beneficios

(Rev. 94, 2-6-04)

20.1 - Usted ha utilizado todos sus días de beneficios por este periodo.

20.2 - Usted ha llegado a su límite de 190 días de servicios psiquiátricos de hospital.

20.3 - Usted ha llegado a su límite de 60 días de reserva vitalicia.

20.4 - (____) de los días de beneficios usados fueron cobrados a sus beneficios de días de reserva vitalicia.

20.5 - Estos servicios no pueden ser pagados porque sus beneficios se han agotado.

20.6 - Los días usados han sido reducidos por el pago del asegurador de grupo primario.

20.7 - De sus 190 días por servicios de psiquiatría a los que tiene derecho, le quedan (____).

20.8 - Algunos días han sido reducidos del total de sus días de beneficios como paciente interno para este período de beneficios.

20.9 - Los servicios recibidos después de mm/dd/yy no pueden ser pagados porque sus beneficios ya estaban agotados.

20.10 - Este servicio fue negado porque Medicare solamente paga hasta 10 horas de entrenamiento en la educación de la diabetes durante el período inicial de 12 meses. Nuestros expedientes indican que usted ya obtuvo 10 horas de entrenamiento.

20.11 - Este servicio fue negado porque Medicare solamente paga por 2 horas de continuación del entrenamiento en la educación de la diabetes durante un año. Nuestros expedientes indican que usted ya obtuvo 2 horas de entrenamiento por este año.

20.13 - Este servicio fue negado porque Medicare solo paga hasta 3 horas por terapia médica nutricional durante un año calendario. Nuestros expedientes indican que usted ya recibio 3 horas de terapia médica nutricional.

20.14 - Este servicio fue negado porque Medicare sólo paga 2 horas al año por servicios de seguimiento de la terapia médica nutricional. Nuestros expedientes indican que usted ya recibió 2 horas de servicios de seguimiento en este año.