# Program Memorandum Intermediaries/Carriers

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

**Transmittal AB-01-131** **Date: SEPTEMBER 21, 2001**

**CHANGE REQUEST 1761**

**SUBJECT: Fiscal Intermediary (FI) Instructions on Applying Payment Bans on Skilled Nursing Facility (SNF) Admissions**

The purpose of this Program Memorandum (PM) is to ensure consistency by fiscal intermediaries (FIs) in applying denial of payment sanctions for new SNF admissions. We have found that there has been some confusion concerning the definition of a new admission. In clarifying this policy, our first priority is ensuring continuity of care for our Medicare beneficiaries.

Under the Social Security Act at §§1819(h) and 1919(h) and CMS's regulations at 42 CFR 488.417, CMS may impose a denial of payment for new admissions (DPNA) against a SNF when CMS finds that a facility is not in substantial compliance with requirements of participation. Further, the regulations require CMS to impose a DPNA when a SNF (1) fails to be in substantial compliance for three months after the last day of the survey identifying the noncompliance, or (2) is found to have provided substandard quality of care on the last three consecutive standard surveys. FIs are responsible for applying these payment sanctions to new SNF admissions resulting from adverse survey findings.

## A. Applying Payment Bans to SNF Services

The State Operations Manual (SOM) must be considered the definitive source in applying payment bans to new SNF admissions. Section 7506(E) of the SOM states that payment bans apply only to Part A services. A Medicare beneficiary who is not in a Part A stay but who is residing in a SNF subject to a Medicare Part A payment ban is entitled to Part B payment for all services that are normally covered under Part B for any SNF resident in a participating facility. Note that §3600.3 of the Medicare Intermediary Manual (MIM) Part 3 contains an inaccurate example, which indicates that the payment ban applies to both Part A and Part B services.

SNFs under a denial of payment sanction are still considered Medicare-participating providers. Section 3600.3 of the MIM defines a "nonparticipating provider" as a hospital or SNF following termination, expiration, or cancellation of its agreement. Section 518.3 of the SNF Manual incorrectly expands the definition of “nonparticipating provider” to include those providers who have received payment denials for new admissions.

## B. New Admissions

The instructions to impose a payment ban on SNF new admissions are described in the SOM §7506(B) through (D) and 42 CFR 488.401. In applying payment bans, refer to the following definition of "new admission" to an SNF contained in 42 CFR 488.401.

> [a] resident who is admitted to the facility on or after the effective date of a denial of payment remedy and, if previously admitted, has been discharged before that effective date. Residents admitted before the effective date of the denial of payment, and taking temporary leave, are not considered new admissions, nor subject to the denial of payment.

Section 7506(E) of the SOM explains the guidelines used in determining the status of residents admitted, discharged, or on *"temporary leave"* and readmitted before or after the effective date of the denial of payment for new admissions. This section of the SOM defines *"temporary leave"* as *residents who leave temporarily for any reason.* This definition would include both beneficiaries who are out of the SNF at midnight but who later return to the SNF and beneficiaries who require inpatient hospitalization and return to the SNF directly upon hospital discharge. If residents were

not subject to a denial of payment when they went on temporary leave, they are not, upon their return, considered new admissions for the purposes of the denial of payment. A beneficiary is considered discharged when he/she leaves the facility with no expectation of return; e.g., a beneficiary transferred to another SNF or discharged to home, etc.

**1. Determining Whether the Stay Represents a New Admission**

For the purpose of applying sanctions, FIs should apply the certification language included in §7506(E) of the SOM and the definition of a new admission contained in 42 CFR 488.401 cited above. Effective immediately, beneficiaries admitted before the effective date of the denial of payment and taking temporary leave, whether to receive inpatient hospital care, outpatient services or as therapeutic leave, are not considered new admissions, and are not subject to the denial of payment upon return. This policy applies even if there are multiple hospitalizations and returns to the SNF during the period sanctions are in effect.

However, a resident who is discharged to a different SNF and is later readmitted to the original SNF, currently under a payment ban, will be subject to the denial of payment sanction. Similarly, a beneficiary who is discharged from an acute care hospital to a long-term rehabilitation hospital, a swing bed, or a hospice would be considered a new admission upon return to the original SNF.

Beneficiaries enrolled through cost-based HMOs are subject to the same requirements as fee-for-service beneficiaries.

Hospices contract with SNFs for services related to the beneficiary's terminal condition. These bills are not processed by the FI. However, there will be situations where a beneficiary is admitted as a hospice patient, but later requires daily skilled care unrelated to the terminal condition. If the beneficiary was initially admitted as a hospice patient prior to the date sanctions were imposed, and meets the requirements for Part A coverage; sanctions will not be applicable. Benefits will be paid under SNF PPS from the first date the beneficiary qualifies for Medicare Part A for care unrelated to the terminal condition. The facility must complete the Medicare-required assessments from the start of care for the unrelated condition.

Although the Medicare payment bans apply to beneficiaries receiving care under any type of Medicare benefit, this PM applies solely to claims processed through Medicare FIs. Procedures have not yet been developed to apply payment bans to other types of Medicare benefits. Until these procedures are established, we encourage risk-based HMOs and other capitated providers to address this issue in their contracts with SNFs.

**2. Beneficiary Notification**

Before admitting a beneficiary, the SNF must notify the beneficiary or responsible family member that sanctions have been imposed, and explain how the sanctions will affect the beneficiary's benefits. This Notice of Non-Coverage also applies to former residents that had been discharged with no expectation of return and are being readmitted after the imposition of the payment ban. SNFs failing to provide this notification will be held liable for all Part A services covered under SNF PPS. The beneficiary notice must meet the following criteria:

a. It must be in writing.
b. It must explain the reason sanctions were imposed.
c. It must explain the beneficiary's liability for the cost of SNF services during the period the payment ban is in effect.
d. It must explain that Medicare Part A benefits may be available if the beneficiary chooses a different Medicare-participating SNF that is not under sanction.

**C. Readmissions and Transfers**

When determining if the beneficiary was admitted prior to the imposition of the ban, the actual status of the beneficiary rather than the primary payor is the determining factor. Therefore, there may be situations where the beneficiary is a private pay patient or a dual eligible who was receiving Medicaid benefits prior to the imposition of the payment ban. If this private pay patient or dual

eligible goes to the hospital for needed care, and meets the Medicare Part A criteria upon return to the SNF, the readmission is exempt from the denial of payment sanction.

However, it is important to remember that when a beneficiary admitted prior to the imposition of sanctions transfers to another SNF, that beneficiary is considered discharged. Medicare benefits will not be available if that beneficiary returns to the first SNF while the payment ban is still in effect. For example, if a beneficiary who is exempt from the payment ban is hospitalized, and then transfers to a hospital-based SNF or swing bed unit, that beneficiary is considered discharged. If that beneficiary returns to the first facility while sanctions are still in effect, the sanctions will apply. When billing for a readmission that is NOT subject to the payment ban, enter Condition Code 57, Readmission, on the UB-92.

In rare situations, the facility under sanction wants to readmit the beneficiary after a qualifying hospital stay, but does not have a Medicare-certified bed available. If the SNF offers and the beneficiary agrees to return to a non-certified bed as a private pay patient (i.e., the beneficiary waives Part A benefits), the beneficiary is not eligible for Part A benefits at this facility. Part A benefits would not be available even if the payment ban was rescinded retroactive to the beneficiary's date of admission. The SNF must file a bill showing beneficiary liability for the non-covered days.

If that beneficiary is later transferred to a Medicare-certified bed while the sanctions are still in effect, the beneficiary would be considered a new admission, and the stay would be subject to the payment sanction (see section E. for billing instructions). If the payment ban is lifted retroactively, the beneficiary would be eligible for Part A coverage starting with the first day in a Medicare-certified bed.. The beneficiary would be considered to have met the transfer requirements if the original placement in the certified bed was within 30 days of the qualifying hospital stay. This provision is limited to those very infrequent situations where a SNF under a payment ban cannot place a returning beneficiary in a certified bed. Payment provisions for beneficiaries returning to Medicare-certified beds after a temporary absence are addressed in section B. of this PM.

### D. Sanctions Lifted: Procedures for Beneficiaries Admitted During the Sanction Period

For new admissions to certified beds, Medicare payments for eligible beneficiaries should begin on the date the sanction is lifted. The beneficiary must meet technical eligibility requirements (e.g., a 3-day hospital stay, etc.), services must be reasonable and necessary and the beneficiary must be receiving skilled care. The date the sanction is lifted is considered the first day of the Part A stay. For SNF PPS payment purposes, the period between the actual date of admission and the last day the sanction was in effect should be billed as non-covered days.

(See section E. below on procedures to track these non-covered days for benefit period and break in spell of illness calculations. In addition, Minimum Data Set (MDS) requirements are discussed in section K.)

### E. Tracking Days to Calculate the Part A Benefit Period

Payment sanctions are applied to days that would otherwise be Part A-payable; i.e., the care is covered but no payment will be made to the provider. Therefore, if the Medicare-participating SNF assumes responsibility for the beneficiary's costs during the sanction period, it will be considered the same as a program payment, and the days will count towards the 100-day benefit period.

The provider is always liable unless the appropriate Notice of Non-Coverage is issued to the beneficiary or appropriate family member or representative. If the SNF issues the appropriate Notice of Non-Coverage, and the beneficiary agrees to make payment either personally or through a private insurer, the days will not be charged towards the 100-day benefit period.

#### 1. Provider Liability Billing Instructions

These days will be charged against the patient’s utilization as is currently done with other types of technical denials (i.e., late filing, late denial notices to the patient, etc.). The SNF must file a non-payment bill with the FI for non-covered days using occurrence span code 77. This code indicates that the facility is liable for the services but that the non-covered days and any applicable

copayments will be charged to the beneficiary's Part A benefit period. See §3624 of the MIM, Part 3 for detailed instructions on nonpayment billing requirements.

**2. Beneficiary Liability Billing Instructions**

The days will not be charged to the beneficiary's benefit period. The SNF should file a non-payment bill for non-covered Part A services, using occurrence span code 76 that indicates beneficiary liability.

**F. Part B Billing**

Facilities subject to a payment ban may continue to bill services for beneficiaries who are not in a Part A stay in the same way as any other SNF. **However, services that would have been payable to the SNF as Part A benefits in the absence of a payment sanction must not be billed to either the FI or the carrier as Part B services.**

**G. Consolidated Billing Requirements**

When the SNF is liable for the Part A stay, the SNF is required to provide all necessary covered Part A services, including those services such as therapies and radiology mandated under consolidated billing. For example, if the beneficiary goes to the hospital for a non-emergency chest x-ray, the SNF will be responsible for the outpatient hospital radiology and any ambulance charges. In this case, the SNF may not charge the beneficiary or family members for any services that, in the absence of a payment sanction, would have been covered under the SNF PPS.

However, the beneficiary is entitled to reimbursement for those services excluded from the SNF PPS rate. Services excluded from consolidated billing such as outpatient hospital emergency care and related ambulance service should be billed by the provider/supplier actually furnishing services, and not by the SNF.

**H. Tracking the Benefit Period**

SNF days during the sanction period will be used to track breaks in the spell of illness. This procedure is consistent with MIM §3035 which states, “A beneficiary’s care in an SNF met the skilled level of care standards if a Medicare SNF claim for the services provided in the SNF was denied on grounds other than that the services were not at a skilled level of care." If the patient is receiving a skilled level of care the benefit period cannot end. Therefore, it should be tracked in CWF.

**I. Beneficiary Financial Responsibility**

When the beneficiary has agreed to accept financial responsibility, no Part A days or copayment amounts will be charged to the beneficiary's benefit period. Services that would have been eligible for Part A benefits in the absence of sanctions cannot be billed as Part B charges. However, the SNF may directly bill the beneficiary, family members or other third party insurers for services provided to that beneficiary.

In situations where the beneficiary was subject to the payment ban, but the provider failed to issue the proper Notification of Non-Coverage, the provider is liable for all services normally covered under the Medicare Part A benefit. Since the beneficiary is receiving benefits, the days will be considered Part A days and charged against the beneficiary's benefit period. The SNF may collect any applicable copayment amounts. Services that would have been eligible for Part A benefits in the absence of sanctions cannot be billed as Medicare Part B charges. .In addition, the SNF may not bill the patient, family or other third party insurer for any other services that would normally have been covered in a Part A stay.

**Determining Whether Transfer Requirements Have Been Met**

It is very important to safeguard the beneficiary while applying necessary sanctions to the provider. It is certainly possible that a beneficiary may remain at a facility under sanction for a period of time

and later transfer to a second SNF. The 30-day transfer requirement will be applied in the same way it would be for a beneficiary transferring between two SNFs that are not under sanction. Part A coverage will be available to the second SNF for all remaining days in the benefit period as long as the beneficiary

1. had a qualifying hospital stay
2. was admitted to a Medicare-certified bed in the first (sanctioned) SNF within 30 days of the hospital discharge, and
3. is receiving a covered level of care at the time of transfer.

**J. Completing MDS Assessments**

The imposition of sanctions does not waive the SNF's responsibility to perform MDS assessments in accordance with the clinical schedule defined in the SOM. Comprehensive admission assessments are still due within 14 days of admission to the SNF. Facility staff must also maintain the schedule for quarterly and annual assessments, and perform significant change and significant correction assessments when clinically appropriate.

Medicare PPS assessments are also required for all beneficiaries in the SNF whose stays are not subject to the payment ban. If, during the sanction period, staff did not perform Medicare PPS assessments for beneficiaries in covered Part A stays, the Part A days can only be billed at the default rate.

For beneficiaries admitted after the effective date of the payment ban, no Part A benefits are available. Therefore, the facility is not required to perform Medicare PPS assessments. As explained in section C., Medicare payments can begin no earlier than the date the sanction is lifted. For Medicare PPS assessment scheduling purposes, the date the sanction is lifted should be considered day 1. In this case, if the sanctions are lifted effected June 15, the assessment reference date for the Medicare 5-day assessment must be set between June 15 and June 22 (i.e., the eighth day of the covered stay).

In some cases, the facility does not receive timely notification that the payment ban has been lifted, and staff would be unaware of the need to start the Medicare-required MDS schedule. In this situation, the facility may use the most recent clinical assessment, generally the 14-day Initial Admission assessment, for SNF PPS payment. The RUG-III group calculated from the most recent clinical assessment would be used to bill covered Part A days from the date sanctions were lifted to the date the SNF is notified. This assessment will be considered the Medicare 5-day assessment for the purpose of MDS coding. The covered days should be billed using the following 5-digit Health Insurance Prospective Payment System (HIPPS) code:

Fields 1-3: The RUG-III group calculated using the most recent clinical assessment,
Fields 4-5: Assessment indicator 01 indicating that the MDS was the initial comprehensive assessment.

The SNF will then follow the Medicare schedule except that the 14, 30, 60 and 90-day Medicare assessments will be prepared using the date of facility notification as day 1.

In rare situations, the amount of time between the end of the sanction period and the date of facility notification is longer than 14 days. In this case, the facility may use the most recent clinical assessment for multiple SNF PPS payment periods. Separate 0022 Revenue Code entries will be required for each SNF PPS payment period. The RUG-III group will remain the same, but the assessment indicator will change as follows: 07 for 14-day assessment, 02 for 30-day assessment, 03 for 60-day assessment and 04 for 90-day assessment.

An SNF may choose to perform the Medicare PPS assessments during the sanction period, but is not required to do so. Generally, a facility should continue to do the Medicare PPS assessments if SNF staff believe the sanction was in error and may be lifted retroactively. In this case, the SNF would be able to bill Medicare at the correct RUG-III rate.

If the sanctions are not lifted retroactively, the most recent assessment (which can be either a clinical or a Medicare PPS assessment) should be used as the Medicare 5-day assessment. The SNF will

then follow the Medicare schedule except that the 14, 30, 60 and 90-day Medicare assessments will be prepared using the date sanctions were lifted or the date of facility notification as day 1, as appropriate.

It is our intention to develop new assessment indicator codes to reflect unusual billing situations resulting from payment bans. Contractors will be notified when these changes have been fully defined and scheduled for implementation.

**K. Physician Certification**

SNFs that are operating under a payment ban are still participating providers, and remain subject to Medicare coverage requirements. Providers are still responsible for evaluating whether beneficiaries meet the Medicare Part A medical necessity and level of care requirements for Medicare Part A coverage, and for obtaining the required physician certifications even though Medicare payment cannot be made for the admission.

The physician certification requirement was not clearly communicated in previous instructions, and it is likely that many providers and FIs were unaware of this requirement. Therefore, when processing reconsiderations for service periods prior to the effective date of this PM, the lack of a physician certification should NOT be used as the sole reason for denial. Instead, the FI should review the medical record, and, determine whether the beneficiary was receiving medically necessary skilled care during the sanction period.

Once a provider has been notified that the sanctions have been lifted, SNF staff will be required to obtain physician certifications. For the purpose of verifying the timeliness of the physician certification, the date of notification will be considered day 1.

When processing a reconsideration for a claim that was billed as a Part A stay but rejected due to an incorrect application of the sanction provision, the physician certification is required regardless of the dates of service. Since the provider clearly believed the stay was eligible for Part A payment, all Medicare coverage requirements should have been met.

**M. SNF PPS Coverage Criteria**

Under the SNF PPS, beneficiaries who are admitted (or readmitted) directly to an SNF after a qualifying hospital stay and who group into one of the top 26 RUG-III groups on the Medicare 5-day assessment are presumed to meet the Medicare level of care criteria. This assumption of coverage is only applicable from the date of admission (or readmission) through the assessment reference date of the Medicare 5-day admission (or reentry/readmission) assessment; i.e., a maximum of 8 days using the admission (readmission date as day 1).

When a beneficiary is admitted to an SNF when a payment ban is in effect, Medicare benefits are not available until the date the sanction is lifted. However, the SNF PPS coverage presumption is calculated from the date the beneficiary was transferred from the hospital to the SNF. Thus, if the sanctions had been in effect for more than 8 days, the SNF PPS coverage presumption does not apply.

If a beneficiary who was in the facility prior to the imposition of sanctions is hospitalized and returns to the SNF, that beneficiary would be entitled to the SNF PPS coverage presumption. The coverage presumption would apply regardless of whether the sanctions are still in effect upon the beneficiary's return to the SNF; i.e., the claim would be considered a readmission, and would not be subject to the payment sanction.

**N. FI Processing Responsibilities**

The FIs will receive notices from the CMS Regional Office when sanctions have been imposed or lifted. In some cases, the FIs may also be notified when sanctions are proposed. It's important to remember that primary objective is always to bring the facility into compliance and avoid imposition of sanctions. In many cases, enforcement activity does not go beyond the notice of intent. For this reason, FIs should initiate action only when notified that sanctions have been imposed.

Then, FIs should follow existing procedures to identify claims from providers subject to the payment ban, and make individual payment determinations when payment is being claimed for services on and after the effective date of the sanction. When the SNF has billed the claim as a readmission (using Occurrence Code 57, showing the prior SNF stay dates in occurrence span code 78), claims examiners should verify the prior SNF stay, and then approve payment. No-payment bills filed as beneficiary liability using Occurrence Span code 76 or as provider liability using Occurrence Span code 77 should be processed.

Claims for new admissions, as defined in this PM, should be denied from the date of admission through the last date of the sanction period.

If the FI is notified of the ban after claims had been improperly paid, the FI must identify the paid claims and recover the overpayments.

The possibility of automating this process is being investigated, but is not addressed in this PM.

**O. Retroactive Removal of Sanctions**

Occasionally, resolution between the state agency and the SNF is reached after the payment ban has been imposed, and the ban is removed retroactive to its effective date. If bills were denied before you received notice that the ban had been reversed, they should be reprocessed and paid. When reprocessing bills, please remember that MDS assessments are needed to support the RUG-III group billed.

**P. Reprocessing Bills Denied In Error**

Beneficiaries and providers may request the FI to reopen and process bills denied as a result of a misunderstanding of the sanction requirements. These reopenings shall be done on a request basis only, and will be limited to service dates on and after January 1, 1999.

**The *effective date* of this PM is for services rendered on and after January 1, 1999. Do not search for claims inappropriately denied, but make payment on those brought to your attention.**

**The *implementation date* of this PM is October 22, 2001.**

**These instructions should be implemented within your current budget.**

**This PM may be discarded after January 1, 2003.**

**For claims processing information, contact Cindy Murphy at (410) 786-5733. For general policy information, contact Sheila Lambowitz at (410) 786-7605. Contractors should contact their regional offices with questions relating to the survey or enforcement process.**