Program Memorandum Intermediaries

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

Transmittal A-01-122 **Date: SEPTEMBER 27, 2001**

This Program Memorandum re-issues Program Memorandum A-00-49, Change Request 1270 dated August 4, 2000. The only change is the discard date; all other material remains the same.

CHANGE REQUEST 1270

SUBJECT: Payment of Skilled Nursing Facility (SNF) Claims for Beneficiaries Disenrolling from Terminating Medicare+Choice (M+C) Plans Who Have Not Met the 3-Day Hospital Stay Requirement

Policy

HCFA will cover SNF care for beneficiaries involuntarily disenrolling from M+C plans as a result of a M+C plan termination when they do not have a 3-day prospective payment system hospital stay before SNF admission. If HCFA does not cover these claims, beneficiaries will be liable to pay them. Beneficiaries in this situation have not been aware of their potential financial liability for their SNF care.

This program memorandum (PM) provides instructions to fiscal intermediaries (FIs) to process claims that SNFs have been instructed to hold until October 2000. Additional instructions that will require changes to the systems logic will be released in several months. FIs will start counting the 100 days of SNF care with the SNF admission date (regardless of whether the beneficiary met the skilled level of care requirements on that date). All other original Medicare rules apply, such as the requirement that beneficiaries meet the skilled level of care requirement (for the period for which the original Medicare fee-for-service program is being billed).

Instructions

FIs will accept hardcopy claims from the SNF with a note indicating that condition code 58 applies to this claim. (Condition code 58 will be used in the future to indicate to the FI systems and to the Common Working File (CWF) that edits at span code 70 are to be bypassed.) Condition code 58 is to be used when the beneficiary has been involuntarily disenrolled from a M+C organization while in a SNF stay and when the 3-day stay requirement has not been met.

Upon receipt of the hardcopy claim, the FI will query CWF to make sure that the beneficiary had been a member of a group health plan where the date of SNF admission is during the enrollment period, and the most recent enrollment period ended before the from date on the claim. The FI does not need to verify that the group health plan was one that terminated.

Once these conditions have been met, the reason code which checks for a qualifying stay will be turned off to get through the front-end processing portion. Once this is done, the FI will then process the claim to pay outside of CWF, using the “force-code” option and following procedures and documentation required in the manual. Once systems changes have been made, these claims will need to be posted to CWF using “CWF-only” adjustment bills that essentially post the claims as original bills.

Once processed, the reason code should be turned back on so that other SNF claims do not bypass the front-end edits.

Notify your SNFs in a newsletter or bulletin about the above clarification or by e-mail if feasible and more timely. Please also indicate to them that original Medicare fee-for-service rules regarding beneficiary cost sharing apply to these cases. That is, providers may only charge beneficiaries for SNF coinsurance amounts.

The *effective date* for this PM is January 1, 2000.

The *implementation date* for this PM is October 1, 2000.

These instructions should be implemented within your current operating budget.

This PM may be discarded after October 1, 2002.

If you have any questions, contact Tony Hausner on (410) 786-1093.