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Medicare Billing: Know When To Submit Benefits Exhaust Claims And No-Pay Bills

Help your SNF stay on top of the billing do's and don'ts.

Confused about when an SNF should submit benefits exhaust claims and no-pay bills? A few key pointers can help you and your facility stay on track with its Medicare billing.

First, realize that the two bill types aren't interchangeable. "Some people refer to the no-pay bill and the benefits exhaust claim as the same thing--and technically they are right because the SNF doesn't get paid when it submits either type of bill," says **Ron Orth, RN, NHA, CPC, RAC-CT**, president of **Clinical Reimbursement Solutions** in Milwaukee. "But the two types of claims are different, and the requirements for submitting them are different."

Put another way: "Benefits exhaust claims and no-pays bills are two different animals," emphasizes **Felice Landry**, senior billing consultant for **Reingruber & Co**. in St. Petersburg, FL.

Submit Benefits Exhaust Claims Monthly

The SNF submits a benefits exhaust claim when a resident has exhausted his 100 Medicare days and will continue to receive a skilled level of care in the SNF, advises Orth. And the SNF must submit these claims on a monthly basis.

Why? The claims prevent the Common Working File from generating a new benefit period of 100 days until the resident has gone for 60 consecutive days at a non-skilled level of care in the facility, Orth explains.

Examples: The resident might have a serious wound that still requires daily skilled nursing care, for example, Orth says. The most common scenario, though, involves a resident receiving a tube feeding who exhausts his 100 days of coverage but continues to receive a tube feeding that meets the skilled care definition (51 percent or more calories or 26 to 50 percent calories and 501 cc or more per day fluid via enteral intake). "In either of those scenarios, the facility would continue to submit a monthly benefits exhaust claim until the resident no longer met the definition for a skilled level of care," Orth instructs. Once the resident's skilled care ends, the billing office should submit a final benefits exhaust claim with occurrence code 22, which is the date active skilled care ended, Orth adds.

"This will tell the Common Working File that the resident is no longer skilled as of that date, so the CWF can start counting the 60-day period toward generating a new 100-day benefit period," Orth says.

Billing example for benefits exhaust claim: A resident's 100th day of Part A SNF coverage is Jan. 4, but he continues to receive a skilled level of care because he has a PEG tube for all of his caloric requirements.

The facility would submit a January bill from Jan. 5 through Jan. 31 just like a covered bill to show the resident received skilled care after day 100, Landry advises.
"Use the default RUG score [a Health Insurance PPS or HIPPS code of AAA00], and bill the number of days of service at that RUG."

Suppose the nursing team weans the resident from his PEG tube on Feb. 15, which ends his skilled care. "The facility will send a benefits exhaust claim from Feb. 1 through Feb. 15 and put occurrence code 22 on the claim that says now the beneficiary's skilled care has ended," Landry says. "The biller puts the 22 code and the Feb. 15 date, which is the last day he was skilled."

Remember: Even if the resident used up his 100 days in a different facility, the SNF caring for the resident must submit benefits exhaust claims, advises **Marilyn Mines, RN, RAC-C, BC,** manager of clinical services for **FR&R Healthcare Consulting** in Deerfield, IL.

Ask this key question: "Admissions staff needs to inquire about whether a resident previously exhausted his or her benefit at another facility prior to admission," adds **Elizabeth Malzahn,** manager of **FR&R Healthcare Consulting**.

Now for the No-Pay Bill

When the SNF determines a resident receiving skilled care under Part A no longer requires that level of care, it has to submit a no-pay bill **if** the person will remain in the facility in a Medicare-certified bed.

If the SNF transfers the resident to a non-Medicare certified bed, if available, then it would not have to submit no-pay bills, Orth advises.

If the resident continues to reside in the facility, its billing department has the option of submitting monthly "no pay" bills--or it can wait until the person is discharged, says Landry.

"The facility only really has to submit one no-pay bill as long as it's submitted within 15 to 26 months of the service," Landry adds.

"But some facilities' software generates monthly bills, and they don't want to have to track the month of services to bill within that 15- to 26-month window," she says.

"Medicare has said you use the default RUG score (HIPPS code AAA00) and the number of days for the claim, just as you do for the benefits exhaust claim." But when you submit a no-pay bill, use a condition code 21 to indicate you are billing for a denial for noncovered services, Landry adds.

Bill Types Are Very Important

You submit a benefits exhaust claim just as if you were submitting a covered claim, Landry says. "The bill type is 21 for a Part A claim, and the number in the third position is a sequential number--if it's a 2, it's the first in a series, a 3 is a subsequent claim, and a 4 is an actual discharge or last claim."

A no-pay is a noncovered bill with the bill type ending in 0. Thus you use bill type 210 for no-pay bills, Landry advises.

Editor's note: Read part 1 of this story, "These Myth-Ridden Part A Coverage Scenarios Will Throw Your SNF For A Payment Loop," in the last MDS Alert (Vol. 6, No. 3). You can access all past issues on the Online Subscription Service or OSS, a free benefit of your subscription. If you haven't yet signed up for this value-added feature, call 1-800-508-2582. You will continue to receive paper copies of the newsletter.