

November 1, 2006

## Medicare No Pay Bills - More Work for Providers

The bad news is that CMS now requires providers to submit “No Pay Bills” which means extra work. The good news is that the programs here at LTC Tools will assist you in completing and submitting these extra claims. This article is provided to help you understand what is behind the no pay bill requirement and why CMS has taken action on this issue.

### What Is A No Pay Bill?

A no pay bill is just what it sounds like; a bill you submit in a situation where you will not receive any money from Medicare. No pay bills are not new, but, CMS has clarified their policy relating to no pay bills. Specifically, CMS has issued instructions that all providers and fiscal intermediaries must now follow. So why is CMS interested in bills that have no payment associated with them and what is the purpose of a no pay bill?

To answer this question, it is important to define a couple of terms:

“Spell of Illness” or “Benefit Period” – Medicare Part-A coverage in a skilled nursing facility (SNF) is limited to 100 day per “spell of illness” or “Benefit Period”. A spell of illness or benefit period starts when a patient has an illness or injury and requires a covered level of care. A spell of illness or benefit period ends 60 days AFTER the patient is no longer receiving a covered level of care. A Medicare Part-A covered level of care is often referred to as “skilled care”. If 60 days pass after the patient is no longer receiving a Medicare Part-A covered (“skilled”) level of care, the spell of illness is “broken” and the patient could be eligible for a new benefit period in the future.

CMS wants to know whether or not the spell of illness period has ended. Unless the provider submits bills AFTER the patient is no longer receiving a Medicare covered level of care, CMS has no way of knowing whether or not 60 days of non-covered level of care have passed and the spell of illness has been broken. If the spell of illness is not broken, the patient will NOT be entitled to a new benefit period (a new 100days of SNF Medicare eligibility) even if that patient has a new illness or injury.

As you can see, understanding the spell of illness, specifically whether or not the spell of illness has been broken is critical to knowing whether or not the patient can be eligible for additional Medicare Part-A coverage. No pay bills are intended to give CMS information that will determine whether or not the spell of illness has been broken.

Medicare Covered Level of Care or “Skilled Care” - Under PPS, providers sometimes forget that Medicare Part-A coverage is more than a certain RUGIII category. Whether or not a patient is covered by Medicare Part-A in an SNF is determined by the SNF coverage guidelines which can be found in the Medicare Benefit Policy Manual (CMS Publication 100-2, internet only manual), Chapter 8 (Coverage of Extended Care (SNF)) on the CMS website at [www.cms.gov](http://www.cms.gov).

Providers should become completely familiar with this section of the coverage manual. Failure to understand the coverage rules in great detail puts you at extreme risk of lost revenue, audits &



investigations and possibly more significant enforcement actions by FIs, the OIG and/or other governmental agencies.

Once you understand the coverage rules you can determine if and when a patient is no longer receiving a covered level of care. This will allow you to complete no pay bills properly and will be the difference between allowing a patient to qualify for additional Medicare coverage or never being covered by Medicare again even after a future illness or injury.

**Benefits Exhausted** – As discussed earlier, a patient can qualify for a maximum of 100 days of Medicare SNF coverage per spell of illness. If a patient is receiving a covered level of care for a full 100 days (which doesn't happen all that often) that patient would have exhausted their SNF benefit (used up their 100 days). Simply exhausting the 100 days does NOT break the spell of illness.

Once again, to break the spell of illness, the patient has to fall below a skilled level of care. In other words, the patient has to have a change of condition where that patient is no longer receiving Medicare Part-A covered services. Therefore, CMS wants providers to provide information about the patients' condition and SNF stay even after the patient has exhausted their 100 days of Part-A coverage by submitting the no pay bills.

To sum this up, no pay bills are intended to provide CMS with information about the patient's level of care and other aspects of their SNF stay even after Medicare Part-A is not paying for the care. This information allows CMS to determine whether or not the spell of illness has been broken. In transmittal 930 (April 28, 2006) CMS indicates that no pay bills are used for:

- "national health planning"
- And also to "enable CMS to keep track of the beneficiary's benefit period".

## **Under What Circumstances Are No Pay Bills Required?**

The two situations where no pay bills are required are:

- When the beneficiary has exhausted his/her 100 day of SNF eligibility
- When the beneficiary no longer needs a Medicare Part-A covered level of care

CMS indicates that the SNF must submit a benefits exhausted bill MONTHLY for those patient that continue to receive skilled care, and, when there is a change in the level of care, even if the services are paid for be a different pay source (e.g., Medicaid, Managed Care or Private Pay).

CMS further indicates that when the level of care changes (the patient drops below the skilled level of care) after the benefits are exhausted, the SNF must submit a bill indicating that the "active care has ended" (the patient is no longer receiving covered services).

CMS acknowledges that different FIs have imposed different no pay bill requirements in the past and they indicate that the current instructions "shall provide a single consistent billing process to be applied to all contractors. Transmittal 930 also states that this requirement only applies to residents who are newly admitted or in a Part –A stay on or after October 1, 2006.

The bottom line is that even after Medicare Part-A stops paying the bill, SNFs need to continue to send UB-04s to their FI on a monthly basis until the patient is discharged from the Medicare certified bed and is no longer at a skilled level of care.

## **Where Can I Learn More About the No Pay Bills?**

First, you can call the professionals at LTC Consulting who provide utilize LTCTools for No Pay Bills and who are happy to answer your questions.

If you want to dig into the written materials issued by CMS, you can review the following:

- Medlearn Matters Article – Medicare Learning Network (MLN) - # MM4292
- CMS Transmittal 930 (pub 100-04) April 28, 2006
- Medicare Claims Processing Manual, Chapter 6 – SNF Inpatient Part-A Billing
- Medicare Benefits Policy Manual (pub 100-2), Chapter 8

## **What Should I do Now?**

You need to begin submitting no pay bills immediately. If you need help with this process or just want a tool that can help you comply with this requirement more easily, that is why ltctools was created. Give us at 866-LTC-TOOLS to start using the program.