

MEDICARE PART A BULLETIN

November 3, 1997

SNF Medicare Bulletin S-18

TO: All Skilled Nursing Facility Providers

FROM: Program Relations

SUBJECT: **SKILLED NURSING FACILITY (SNF) DEMAND BILL PROCESS**

ATTENTION MEDICARE BUSINESS OFFICE: Please distribute to all appropriate health care facility personnel.

The Health Care Financing Administration (HCFA) requirements and guidelines for provider submission of "Demand Bills" may be referenced via the Medicare Skilled Nursing Facility (SNF) Manual (HCFA Publication 12). Essentially, a provider must submit, at the demand of the beneficiary or the beneficiary's representative, claims for services the provider believes are noncovered.

SUBMITTING BENEFICIARY DEMAND BILLS FOR NONCOVERED SNF SERVICES

If a beneficiary, or their representative, requests a bill to Medicare for services that the SNF believes are noncovered, the SNF provider must submit the "demand bill" in the next billing cycle. Report the charges as noncovered and report condition code 20 (form locators 24-30 of the HCFA-1450 (UB-92) billing format) to indicate the beneficiary requested a "demand bill" (i.e., thinks the services are covered).

The HCFA requires fiscal intermediaries to review 100% of all SNF demand bills. Further, providers are required to:

- Give the beneficiary proper (written) notice of noncoverage, prior to rendering noncovered services;
- Submit a demand bill upon request, in the next normal billing cycle;
- Furnish required medical information upon intermediary request; and
- Give the patient or representative a copy of the "demand bill" claim, or provide them with a written statement validating submission of the bill to Medicare.

The intermediary will advise both the provider and the beneficiary of its decision. Until a Medicare decision is made, the SNF provider may only bill the beneficiary for charges for services not covered by Medicare. However, the SNF may request payment for potential Part A coinsurance amounts as of the days to which they apply, if the services are found to be covered.

NONCOVERED SNF DETERMINATIONS

Following are some determinant reasons for "noncovered care;" however, this is by no means an all-inclusive list:

- Lack of 3-day admission to an acute-care Medicare facility (e.g., hospital);
- Admission of a patient whose primary diagnosis and care needs are psychiatric in nature;
- Failure to admit a patient to a skilled level of care within 30 days of discharge from an acute-care Medicare facility;
- All available Medicare benefit period days have been exhausted (e.g., 100 SNF days);
- The patient has no rehabilitation potential or has reached a plateau in their rehabilitation program (e.g., maintenance or custodial care); or
- The patient has no need for skilled observation and management, or no longer requires the skills of SNF nursing staff.

When a decision is made regarding noncoverage, the SNF provider must issue a proper **advance notice of noncoverage** to the patient and/or their legal representative. Providers are held accountable for issuing proper notification of noncovered care. Without proper advance notification, providers are (financially) responsible for all noncovered services. Under these circumstances, the provider may at no time bill the patient (or any other party) for the noncovered services rendered.

NOTICE OF NONCOVERED SNF SERVICES

A proper advance notice of noncoverage must minimally contain the following elements:

- The date that covered care is to be terminated;
- The reason that a covered level of care is not required, or is no longer required;
- The date that the patient and/or their representative was notified (date must be prior to the actual date of noncoverage); and
- The notice must be signed and dated by the patient or their representative, or a telephone notification must be documented and validated by a representative from the treating facility.

Providers should continue to submit SNF demand bills in the most expedient manner (e.g., via electronic claim submission). Once the intermediary requests medical documentation for a demand bill, the provider has 30 days (from the date of the intermediary's request) to submit the following documentation elements to the Medical Review Department:

- A copy of the beneficiary's signed/dated, advance noncoverage notice;
- Admission orders;

- Minimum Data Set (MDS) information (for nursing home assessment and care screening);
- Nursing notes;
- Itemized breakdown of charges;
- Any/all documentation from the SNF's rehabilitation areas (e.g., physical therapy, occupational therapy, speech pathology, or respiratory therapy).

Note: If services were recently discontinued (i.e., any of the above therapies), it is necessary that the intermediary be made aware of the date that these services were terminated.

DESIGNATED MAILING ADDRESS FOR SUBMISSION OF MEDICAL RECORDS

In all instances where the fiscal intermediary has requested supporting medical documentation, not only for SNF Demand Bills, providers should submit the requested medical documentation to the *post office box designated specifically for receipt of medical records*. Sending the requested information to the designated address will serve to expedite receipt of the requested documentation and subsequent processing of the suspended claim:

**Medicare A - Medical Review
Post Office Box 44159
Jacksonville, FL 32203-4159**

APPLICATION OF "GRACE DAYS"

Effective October 1, 1990, a participating SNF is no longer required to have a plan for utilization review (UR). Section 4201(a)(1) of the reform provisions of the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) deleted the SNF requirement for participation formerly contained in §1861(j)(8) of the Act. Thus, UR in SNFs is optional, and the SNF that wishes to discontinue performing UR activities is free to do so.

OBRA 1987, however, did not delete references to SNF UR activities elsewhere in the statute. Specifically, Congress retained the references to SNFs in the definition of UR itself in §1861(k) of the Act. Congress also retained §1814(a)(6) of the Act which provides for a 3-day (maximum) grace period during which an SNF can continue to receive payment for services that a *UR committee has determined to be medically unnecessary*. Although SNFs are no longer required to perform UR, they are free to elect to continue performing it if they wish. *Further, a UR committee (assuming that an SNF elects to retain one) meeting the definition in §1861(k) of the Act can continue to generate grace period payments under §1814(a)(6). (See §340.2 of the Medicare SNF Manual (HCFA Publication 12) for "Limitations on Payment for Inpatient Services Following Adverse Finding by URC".)*

If the facility's utilization review committee (URC) has reason to believe that an inpatient admission was not medically necessary, it may review the admission at any time. The decision of a URC in one institution is not binding upon the URC in another.

When it is determined that the beneficiary's stay is not covered and a determination is made that more

time is needed to arrange postdischarge care, the Medicare program may pay for a grace period of one (1) day (24 hours) after the date of notice of noncoverage to the beneficiary. If it is determined, and documented, that even more time is required in order to arrange postdischarge care, one (1) additional “grace day” may be paid by the Medicare program.

Providers are not to “routinely” apply grace days. The application of grace days should be limited to sudden and/or unpredictable discharges from a skilled level of care. Discharge planning is part of routine skilled care and is initiated at the time of the patient’s admission into the SNF.

SNF PROVIDER IMPROVEMENT PROCESS

As a process improvement, a SNF provider may need to implement a quality assessment program to ensure that Medicare beneficiaries are issued proper advance notification of noncoverage. Historically, this intermediary has experienced difficulty in obtaining proper advance beneficiary notification of noncoverage from SNF providers. Or, if available, the notices are often of poor quality. (See Sections 356 and 358 of the Medicare SNF Manual (HCFA Publication 12) for definition of notice.) Further, the provider’s quality assessment program should ensure that the facility’s medical documentation supports any noncoverage decision, as well as any application of “grace days.” Finally, the provider’s quality assessment program should ensure that medical documentation is submitted (based on intermediary request) to the appropriate post office box mailing address (i.e., ***Post Office Box 44159***), rather than the street address or general mailing address for this Medicare intermediary.

Questions regarding this bulletin may be addressed to the Medicare Part A Customer Service Department by calling 904/355-8899.