The following is the general rule and will usually apply to most situations. However, there may be exceptions to the rule and it is the facility’s responsibility to know those exceptions.

**WHAT IS A NO PAY CLAIM?** It's a claim required to be submitted to MCR when a resident has been admitted to your facility under the Medicare A program and later the resident has been determined to no longer require *Skilled* care **AND** the resident continues to reside in your facility on a MCR Certified Unit.

How do you know if your facility is 100% certified or if you have a unit/wing that has been designated as a Distinct MCR Unit? First, you should verify this with your Administrator. Second, you should check your Accounting Profile to make sure you have been set up properly in HTS.

Resident Accounting > Libraries > Facility > Accounting Profile.

If your facility is 100% Medicare Certified, you should see the checkbox checked.

If you are not 100% Medicare Certified, you will need to determine which units/wings are the Medicare Distinct Units. Access each unit that is a MCR Distinct Unit and check the box to indicate that unit is a MCR unit.

Facilities that are **100% Medicare-Certified** (all beds are Licensed by Medicare), must submit **NO-PAY CLAIMS** until the resident is discharged from the facility.

Facilities that have distinct MCR units must submit No-Pay Claims until the resident is discharged to a non-Medicare certified unit or discharged from the facility.

The first claim, which will cover the day following the last covered Medicare Day through the end of the month, must be submitted as soon as possible. The continuing bills may be submitted as often as once a month, quarterly, yearly, or on date of discharge.

**However, HTS allows for billing monthly ONLY.**

**Be cautious of MCR’s timely filing requirement.**

The reason you will want to submit that first No Pay Claim is to prevent issues if you later need to bill for therapy charges. You may get rejections or denials if Medicare does not know the resident has been moved to a lower level of care. Even if your last Medicare claim shows the code 22, you can run into issues with Medicare.

Census and stay tables
• Medicare A lower level of care (4/4/14)

- Opens a new stay for the new Payer
- Puts an LL in the Stay Table

Screen 1 of the Stay Table:

Screen 2 of the Medicare A Stay Table:
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See “A” Medicare covered days

Resident Theresa Aniston, Resident ID#1273-Lower Level of Care Event
Last covered Medicare A Day = 01/07/14

The Thru date equals the last covered Medicare Day.
Code 22 with the Last Covered Day will start the 60 days non-skilled time line
which may give the resident another 100 Medicare skilled days.

See “B” First No Pay Claim

Resident Theresa Aniston, Resident ID# 1273

- **If you have a situation when the lower level of care did not happen originally through census and you are now trying to accommodate for No Pay billing, you will want to start with the Stay Table.**

  - A Medicare A Stay Table with an end date, but no discharge date and an LL in the d/c to field. LL means lower level of care.
  - The Stay Table must have covered Medicare days after 9/30/06. The date 10/01/06 is the effective implementation date of No-pay Bills.
  - The Stay Table end date is the start date of another Non-Medicare Stay.
  - The Stay Table discharge date in the Non-Medicare Stay and the Discharge Status will be used to determine if a claim is a final claim and the discharge status will pull to the Patient Status Code.

This is where you could run into issues if you are trying to create a No Pay Bill after other changes have been made through the census program. If you are having issues and are not getting the correct information, you can edit the UB. However, you may want to consult our Manual to determine the required fields.

If the change has happened through the census program, all necessary information should be pulled to the No Pay Claims through our billing program.

- Type of Bill of 210
- FLN #18 Condition Code 21
- FLN #17 Correct Patient Status. If this is a continuing No-pay Bill, the Status Code should be 30. However, if the thru date is less than the end of month date and there is a non-Medicare stay table with a discharge date and a discharge status, the discharge status will be used as the Patient
Status Code. The reason for this is to notify Medicare that the resident has been discharged from the facility.

- FL# 39a Value Code 81, Value Code Amount = non-covered days.

The AAA00 represents the default rug category with the corresponding number of days.
The 120 Revenue Code is the Medicare Required Code.
The Rate represents the Standard Rate.
Total Charges equals the units x Standard Rate.
Non Covered equals the same as Total Charges.
Therapy charges are not required on No Pay Bills.

FLN# 80 Remarks. The Occurrence Code 22 with the corresponding last covered Medicare day must be included in the Remarks Section for subsequent No Pay bills.

This code and date will show on both the electronic Remarks field and the Printed Bill Only field to accommodate for both situations.

FYI: The purpose of the code 22 is to notify Medicare that a person no longer needs Skilled Care. At this time, the new spell of illness requirement of 60 days of non-skilled care starts running. A person must be non-skilled for 60 days before they are entitled to a new 100 days.

When a resident is discharged, we will pull a no pay claim that includes the days up to the discharge date. We will not continue to pull a no pay claim after the d/c date.
Exhausted Benefits

WHAT ARE BENEFITS EXHAUSTED:

Benefits Exhausted result when a resident has used all the 100 Medicare Skilled Days, continues to reside in your facility and continues to receive skilled care.

Medicare requires that you continue to send bills monthly to Medicare until the resident no longer requires skilled care or is discharged. The purpose of this requirement is to update the Common Working File (CWF).

Furthermore, when a change in level of care occurs after exhaustion of benefits, you must submit the benefits exhaust bill indicating that active care has ended. This will start the 60-day window for non-skilled care. Once the resident has 60 days of non-skilled care, they may be entitled to another 100 SNF days.

If the resident continues to reside on a MCR Certified Unit or your facility is 100% Medicare Certified, you will continue to send No Pay Bills.

Census change to record a Benefits Exhausted event:
This resident’s last covered day was 04/23/2014. Benefits Exhausted started on 04/24/2014. The co-insurance days = 23 days.

When entering the census change for a benefits exhausted, you will get a pop up box that asks you “Have the Medicare A Benefits been Exhausted?”. When you answer YES, the system will mark this claim as a benefits exhausted. If you answer NO, the system will look at this as Lower Level of care situation.

Medicare A Benefits Exhausted

Sample Stay Table

- This change will put the end date in the Stay End Date, but will not close the stay
- Opens a new stay for the new Payer
- When Benefits Exhausted billing is done, HTS will look to the stay tables and expects to see the MCR A stay still open, no LL in Disc to field and a new stay that starts the same date as the one ended.

Partial Benefits Exhausted (1301 Bryant 04/01/14-04/30/14)

See “C”

Date of Admission: 01/10/14. Benefits Exhausted on 04/19/14
Covered Days 04/01/14-04/19/14 – Last Covered Medicare Day is 04/19/14
When benefits exhaust during a month of covered Medicare days, certain required information/form locators/codes must be pulled to the UB:
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- Type of Bill = 211, 212, 213, 214 depending on the situation. **DO NOT USE TYPE OF BILL OF 210**
- From/thru = Statement covered period (full month)
- Patient Status Code = 30
- Field Locator 39 Value Codes and Amount:
  - 80 = Covered Days = All days in billing period
  - 81 = Non-Covered Days = No days
  - 82 = Co-Insurance Days = Number of days that are co days
  - 09 = With a value 1

The days related to the Benefits Exhausted will pull to the UB with the default RUG Code (AAA00) with corresponding days. All charges will fall under the Column Total Charges.

Full Exhausted Benefits Claim (005/01/2014 - 05/31/14)

SEE “D”

As long as the resident continues to receive skilled care, facility **MUST** continue to send claims to Medicare. The claims must include:

- Type of Bill = 211, 212, 213, 214 depending on the situation. **DO NOT USE TYPE OF BILL OF 210**
- Statement From/Thru = the current month
- Patient Status = 30
- Field Locator 39 Code 80 and # of days (this should equal the from/thru days)
- Field Locator 39 Code 09 and the Value code 1
- 0022 with AAA00 and number of units (equal to the from/thru days)
- 0120 with daily rate/total number of days and Total Charge (Field Locator 47).

Exhausted Benefits with a true discharge (True Discharge date of 06/14/14)

SEE “E”

When a resident is truly discharged (to home/hospital, etc), an Exhausted Benefits discharge claim must be submitted to Medicare:

- Type of Bill = 214
- Statement From/Thru = current month with the thru date the date of discharge.
- Patient Status = the discharge status code.
- Field Locator 39 Code 80 = # of days (this should equal the from/thru date – minus 1 day)
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- Field Locator 39 Code 09 = 1.00
- 0022 with AAA00 and number of units (equal to the from/thru days – minus 1 day)
- 0120 with daily rate/total number of units (equal to the from/thru days – minus 1 day) and total charges.

Exhausted Benefit: Change in level of care (SNF to NF) and Skilled Unit
When a resident who has exhausted benefits, is later deemed to no longer need skilled services and continue to reside on the Skilled Unit, facility must notify Medicare of this change by submitting a claim with this information:
- Type of Bill = 213
- Statement From/Thru = current month with the thru date being the last covered day. **Must Edit the through date.**
- Patient Status = 30
- Field Locator 39 Code 80 = # of days. **Must Edit for the correct # of days.**
- Field Locator 39 Code 09 = 1.00
- Field Locator 31 Code 22 and the last SNF covered day (should equal the thru date of the claim). **This will have to be manually entered.**
- 0022 with AAA00 and number of units (equal to the from/thru days) **This must be manually edited.**
- 0120 with daily rate/total number of units (equal to the from/thru days) and total charges. **Number of Days and Total Charges must be edited.**
- This will trigger a **NO-PAY** bill (210) event and the facility must continue to submit no pay bills until the resident is discharged from the facility or is transferred to a NF unit. **An LL must manually be entered in the MCR A stay table AFTER the level of care change has been submitted.**

MCR C – No Pay Bills to be Submitted to Medicare

Facilities who have residents who are enrolled in a Medicare C Program, must submit a claim to Medicare in order for Medicare to subtract benefit days from the Common Working File. Or HETS HIPAA Eligibility Transaction System.

However, if the resident no longer requires skilled care, discharge the resident with a code status of 04. The facility is not required to continue sending Medicare No Pay bills for residents enrolled in a MCR C program.

A resident who is admitted, needs and received Skilled Services and who has not satisfied the 3 mid-night hospital stay needs to be billed to Medicare similar to a Benefits Exhausted.

You may refer to the Medicare Claims Processing Manual Chapter 6 Section 40.8.2
40.8.2 - Billing When Qualifying Stay or Transfer Criteria are Not Met (Rev. 1618, Issued: 10-24-08, Effective: 04-01-09; Implementation: 04-06-09) SNF providers are required to submit claims to Medicare for beneficiaries that receive a skilled level of care. This includes beneficiaries that do not meet the qualifying stay or transfer criteria. Although these claims will not be paid by Medicare, providers must submit these claims as covered in order to extend existing beneficiary spells of illness in CWF. A prior qualifying hospital stay (occurrence span code 70) would not be applicable and shall not be included with these claims. This will allow Medicare systems to deny the claim for the appropriate reason.

In some cases, you may have to edit the UB especially if you have not entered the information correctly through the census program or if you are trying to pull the information from older months. You may refer to our manual for the required information prior to submitting your claims.
<table>
<thead>
<tr>
<th>MCR A</th>
<th>LAST COVERED MCR A DAY</th>
</tr>
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</table>

| 0022  | SK UNIT MEDICARE DAYS | RVA50 | 7 |
| 0160  |                          | 210.00 | 010114 | 7 | 1470 00 |
| 0250  | PHARMACY                |        |       |    | 285   00 |
| 0421  | PHYSICAL THERAPY SVC    |        |       |    | 300   00 |
| 0431  | OCCUPATIONAL THERAPY    |        |       |    | 350   00 |

| 051514 | TOTALS            | 2405 00 |

| Z      | MEDICARE          | 6141950 | Y | Y |
| G      | BLUE CROSS        | 20180   |   |   |
| D      | MAINECARE         | 987654321 | Y | Y |

| ANISTON, THERESA | 18 5452152127D |
| ANISTON, THERESA | 18 XTHSC4517   |
| ANISTON, THERESA | 18 52152478A   |

<p>| 250.00  | 278.01  | 789.9  | 311   | 698.3 | 300.00 | 317    | 244.9  | 427.31 |
| 338.29  | 564.00  |        |       |       |        |        |        |        |</p>
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<thead>
<tr>
<th>Code</th>
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<th>Description</th>
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<tbody>
<tr>
<td>0022</td>
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<tr>
<td>0120</td>
<td>013114</td>
<td></td>
<td>5040.00</td>
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**Remarks:**
- **1st No Pay Bill**
### Medicare Reimbursement Details

**Date:** 04/20/14  
**Total:** $6750.00

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<tbody>
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<tr>
<td>920500</td>
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</tbody>
</table>

**Coinsurance:** 100%

**Net Amount:** $2250.00

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**Recipient Information:**

**Name:** BRYANT, MARGARET  
**Address:** 5 WINWOOD RD, PORTLAND, ME 04225  
**Telephone:** 2074747122  
**Tax ID:** 2074747122

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**Additional Details:**

- **ICD-10 Code:** C50.1  
- **Diagnosis:** Cancer of the colon, descending

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**Certification:**

The certifications on this form apply to this bill and are made a part hereof.

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**Notes:**

- Include with Reg UB LCD-4/19/14

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**Signature:**

[Signature]

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**Other Information:**

- **Medical Provider:** MDMECARE  
- **Medical Provider ID:** 995877417A

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**Reimbursement Details:**

- **Beneficiary Name:** BRYANT, MARGARET  
- **Beneficiary ID:** 085454994

---

**Provider Information:**

- **Provider Name:** MDMECARE  
- **Provider ID:** 995877417A