

Blue Cross Blue Shield of Michigan
Medicare Advantage Private Fee-for-Service

Skilled Nursing Facility

January 1, 2008
Updated October 1, 2008

SKILLED NURSING FACILITY

A skilled nursing facility provides skilled care such as nursing or rehabilitation services to individuals who can no longer care for themselves following an injury or illness. It can be a separate facility, or part of a hospital or other health care facility.

ORIGINAL MEDICARE

Original Medicare benefits cover extended care services that are provided in a Medicare certified skilled nursing facility. There is a limit of 100 days for each benefit period. The benefit period is renewed when the beneficiary has not been in a skilled nursing facility for 60 days. There is no limit to the number of benefit periods a beneficiary can have.

The beneficiary must meet the following requirements to be eligible for coverage:

- The beneficiary must be an inpatient of a hospital for a medically necessary stay of at least three consecutive calendar days prior to discharge.
- The beneficiary must be transferred to the skilled nursing facility within 30 days after discharge from the hospital.
- In certain circumstances, the 30-day period may be extended if, at the time of hospital discharge, it is predictable that extended care services will be required subsequent to hospital care¹.

MEDICARE ADVANTAGE

Coverage for services provided in a Medicare certified skilled nursing facility is provided under all Medicare Advantage private fee-for-service plans, however additional benefits are provided. The three day hospital stay requirement under Original Medicare is waived for all group and individual Medicare Advantage private fee-for-service members. In addition, select Medicare Advantage private fee-for-service group plans offer enhanced benefit days per benefit period. The member's cost-sharing is determined by the group.

Conditions for Payment

BCBSM Medicare Advantage private fee-for-service plans use the Centers for Medicare & Medicaid Services deemed provider² concept for group specific benefits.

¹ CMS Benefit Policy manual Publication 100-02, chapter 8, section 20.2.2.1

² 2008 Terms and conditions

The table below specifies payment conditions for a skilled nursing facility:

Conditions For Payment	
Eligible providers	Consistent with Original Medicare
Deemed provider	See terms and conditions on bcbsm.com/ma
Payable locations	Consistent with Original Medicare
Frequency / Limitations	<ul style="list-style-type: none"> • Medically necessary stay of at least three consecutive calendar days in an inpatient hospital is not required. • Days per benefit period vary by MA group plan: <ul style="list-style-type: none"> • 120 days per benefit period • 730 days per benefit period • Unlimited days per benefit period
CPT/HCPCS codes	Consistent with Original Medicare
Diagnosis restrictions	
Age restrictions	

Reimbursement

The maximum payment amount for the skilled nursing facility benefit is consistent with Original Medicare. The provider will be paid the skilled nursing facility prospective payment system rate, minus the member's cost-share for all Part A inpatient services. This represents payment in full and providers are not allowed to balance bill the member for the difference between the allowed amount and the charge.

Member Cost-Sharing

- Deemed providers must agree to collect from the member only the cost-sharing amounts described in the table below. They may not otherwise charge or bill the member.
- If the member elects to receive a noncovered service, he or she is responsible for the entire charge associated with the noncovered service.

The cost-sharing chart below identifies members who have coverage for more than 100 days per benefit period.

Member Cost-Sharing Responsibilities							
Group Name and Number	Days Per Benefit Period	Annual Deductible		Coinsurance		Out-of-Pocket Maximum	
				Facility Claim			
		2007	2008	2007	2008	2007	2008
BCBSM Retirees ³ 80311, 80312	120	No MA PFFS plan	\$250	No MA PFFS plan	5%	No MA PFFS plan	\$1000

³ BCBSM Retirees Benefit grid

Member Cost-Sharing Responsibilities							
Group Name and Number	Days Per Benefit Period	Annual Deductible		Coinsurance		Out-of-Pocket Maximum	
				Facility Claim			
		2007	2008	2007	2008	2007	2008
City of Detroit Option E ⁴ 81100, 81101	730	\$0	\$0	Does not apply		Does not apply	
City of Detroit Option F ⁵ 54731, 81097	120						
City of Detroit Option G ⁶ 04436	Unlimited						
State of MI Retirees ⁷ 81820, 81821, 81828	120	No MA PFFS plan	\$200	No MA PFFS plan	Does not apply	No MA PFFS plan	Does not apply

Billing Instructions

1. Bill services on the UB-04 (CMS-1450) or the 837 equivalent claim.
2. Use the Medicare Advantage private fee-for-service unique billing requirements.
3. Report CPT/HCPCS codes and diagnosis codes to the highest level of specificity.
4. Report your National Provider Identifier number on all claims.
5. Submit claims to your local BCBS plan.
6. Use electronic billing:
 - a. Michigan providers:
 - A copy of the ANSI ASC X12N 837 and 835 Institutional Health Care Claim and Health Care Claim Payment/Advice (BCBSM Electronic Data Interchange (EDI) Institutional 837/835 Companion Document) is available at:
http://www.bcbsm.com/pdf/837_835_institutional_companion.pdf
 - b. Providers outside of Michigan should contact their local BCBS plan.

⁴ City of Detroit - Option E Benefit grid

⁵ City of Detroit - Option F Benefit grid

⁶ City of Detroit - Option G Benefit grid

⁷ State of Michigan Retirees Benefit grid