Skilled nursing facility
Applies to:

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

☐ Medicare Plus Blue℠ PPO ☐ Medicare Plus Blue℠ Group PPO ☒ Both

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 care.

Medicare Plus Blue

Medicare Plus Blue plans provide at least the same level of benefit coverage as Original Medicare (Part A and Part B) and provide enhanced benefits beyond the scope of Original Medicare within a single health care plan. This flexibility allows BCBSM to offer enriched plans by using Original Medicare as the base program and adding desired benefit options.

Coverage for services provided in a Medicare certified skilled nursing facility is provided to members under select individual Medicare Plus Blue PPO and select standard Medicare Plus Blue Group PPO plans. The three–day hospital stay requirement under Original Medicare is waived for all Medicare Plus Blue members. In addition, select Medicare Plus Blue Group PPO plans offer additional days per benefit period. The member's cost-sharing is determined by the group.

Conditions for payment

The table below specifies payment conditions for skilled nursing facility.

Conditions for payment	
Eligible provider	Consistent with Original Medicare
Payable location	Consistent with Original Medicare
Frequency	Medically necessary stay of at least three consecutive calendar days in an inpatient hospital is not required. Days per benefit period vary: • 100 days per benefit period - standard benefit • 120 days per benefit period (group only option) • Unlimited days per benefit period (group only option)
CPT codes	Consistent with Original Medicare
Diagnosis restrictions	
Age restrictions	

Reimbursement

Medicare Plus Blue plan's 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

- Medicare Plus Blue providers should collect the applicable cost-sharing from the member at the time of the service when possible. Cost–sharing refers to a flat–dollar copayment, a percentage coinsurance or a deductible. You can only collect the appropriate Medicare Plus Blue cost–sharing amounts from 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.

For detailed information about a Medicare Plus Blue member's benefits and cost–share, providers may verify member benefits via web–DENIS or call CAREN at 1–866–309–1719.

Billing instructions for members

1. Bill services on the UB-04 (CMS–1450) or the 837 equivalent claims
2. Use the Medicare Advantage PPO 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: ***bcbsm.com/pdf/837_835_institutional_companion.pdf***
      — A copy of the BCBSM EDI Professional 837/835 Companion Document is available at: ***bcbsm.com/pdf/systems_resources_prof_837_835.pdf***
   b. Providers outside of Michigan should contact their local BCBS plan.