

Date: January 24, 1994 BQC-94-005
To: Nursing Homes NH 2
From: Judy Fryback, Director
Bureau of Quality Compliance
Subject: Medicare Demand Billing (F Tags 160, 163, 492)

Applies Only to MEDICARE CERTIFIED Nursing Homes

The Bureau of Quality Compliance (BQC) has recently received a program letter from the Health Care Financing Administration Region V (HCFA) regarding "Clarification of Long Term Care (LTC) Procedures for Demand Billing" which is in answer to questions the Bureau of Quality Compliance had posed to HCFA. This BQC numbered memo will reiterate those questions and HCFA's response.

LTC surveyors are instructed by Section VII, Part I of Appendix P (pages P-37-38) of the State Operations Manual (SOM) to verify compliance with demand billing requirements resulting from the Sarassat vs. Sullivan settlement agreement of May 17, 1989. That agreement requires long term care facilities to use standard denial notices whenever a Skilled Nursing Facility (SNF) determines that a Medicare beneficiary does not require services or levels of care covered by the Medicare program, either on admission to the facility or upon change in the required level of care. The settlement also requires HCFA to monitor facility compliance with the agreement through the survey and certification procedures conducted by the State Survey Agency.

1. Are skilled nursing facilities/nursing facilities (SNF's/NF's) with Medicare distinct parts required to provide notice of non-coverage under Medicare to beneficiaries admitted to the Medicare distinct part only, or to all beneficiaries admitted to the facility in its entirety?

Answer: All beneficiaries. If the facility is certified under the Medicare program, whether it be a Medicare distinct part or SNF/NF, then any individual residing in the facility who is a Medicare beneficiary must be provided notice of non-coverage under Medicare.

2. When a beneficiary has exhausted benefits or does not have the qualifying hospital stay prior to admission, must the facility provide the beneficiary with the mandatory denial notice found in section 358 of the Health Care Financing Administration Skilled Nursing Facility Manual?

Answer: No. When a beneficiary has exhausted the 100-day benefit period or has not had a 3-day qualifying hospital stay, the beneficiary is "technically denied" from Medicare coverage for the stay in the skilled nursing facility (SNF). Unlike denials based on the level of care, in cases of technical denial the facility is not obligated to inform the beneficiary of demand billing rights. However, if the beneficiary requests that the facility submit his/her bill to the Medicare intermediary at any time, the facility must do so.

3. Is the facility prohibited from billing the resident while the demand bill is under review?

Answer: For Cases Of Technical Denials (e.g., the 100 day benefit period has been exhausted or the beneficiary has not had a 3-day qualifying hospital stay): the facility may bill the resident for the daily or monthly rate charged to non-Medicare residents until a decision is made by the Medicare payor on the demand bill.

Answer: For Cases That Are Not Based On Technical Denials But Rather Level Of Care Denials: the facility may bill only for coinsurance, deductibles, and "personal comfort charges" (e.g., private telephone) until a decision is made by the Medicare payor on the demand bill.

4. May a SNF transfer a resident out of a distinct part SNF bed after the facility provides notice of non-coverage and the beneficiary requests demand billing?

Answer: The only circumstances under which a facility may transfer or discharge a resident are listed at 42 CFR 483.12 (a)(2). Non-payment is one of these circumstances and may apply in cases of technical denials.

If the facility's determination of non-coverage is a technical denial, the facility may bill the resident the daily or monthly rate charged to non-Medicare residents before the decision on the demand bill is rendered. If the resident fails to pay that bill, the facility may transfer or discharge him/her for non-payment in accordance with the requirements at 42 CFR 483.12.

If the basis of the non-coverage is not a technical denial, the facility may not transfer or discharge the resident for non-payment while the decision on the demand bill is pending.

(For issues regarding Transfer, Room Change and Discharge, refer to BQC memo 93-033 dated April 15, 1993).

5. At what point does the deficiency cited become a violation of the provider agreement for which the State Survey Agency must submit a recommendation for termination to the HCFA Regional Office (RO)?

Answer: If a facility is in violation of the provider agreement with respect to resident billing requirements and is cited for a deficiency at tag F492, 42 CFR 483.75(b), Compliance With Federal, State and Local Laws and Professional Standards, the State Survey Agency should forward this information to the HCFA Division of Health Standards and Quality for investigation of billing practices. This investigation is coordinated with the HCFA's Regional Office Division of Medicare. If a violation of the provider agreement is found, then the HCFA Regional Office will take appropriate action.

6. How far back must a facility go in submission of claims if it is determined it has failed to abide by the demand billing requirements? In other words, if the survey revealed that demand bills were not processed for 8 residents in the past 6 months, would submission of demand bills for those 8 residents suffice, or would an audit have to be undertaken to determine the extent of the problem?

Answer: If a facility has failed to comply with demand billing requirements, then its plan of correction should address the steps the facility will take to remedy current violations within a specific timeframe. The Social Security Act provides that this timeframe for review of submissions of claims is a maximum of 15 months.

The facility's plan of correction should also present methods to correct systemic problems in order to prevent future demand billing violations. Within the timeframe permitted under the Act, the survey agency may decide how far back the review submissions of claims, keeping in mind that the facility's plan of correction should emphasize its remedies for systemic demand billing problems and its strategy to prevent future violations.

If you have questions regarding Medicare Demand Billing and the survey process, please contact your Field Operations Manager.