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 for 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's predictable that extended care services will be required subsequent to hospital care.

Medicare Plus Blue℠ PPO enhanced benefit

Medicare Plus Blue is a Medicare Advantage plan, which provides at least the same level of benefit coverage as Original Medicare (Part A and Part B) and may provide enhanced benefits beyond the scope of Original Medicare within a single health care plan. This flexibility allows Blue Cross 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 individual Medicare Plus Blue PPO and Medicare Plus Blue PPO group plans that select this benefit. 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 Blue Cross for individual coverage and by the group for group-based coverage.

Conditions for payment

The following table specifies payment conditions for skilled nursing facility coverage.

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 isn't 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)
HCPCS codes	Consistent with Original Medicare
Diagnosis restrictions	
Age restrictions	

Reimbursement

Medicare Plus Blue PPO's plan maximum payment amount for skilled nursing facility benefit is consistent with Original Medicare. Reimbursement is made at the skilled nursing facility prospective payment system rate, minus the member's cost share for Part A inpatient services. This represents payment in full and providers aren't allowed to bill the member for the difference between the allowed amount and the charge.

Member cost sharing

- Medicare Plus Blue PPO 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. Providers can only collect the appropriate Medicare Plus Blue Group cost sharing amount from the member.
- If the member elects to receive a noncovered service, he or she is responsible for the entire charge associated with that service.
- Providers may not have members sign an ABN to accept financial responsibility for noncovered items or services. If there is any question about whether an item or service is covered, seek a coverage determination from Blue Cross before providing the item or service to the member. If a provider provides a noncovered item/service to a member without first obtaining a coverage determination, the member must be held harmless for all charges except for any applicable cost-share.

To verify benefits and cost share, providers may utilize our provider portal or call 1-866-309-1719.

Billing instructions for providers

1. Bill services on the CMS-1450 (UB-04) or 837 equivalent claim form.
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. Send your claims to your local Blue Cross plan.
6. Use electronic billing:
   a. Michigan providers
      Copies of the ANSI ASC X 12N 837 and 835 Institutional Health Care Claim and Health Care Claim Payment/Advice (Blue Cross Electronic Data Interchange (EDI) Institutional 837/835 Companion Documents) are available on the Blue Cross website under the reference library section at: **bcbsm.com/providers/help/edi/**.
   b. Providers outside of Michigan should contact their local Blue Cross plan.

Revision history

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