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Medicare 2021
A Journey to a Healthier Future and Partnership

Skilled Nursing Facility Consolidated Billing
Who is Responsible for Billing Medicare?

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

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Objectives

- Provide a comprehensive overview of SNF CB for all Part A providers
- Clarify the “billing under arrangement” process to ensure that the correct entity is billed and providers reimbursed properly for services

Agenda

- SNF PPS
- SNF CB
  - Facilities and Services Subject to CB
  - Major Categories and CB Exclusions
  - SNF CB Editing
- Services Provided Under Arrangement
  - Best Practices

SNF PPS Billing and Reimbursement

- SNF PPS payment calculation based on patient's RUG score and services included on inpatient claim
- SNFs should submit all covered services rendered to patient and considered included in SNF PPS on SNF claim
  - Even if services are rendered by outside provider of service – no separate payment made
  - Can help determine if increase in RUG payment should be made

SNF PPS Reminder

- Neither SNF nor another provider or practitioner may bill Medicare for services under Part B
  - Except for services specifically excluded from PPS payment and associated CB requirements

What is SNF CB?

- Requirement in section 1862(a)(18) of Social Security Act
  - Effective on or after 7/1/1998
- Places responsibility on SNF for all services patients receive during Part A stay
  - Except for services designated by CMS as excluded from SNF CB

SNF Consolidated Billing Terminology

- Included in SNF CB
  - Services designated as *included* in SNF CB must be billed by the SNF - these services are included in the SNF PPS reimbursement methodology
- Excluded from SNF CB
  - Services designated as *excluded* from SNF CB must be billed by the outside entity

SNF Consolidated Billing Terminology

- Bundled services
  - Services designated as included in the SNF PPS reimbursement are also referred to as *bundled* services because these services must be included on the SNF bill
- Outside entity
  - Refers to a provider of service other than the SNF that provides services for the SNF patient

SNF CB

- All SNF PPS services considered **included** in SNF CB must be billed directly to Medicare by SNF on Part A inpatient claim
- SNF must either furnish service directly, or obtain the service from an outside entity under an “arrangement”
  - Services designated as included in SNF CB and provided by outside entity are reimbursed by SNF

Why SNF CB?

- Avoids duplicate billing
- Decreases beneficiary liability
- Enhances SNF's ability to meet its existing responsibility to oversee and coordinate total package of care its residents receive

Questions the SNF Should Answer

- Is this Medicare beneficiary in a Part A SNF stay? Does CB apply?
  - Part A stay defined: Are you (the SNF) billing covered days to the Medicare Program?
  - Make sure your billing staff are able to assist the outside entity so they know whether the bill comes to you as the SNF or should the outside entity bill Medicare directly

Questions for the Outside Entity

- Outside entity – do not just assume, contact SNF if no indication
  - Make sure you talk to correct person in billing or registration/admission department
- Do you have agreement with SNF?

Facilities Subject to SNF CB Requirements

- SNF CB applies to
  - Participating SNFs
  - Short-term hospitals
  - Long-term hospitals
  - Rehabilitation hospitals certified as swing bed hospitals, except CAHs certified as swing bed hospitals

Did You Know

- SNF swing bed in a CAH is exempt from using the list of Major Categories for SNF CB and should not separately bill the patient for OP services when they are provided while the patient is in a SW Bed
- Services provided during a covered Part A CAH SW Bed stay must be billed on the SW Bed claim – TOB 18X

Services Not Subject to SNF CB

- Services designated by CMS as **excluded** are separately billable under Part B when furnished to Part A SNF resident
  - Some services excluded by statute
  - Others excluded administratively in regulations

Major Categories of Exclusion

- CMS identifies five major categories of services, which are excluded from SNF CB guidelines
- Detailed explanation of major categories is found at
  - General Explanation of the Major Categories for Skilled Nursing Facility (SNF) Consolidated Billing

SNF CB Enforcement

- Enforcement of CB is done through editing using lists of HCPCS codes that are subject to the CB provision of SNF PPS
- To assure proper payment in all settings editing includes services both included and excluded from CB
- CMS Transmittals with instructions provide updates to previous lists of the exclusions, and some inclusions to CB

Services Excluded From SNF CB

- It is important you understand what services are EXCLUDED from SNF PPS reimbursement whether you are a SNF or outside entity
- SNF CB Part A MAC Update
  - Scroll to bottom of page and select zip file under “Downloads”

Tips for Interpreting the Excel File

- Use search function – Ctrl F
- HCPCS code listed on file is considered **excluded** from SNF CB
  - Surgical range HCPCS code listed on file = ***included*** in SNF CB

Physicians' Services

- PC of most physician services **excluded** from Part A PPS payment and SNF CB and billed to carrier on CMS-1500 claim form
- TC of most physician services **included** in Part A PPS payment and SNF CB and billed by SNF on UB-04 claim form

Physicians' Services

- PC/TC component billing example
  - PC of radiological procedure billed on CMS-1500 claim form for SNF patient in covered Part A stay
    - TC of same radiological procedure included on SNF bill to Medicare on UB-04 claim form

Special Situation - Therapy Services

- PT, OT and SLP services always subject to SNF PPS and CB for residents in skilled stay
  - Charges for these services must be billed to Medicare by SNF
  - Therapy providers seek payment from SNF directly
    - Cannot bill carrier on CMS-1500 claim form
- Applies even when performed by type of practitioner (e.g., physician) whose professional services would otherwise be excluded from CB

Facility Charge in Connection With Clinic Services of a Physician

- Beneficiary receives clinic services from a hospital-based physician
  - Physician bills A/B MAC (B)
  - Hospital bills a “facility charge” for overhead expenses to A/B MAC (A)

Major Category I Services

- Exclusion of services beyond scope of SNF
  - Excluded from SNF PPS and CB for patient in Medicare-covered inpatient Part A SNF stay
  - Services must be provided on outpatient basis at hospital or CAH to be excluded
  - Services directly related and for same POS and same LIDOS, excluded
  - Excluded services provided in SW Beds that are subject to SNF PPS are to be billed on TOB 13X by the SW bed hospital

Major Category I Services

- Outpatient surgery and related procedures
- ER services
- Ambulance trips
- Radiation therapy
- CT scan
- Cardiac catheterization
- MRI
- Angiography, lymphatic, venous and related procedures

Outpatient Surgery and Related Procedures

- Inclusions, rather than exclusions, are given in this one case because of the great number of surgical procedures that are excluded and can only be safely performed in a hospital operating room setting
  - Note that anesthesia, drugs, supplies and lab services will be bypassed by enforcement edits when billed with outpatient surgeries excluded from SNF CB

Major Category I Services

- Anesthesia, drugs incident to radiology and supplies (revenue codes 37X, 25X, 27X and 62X) bypassed when billed with
  - Computerized Axial Tomography Scans
  - Cardiac Catheterizations
  - Magnetic Resonance Imaging
  - Radiation Therapy
  - Angiography
  - Outpatient Surgery

Major Category I Services

- ER services
  - Identified by 45X revenue code
  - Related services same LIDOS also excluded
  - ET modifier appended when ER service spans two days
    - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 6 Section 20.1.2.2

Ambulance Services

- Ambulance services not identified as type of service categorically excluded from SNF CB
  - Ambulance trips – must meet medical necessity
  - Ambulance associated with Major Category I
    - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 6, Section 20.3.1

Ambulance Services

- Transfers between two SNFs
  - When beneficiary travels from SNF 1 and is admitted to SNF 2 by midnight of same DOS, ambulance bundled back to SNF 1
    - Beneficiary is considered patient of SNF 1 until admitted to SNF 2
- Round-trip to physician office
  - If R&N beneficiary ambulance transport destination is physician office, the round-trip transport is responsibility of SNF and included in SNF PPS rate

Ambulance Services

- Transports to/from diagnostic or therapeutic site other than hospital
  - Services provided at IDTF responsibility of SNF therefore R&N ambulance transport is responsibility of SNF
- Transport to/from RDF
  - R&N ambulance transport for purpose of receiving dialysis excluded from SNF CB

Did You Know

- Medicare simply does **not** provide coverage under Part A or Part B for any nonambulance forms of transportation
  - Ambulette
  - Wheelchair van
  - Litter van
- SNF may provide appropriate notification to resident for this noncovered service for which patient may be financially liable

Major Category II Services

- Additional services excluded when rendered to specific beneficiaries
  - Dialysis, Acute Dialysis, EPO, Aranesp, and other dialysis related services for ESRD beneficiary
  - Hospice care for beneficiary's terminal illness

Major Category II Services

- ESRD services must be provided in RDF
  - Specific coding differentiates dialysis and related services excluded from SNF CB for ESRD beneficiaries in three cases
    - When services provided in RDF
    - Home dialysis when SNF constitutes patient's home
    - EPO or Aranesp used for ESRD patient and given by RDF

Major Category II Services

- Hospice must be only type of provider billing for hospice services
  - Billed by hospice on TOB 81X or 82X
  - Services unrelated to beneficiary's terminal condition billed by SNF and designated with CC 07

Major Category III Services

- Additional excluded services rendered by certified providers except SNF
  - Certain chemotherapy
  - Certain chemotherapy administration
  - Certain radioisotopes and their administration
  - Certain customized prosthetic devices

Major Category IV Services

- Coverage of screening and preventive services is a separate Part B inpatient benefit when rendered to patient in covered Part A stay
  - Subject to SNF CB
  - Billed by SNF for beneficiaries in Part A stay
  - SNFs bill on 22X TOB – Beneficiary in certified bed
  - SNFs bill on 23X TOB – Beneficiary in noncertified bed
  - Swing bed providers bill on 12X TOB

Major Category IV Services

- Screening and preventive services
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 18
    - Frequency parameters
    - Diagnosis criteria
    - HCPCS codes
    - Deductible – coinsurance
    - Age requirements
- SNF patient must have current Medicare Part B coverage

Did You Know

- CMS published a convenient tool that provides the following information on each Medicare preventive service
  - Medicare Preventive Services
    - HCPCS/CPT codes
    - ICD-10 codes
    - Coverage requirements/frequency requirements
    - Beneficiary liability

Major Category V Services

- Part B services included in SNF CB
  - Therapy services subject to SNF Part B CB requirement and billed on 22X TOB by SNF alone for Part B residents in “certified” bed
  - Resident in noncertified bed - therapy service NOT subject to SNF CB and billed by SNF on 23X TOB or billed by entity providing therapy

Therapy Services – Wrap up

- The SNF is responsible for billing ALL of the therapy that the SNF patient receives while in a **certified bed** within the SNF even when the SNF patient is in a noncovered stay
- SNF must bill for the “therapy” services for patients in a certified bed in a noncovered stay on the 22x TOB

Services Furnished Under Arrangement

- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 6, Section 10.4 – 10.4.2
- Any service subject to SNF CB must be provided directly by SNF or by outside entity under arrangement

Did You Know

- Having an arrangement with an outside provider to provide those services subject to CB and not rendered by the SNF is very important because it ensures that all parties are billing according to Medicare regulations

Services Furnished Under Arrangement

- SNF must reimburse outside entity
  - Whenever possible, “arrangement” must constitute written agreement to reimburse outside entity for services provided Part A beneficiary
  - Exact reimbursement amount for service is determined by mutual agreement of both parties – Medicare does not dictate reimbursement amount
    - CMS Physician Fee Schedule may be starting point for reimbursement negotiation

Services Furnished Under Arrangement

- SNFs should document arrangements in writing
- Ensures arranged services meet quality standards
- SNFs must ensure arranged services meet professional standards and principles
  - Applies to professionals providing such services

Services Furnished Under Arrangement

- In absence of written agreement, supplier may encounter difficulty obtaining payment from SNF
- Absence of written agreement does not invalidate SNF's responsibility to reimburse suppliers for services included in SNF CB

Problem Situations

- Situations most commonly arise in one of the following two scenarios
  - A SNF does not accurately identify services as being subject to SNF CB when ordering such services from a supplier or practitioner
  - A supplier fails to ascertain a beneficiary's status as a SNF resident when the beneficiary seeks to obtain such services directly from the supplier without the SNF's knowledge

What Is Your Process?

- If SNF patient is sent to outside provider of service
  - Do you identify SNF patient to provider?
    - Do you make transportation arrangements?
    - Do you make prior arrangements with provider for services being rendered?
- Submit all services on inpatient claim

Making an Arrangement

- Both parties need to reach common understanding on terms of payment
  - How to submit invoice, how payment rates are determined, and turn-around time between billing and payment
- Without reaching an understanding it is difficult to maintain strong relationships necessary between SNFs and their suppliers

Steps in the Right Direction

- Both SNF and supplier should understand services subject to SNF CB
  - Outpatient facility must avoid situations where they might improperly attempt to bill Part B directly for services
  - SNFs should be prepared to honor payment under arrangement guidelines and enter into agreements with outpatient suppliers
  - Whenever possible, SNF should document arrangements with suppliers in writing

CMS Best Practices Guidelines

- Provides sample agreements and communication tools
  - Use of these sample documents not “required”
  - Documents may be modified
  - Sample language and formats
    - CMS Best Practices Guidelines

Resources

Physician Fee Schedule Lookup

- CMS Physician Fee Schedule lookup website
  - Search for fee schedule amounts by HCPCS code
  - Medicare does not dictate reimbursement provided for services under arrangements
  - CMS Physician Fee Schedule Overview
  - MLN Booklet® *How to Use the Searchable Medicare Physician Fee Schedule (MPFS)*

Resources

- CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 6
- CMS SNF Consolidated Billing Website
- MLN Matters® *SE0431: Skilled Nursing Facility Consolidated Billing*

Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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