Basics of Skilled Nursing Facility Consolidated Billing (SNF-CB)

Medicare Part A and B Presentation
March 19, 2013
Agenda

- Skilled Care Defined
- Background on SNF-CB
- Under Arrangements
- Inclusions and Exclusions
- Common Part A and Part B Errors
- Medicare Updates
Disclaimer

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What is Skilled Care?

- Require the skills of a nurse, licensed practical nurse, physical therapist (PT), occupational therapist (OT) and speech language pathologists (SLP) or audiologist

- Requires general supervision of skilled personnel

- SNF resident is a beneficiary admitted to a Medicare participating SNF or the participating, Medicare certified distinct part unit (DPU) of a larger institution
Skilled Nursing Facility (SNF) Coverage Qualifications

• Must be eligible for Medicare Part A
• Require daily skilled services
• At least 3 consecutive days of inpatient hospital care for a related illness or injury
• Admitted to SNF within 30 days of hospital discharge
## SNF Benefit Coverage

<table>
<thead>
<tr>
<th>Day 1-20</th>
<th>Covered</th>
<th>No deductible, no coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 21-100</td>
<td>Covered</td>
<td>Daily coinsurance ($148.00)</td>
</tr>
<tr>
<td>Beyond day 100</td>
<td>Not covered</td>
<td>Beneficiary liable</td>
</tr>
</tbody>
</table>
SNF Consolidated Billing (CB)

Background

- SNFs had the option to furnish services either:
  - Directly, using its own resources;
  - Through the SNF’s transfer agreement hospital; or
  - Under arrangement with an independent therapist

- “Unbundling” services were allowed

- Process created several billing and liability issues
SNF Consolidating Billing Background

- CB required under Section 4432 (b) of the Balanced Budget Act
- Prospective Payment System (PPS)
- SNF must submit all Medicare claims for services that its residents receive
  - Excluded services are not subject to CB
Providers Affected by SNF-CB

- Physicians
- Hospital swing beds
- Imaging centers
- Ambulance suppliers
- Hospitals/CAHs
- Radiology centers
“Under Arrangements”

- SNF furnish services directly or under arrangement
- Outside supplier must look to the SNF for payment
- Both parties need to reach a common understanding on terms of payment
  - How to submit an invoice
  - How payment rates will be determined
  - Turn-around time between billing and payment
When Does SNF-CB End?

• Admitted as an inpatient to a hospital, Critical Access Hospital (CAH) or to another SNF

• Receives services from a home health agency under a plan of care

• Receives outpatient services from hospital or CAH

• Formally discharged from the SNF unless readmitted by midnight of the same day
Inclusions

- All services furnished to a SNF resident in a covered Part A stay
- Psychological services furnished by a clinical social worker
- Services “incident to” the professional services of a physician or other health care professional
Major Category I

- Computerized axial tomography (CT) scans
- Cardiac catheterization
- Magnetic resonance imaging (MRIs)
- Radiation therapy
- Angiography, lymphatic, venous and related procedures
- Outpatient surgery and related procedures - INCLUSION
- Emergency services
- Ambulance transportation (medically necessary)
Major Category II

• Home dialysis supplies and equipment, self–care home dialysis support services
• Institutional dialysis services and supplies
• Epoetin alfa (EPO) and Darbepoetin alfa (Aranesp)
• Hospice care related to the terminal illness
Major Category III

- Chemotherapy
- Chemotherapy administration services
- Radioisotope and their administration
- Customized prosthetic devices
**Major Category IV**

These services must be billed by the SNF on TOB 22X

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammography</td>
<td>Vaccines (pneumococcal, flu or hepatitis B)</td>
</tr>
<tr>
<td>Vaccine administration</td>
<td>Screening pap smear</td>
</tr>
<tr>
<td>Pelvic Exams</td>
<td>Colorectal screening</td>
</tr>
<tr>
<td>Prostate cancer screening</td>
<td>Glaucoma screening</td>
</tr>
<tr>
<td>Diabetic screening</td>
<td>Cardiovascular screening</td>
</tr>
<tr>
<td>Initial Preventive Physical Exam (IPPE)</td>
<td>Abdominal Aortic Aneurysms (AAA) screenings</td>
</tr>
</tbody>
</table>
Annual Coding File for Part A

Major Category V - Inclusion

• This category applies to therapies billed with revenues codes
  • 42x (physical therapy)
  • 43x (occupational therapy)
  • 44x (speech-language pathology)

• Must be billed by the SNF for its Part B residents and non-residents
Frequency of Billing

SNF claims are billed to Medicare:

• Upon discharge of the resident
• Benefits exhausted
• Resident ceases to need skilled care
• Billed on a monthly basis
Demand Bills Reminder

- Demand bills are submitted by the provider as requested by the beneficiary

- Condition code 20 should be included on the claim for demand bills

- All charges associated with Condition code 20 must be submitted as non-covered
Common SNF-CB Issues

- SNF fails to inform the supplier resident is in a covered Part A stay
- Valid payment contract was not arranged
- Resident temporarily leaves SNF and obtain services subject to CB from another provider
SNF Responsibilities

• Notify outside providers/suppliers that services may be subject to CB

• Inform beneficiary about CB requirements

• Ensure valid payment arrangements are established with outside provider
  • Model agreements and notifications forms are available http://www.cms.gov/SNFPPS/o8_BestPractices.asp
Common Part A SNF Claim Submission Errors

• Reason code EA031 – claim processing system shows patient has an HMO
  • Add Condition code 04 to the claim if patient has an HMO

• Reason code C7010- claim overlaps a hospice election period
  • If services are unrelated to the terminal illness include Condition code 07 on the claim
Common Part A SNF Claim Submission Errors

• Reason code 38119 – SNF claims should be billed in sequence
  • Submit the prior bill

• Reason code 12206 – Sum of covered days and non-covered days must equal the statement covers period
  • Verify the following:
    • Covered and non-covered days
    • Statement from and through dates
    • Patient status
Top Claim Submission Errors Page

Top Claim Submission Errors and How to Resolve Them

Claim Submission Errors (CSEs) cause your billing transactions to either reject or move to your Return to Provider (RTP) file for correction and create unnecessary costs to the Medicare program. Remember that it is your responsibility as a Medicare provider to ensure the information submitted on your billing transaction is correct and compliant with Medicare regulations.

Providers should be aware what action may be taken when they demonstrate a pattern of submitting claims inappropriately, incorrectly or erroneously, including a referral to the Office of Inspector General (OIG) for Medicare fraud or abuse.

Below is a list of the most recent top errors by state. Scroll down the page to access the specific error/reason code (numeric/alpha order), as well as resources you can use to avoid future billing errors.

Fourth Quarter 2012 (October, November & December)

<table>
<thead>
<tr>
<th>Alabama Providers</th>
<th>Georgia Providers</th>
<th>Tennessee Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>36200</td>
<td>36200</td>
<td>36200</td>
</tr>
<tr>
<td>C7010</td>
<td>32402</td>
<td>32200</td>
</tr>
<tr>
<td>39132</td>
<td>19201</td>
<td>31577</td>
</tr>
<tr>
<td>39529</td>
<td>C7010</td>
<td>16701</td>
</tr>
</tbody>
</table>

http://www.cahabagba.com/part-a/claims/top-claim-submission-errors-how-resolve-them/
Claims Issues Log - Part A

https://www.cahabagba.com/part-a/claims/claims-log/#
SNF-CB CMS Manual References

- Medicare Claims Processing Manual, Publication 100-04, Chapter 6 - SNF Inpatient Part A Billing and SNF Consolidated Billing

- Medicare Claims Processing Manual, Publication 100-04, Chapter 7 – SNF Part B Billing (Including Inpatient Part B and Outpatient Fee Schedule)
The Part B Perspective (SNF-CB)

Know Your SNF Resident – IT is KEY!
A SNF resident is defined as a beneficiary who is admitted to a Medicare-participating SNF, or to the nonparticipating portion of a nursing home that also includes a Medicare-participating SNF, regardless of whether Part A covers the stay.
## Helpful Terminology

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td><strong>SNF-CB</strong></td>
<td>(also called Skilled Nursing Facility Consolidated Billing) Section 4432 (b) of the Balanced Budget Act (BBA) requires consolidated billing for SNFs. Under the consolidated billing requirement, the SNF must submit ALL Medicare claims for ALL the services that its residents receive under Part A, except for certain excluded services described in §§20.1 – 20.3, and for all physical, occupational and speech-language pathology services received by residents under Part B</td>
</tr>
<tr>
<td><strong>CWF</strong></td>
<td>(also referred to as the Common Working File) - It is comprised localized databases called Hosts. Hosts maintain total beneficiary claim history and entitlement information for the beneficiaries in their jurisdiction. You may find general information on CWF in the Centers for Medicare and Medicaid Services Internet Only Manual, Pub. 100-04 Medicare Claims Processing Manual, Chapter 27 – Contractor Instructions for CWF</td>
</tr>
<tr>
<td><strong>Outside entity</strong></td>
<td>A provider of service other than the SNF that provides services for the SNF patient. For today’s purposes, this will be the Part B provider.</td>
</tr>
</tbody>
</table>
What is Medicare Part B?

- **Covers care outside of inpatient stay**
  - Office or clinic
  - Emergency room services
  - Outpatient clinic visits
  - Diagnostic and screening tests
  - Outpatient surgery
- **Services provided in various locations**
  - Physician’s office
  - Free standing testing center
  - Facility outpatient settings
SNF-CB
Part B Perspective

• SNFs no longer able to unbundle services
• SNF must submit claims and bill to Medicare (except for certain excluded services)
  ▫ Rather than the provider of the services or supplies

• CMS Internet Manual Instructions found at Publication 100-04 Medicare Claims Processing, Chapter 6, Section 10.1 Consolidated Billing Requirement for SNFs and 110 Consolidated Billing

Outside provider must look to SNF for payment!
What is the Part B Provider’s Responsibility for SNF-CB?

- Review the SNF-CB guidelines
  - *Included* in SNF CB: services indicated by CMS as included in SNF CB must be billed by the SNF because these services are included in the SNF PPS reimbursement methodology

  - *Excluded* from SNF CB: Services indicated by CMS as excluded from SNF CB may not be billed by the SNF and must be billed by the outside entity because these services are not included in the SNF PPS reimbursement methodology
Services Excluded from CB

• Services separately reimbursed under Medicare Part B
  ▫ Professional services (professional component of diagnostic tests)
  ▫ Certain dialysis-related services, including covered ambulance transportation to obtain the dialysis services;
  ▫ Certain chemotherapy drugs and administration services
  ▫ Radioisotope services
  ▫ Customized prosthetic devices

• Visit the SNF-CB page on the CMS website at http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html
What is the Part B Provider’s Responsibility for SNF-CB?

- Familiarize yourself with the “under agreement” provision
  - Enter a private agreement or contract between the Skilled Nursing Facility (SNF) and an outside entity is recommended
  - This will protect both the SNF and the outside entity

- Part B provider is reimbursed by the SNF-not by Medicare or the beneficiary
Sample Forms

- Providers should refer to the Best Practice Guidelines to download sample agreements and notifications at
  http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/BestPractices.html
Services Excluded from CB

• To make a long story short:
  ▫ Know the exclusions

• If service is not an exclusion, it is more than likely included in CB
  ▫ CMS provides an annual update of HCPCS for SNF CB on their website
What is the Part B Provider’s Responsibility for SNF-CB?

- Ask yourself the following questions
  - Is your Medicare patient in a Part A SNF stay?
  - Are there any noticeable indicators that this patient may not be a resident in his/her own home?

- Front office staff should not make assumptions
  - Make contact with the SNF if in doubt
  - Communicate with the person responsible for billing and has a knowledge of SNF-CB “bundling edits”
What does the Medicare Part B Provider See?

- Medicare Part B providers will receive a remittance advice
  - CO-109: Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor
  - N538: A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents
- Your initial reaction may be “Why am I receiving this denial on a service that has already been paid?”
What is the Part B MAC Responsibility for SNF-CB?

- Cahaba is bound by CMS regulations to implement billing edits
  - The common working file will receive a bill from the SNF that shows the beneficiary became a resident of the SNF
  - The SNF stay is posted to history of Medicare beneficiary
  - Medicare contractors system must implement an automated resolution process when a rejection is received from CWF (known as unsolicited response)
What is the Part B MAC Responsibility for SNF-CB?

- Systems are setup to search paid claim history and compare the period between the SNF and service dates of claims in history
- Services subject to CB must be denied
- Will only apply to the line item
- Any monies due back to Medicare resulting from these denials will be recovered using current recovery procedures**

**Note: There are times that SNF-CB services are denied in error. If this happens, Medicare contractors will be instructed by CMS to make adjustments.
Common Part B Errors

• Providers will submit the global portion of radiology services

• Claims submitted for injections that are covered under the Part A stay

• Verification of the beneficiary has not been established
SNF CB Claim (Denial)

Imaging center submits a claim for the global services for a chest x-ray (CPT 71010) to Medicare Part B contractor. Claim will deny since global service includes professional (modifier 26) and technical component (modifier TC). Part B pays for professional component (26) and the SNF is responsible to make a payment to the Part B provider for payment of the technical component (TC).
SNF CB Claim (Partial Payment)

Physician submits a claim for a short arm cast application (CPT 29075) and the global service for a complete wrist radiologic exam (CPT 73110). Claim will deny diagnostic global service since it includes professional (modifier 26) and technical component (modifier TC) and allow payment for CPT 29075 since it is listed as an excluded physician service. Note: Part B will pay for professional component (26) and the SNF is responsible to make a payment to the Part B provider for payment of the technical component (TC).
SNF CB Annual Code Update

• There are four files for Part B
  ▫ File 1 – Part A Stay – Physician Services
  ▫ File 2 – Part A Stay – Professional Components of Services to be submitted with a 26 modifier
  ▫ File 3: Part A Stay – Ambulance
  ▫ File 4: Part B Stay Only – Therapy Services

• Files provide listing of procedure codes

• 2013 Carrier/A/B MAC Update:
**SNF Consolidated Billing**

**Skilled Nursing Facility (SNF) Consolidated Billing (CB):**

In the Balanced Budget Act of 1997, Congress mandated that payment for the majority of services provided to beneficiaries in a Medicare-covered SNF stay be included in a bundled prospective payment made through the fiscal intermediary (FI)/A/B Medicare Administrative Contractor (MAC) to the SNF. These bundled services had to be billed by the SNF to the FI/A/B MAC in a consolidated bill. No longer would entities that provided these services to beneficiaries in a SNF stay be able to bill separately for those services. Medicare beneficiaries can either be in Part A covered SNF stay which includes medical services as well as room and board, or they can be in a Part B non-covered SNF stay in which the Part A benefits are exhausted, but certain medical services are still covered though room and board is not.

The consolidated billing requirement confines the SNF the billing responsibility for the entire package of care that residents receive during a covered Part A SNF stay and physical, occupational, and speech therapy services received during a non-covered stay. Exception. There are a limited number of services specifically excluded from consolidated billing, and therefore, separately payable.

For Medicare beneficiaries in a covered Part A stay, these separately payable services include:

- physician's professional services;
- certain dialysis-related services, including covered ambulance transportation to obtain the dialysis services; certain ambulance services, including ambulance services that transport the beneficiary to the SNF initially, ambulance services that transport the beneficiary from the SNF at the end of the stay (other than in situations involving transfer to another SNF), and roundtrip ambulance services furnished during the stay that transport the beneficiary offsite temporarily in order to receive dialysis, or to receive certain types of intensive or emergency outpatient hospital services;
- erythropoietin for certain dialysis patients;
- certain chemotherapy drugs;
- certain chemotherapy administration services;
- radiolabels services; and
- customized prosthetic devices.

For Medicare beneficiaries in a non-covered stay, only therapy services are subject to consolidated billing. All other
2013 Carrier/A/B MAC Update

2013 Carrier/A/B MAC Update

2013 Annual Carrier Update

The SNF consolidated billing files reflect new codes that have been developed for 2013 and codes that have been discontinued for 2013. In addition, the files reflect any additions and deletions to categories of services excluded from consolidated billing. These files are effective for claims with dates of service on or after 1/1/2013 unless otherwise noted.

File 1 - Part A Stay - Physician Services (see file below)

Services represented by these codes are not subject to skilled nursing facility (SNF) consolidated billing for Medicare beneficiaries in a SNF Part A covered stay. They should be submitted to the Part B Medicare carrier for Durable Medical Equipment Regional Carrier, as appropriate, for payment consideration.

The following codes when billed globally, or as a separate technical component or professional component billed with a TC or 28 modifier, are excluded from consolidated billing and may be separately by the Medicare Part B contractor: 78004, 75200, 75320, 75403, and 75440. These codes therefore appear on both File 1 and File 2.

File 2 - Part A Stay - Professional Components of Services to be Submitted with a 25 Modifier (see file below)

Note: The professional component of the services represented by these codes are not subject to skilled nursing facility (SNF) consolidated billing and will be considered for payment by the Part B Medicare carrier for Medicare beneficiaries in a SNF Part A stay. These codes must be submitted with a modifier of 25 to indicate "professional component".

File 3 - Part A Stay - Ambulance (see file below)

Note: These are ambulance codes that will always be denied by the Part B Medicare carrier for Medicare beneficiaries in a skilled nursing facility Part A covered stay when submitted with an NN modifier. Effective 10/4/04, per Transmittal 163, these ambulance codes will also be denied when submitted with modifiers ND or DN.

File 4 - Part B Stay Only - Therapy Services (see file below)

Note: Services represented by these codes are the only services subject to skilled nursing facility (SNF) consolidated billing for Medicare beneficiaries in a SNF Part B stay. The file includes codes for physical, occupational, and speech
CMS Web Consolidated Billing

Consolidated Billing

Background

Prior to the Balanced Budget Act of 1997 (BBA), a SNF could elect to furnish services to a resident in a covered Part A stay, either:

- Directly, using its own resources;
- Through the SNF’s transfer agreement hospital; or
- Under arrangements with an independent therapist (for physical, occupational, and speech therapy services).

In each of these circumstances, the SNF billed Medicare Part A for the services.

However, the SNF also had the further option of “unbundling” a service altogether; that is, the SNF could permit an outside supplier to furnish the service directly to the resident, and the outside supplier would submit a bill to Medicare Part B, without any involvement of the SNF itself. This practice created several problems, including the following:

- A potential for duplicate (Parts A/B) billing if both the SNF and outside supplier billed;
- An increased out-of-pocket liability incurred by the beneficiary for the Part B deductible and coinsurance even if only the supplier billed; and
- A dispersal of responsibility for resident care among various outside suppliers adversely affected quality (coordination of care) and program integrity, as documented in several reports by the Office of the Inspector General (OIG) and the General Accounting Office (GAO).

Congress then enacted the Balanced Budget Act of 1997 (BBA), Public Law 105-33, Section 4422(b), and it contained a Consolidated Billing (CB) requirement for SNFs. Under the CB requirement, an SNF itself must submit all Medicare claims for the services that its residents receive (except for specifically excluded services listed below).

Conceptually, SNF CB resembles the bundling requirement for inpatient hospital services that’s been in effect since the early 1980s—assigning to the facility itself the Medicare billing responsibility for virtually the entire package of services that a facility resident receives, except for certain services that are specifically excluded.

CB eliminates the potential for duplicative billings for the same service to the Part A fiscal intermediary by the SNF and the Part B carrier by an outside supplier. It also enhances the SNF’s capacity to meet its existing responsibility...
Question: What happens when a diagnostic test includes both a technical and a professional component?

Answer: Basically, the professional component (representing the physician’s interpretation of the diagnostic test) is considered a physician service and is separately billable to the carrier. However, the technical component (representing the test itself) is considered a diagnostic test that is subject to consolidated billing and must be billed by the SNF. The interim final rule on the SNF Prospective Payment System (63 FR 26296-97, May 12, 1998) explains the applicability of the consolidated billing exclusion in the case of certain types of diagnostic procedures that previously were billed to the Part B carrier in conjunction with related physician services and paid under a single, global fee. Because the technical component is already included within Part A’s comprehensive per diem payment to the SNF for the covered stay, an outside entity that actually furnishes the technical component would have to look to the SNF, rather than to Part B, for payment.

Reference Source: CMS website – “Historical Questions & Answers on SNF Consolidated Billing”
SNF CB Tips for the Part B Provider

- Obtain the most current information from the Medicare beneficiary
- Verify whether their residence
  - Is it a home, nursing home or a skilled nursing facility?
- Work with the administration of the SNF to verify patient information
- Establish an agreement that outlines payment amounts and timing
- Make billing staff aware of the excluded and included services for the SNF CB major categories
- Watch your remittance advice
SNF CB Transmittals

- MM8044 – Manual Updates to Clarify SNF Claims Processing

- MM8034 – 2013 Annual Update of HCPCS for SNF CB Update

- View past and current SNF CB transmittals at
Comprehensive Error Rate Testing (CERT)

CERT Contractor Goals

- Protect the Medicare trust fund
- Measure Medicare’s ability to pay claims correctly
- Assess provider behavior
- Evaluate contractor performance
ForeSee

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