



**Wisconsin Physicians Service Medicare  
Ask-the-Contractor Teleconference (ACT) – MINUTES  
“CAH Swing Bed Consolidated Billing Exception”  
December 4, 2008  
Chairperson: Tanya Hoagland**

**Critical Access Hospital (CAH) Swing Bed Billing Clarification**

After extensive research of the Federal Rules and Regulations and much discussion with the Centers for Medicare & Medicaid Services (CMS) Central and Regional Office staff on the proper billing of CAH Swing bed services, we are providing the following clarification.

CAH Swing beds are exempt from SNF consolidated billing, however they do need to follow the direction in the CMS Internet Only Manual (IOM), Publication 100-4, Chapter 3, Section 10.4 on bundling hospital charges. These charges should be included on the 18X type of bill.

Services provided by the CAH, while the beneficiary is inpatient in the CAH Swing bed that are considered exclusions from SNF Consolidated Billing, shall be billed on an 85X type of bill. All related outpatient charges shall be included on the 85X type of bill that would typically be billed for outpatient services.

Certified Registered Nurses Anesthetists (CRNA) charges are not billable under a CAH Swing bed claim. These charges should be submitted on an 85X type of bill with the related outpatient charges. The only appropriate charge, per the IOM, Publication 100-4, Chapter 4, Section 250.3.3, billable on an 85X type of bill for a CRNA are anesthesia charges.

As stated in the IOM, Publication 100-4, Chapter 3, Section 60, swing bed services must be billed separately from inpatient hospital services. Therefore, any swing bed patient who requires inpatient hospital services must be discharged from the swing bed and admitted as a hospital inpatient.

Medicare regulation is the basis for the clarification provided. If you feel that there is Medicare regulation that contradicts this clarification, please contact Customer Service.

The J5 MAC ACT, “CAH Swing Bed Consolidated Billing Exception” teleconference was called to order by Tanya Hoagland, Medicare Outreach Analyst – Omaha Office, at 10:00 AM CT.

Tanya began the teleconference by introducing herself. She was joined by other members of the Provider Outreach & Education (POE) staff and Customer Service. The introductions were followed by a brief description of the information available on the WPS Medicare Website. Participants were encouraged to sign up for the WPS and CMS electronic mailing lists.

The introductory discussion was followed by a review of the presentation and handouts that had been e-mailed to the registered teleconference participants.

At the conclusion of the presentation, the line was opened up for questions from the participants.

**OPEN QUESTION AND ANSWER SESSION:**

Q1: I had sat in on a teleconference out of Colorado in which it was stated that ancillary charges could be billed separately, and I wanted to make sure that is not correct.

**A1: Please see above clarification.**

Q2: I have a question on billing an excluded service. I had billed an MRI that was excluded from Consolidated Billing on a 121 TOB. When it came back processed it had no payment, so I called Medicare. A Tier 2 called me back and told me it should be billed on a 851 TOB because we are Critical Access.

**A2: If the CAH performed the MRI, then the MRI would need to be billed on an 85x TOB.**

Q3: We too sat in on the teleconference from Colorado. I questioned the exclusion of MRIs and CTs from the bundling. I called in to WPS and they sent me to a Tier 2 and was told per the Manual 100-4, Chapter 6, Section 10.2 CTs, MRIs, etc, are billable separate from the bundled consolidated bill.

**A3: That is correct as long as the HCPC for the service being billed is listed as an excluded service. There is a reference on slide 8 of the presentation, the 2<sup>nd</sup> bullet, that will give you the list of exclusions where you can look up a specific HCPC code. Please see above clarification on how to bill this type of service.**

Q4: When a Swing Bed patient needs a surgical procedure that is considered an outpatient procedure, like a colonoscopy, does the patient have to be discharged from the swing bed and then readmitted? Or can we just pull those charges out of the Swing Bed stay and bill them separately?

**A4: You would not have to discharge the beneficiary from the Swing Bed for outpatient services. These services can be done while the patient is in the Swing Bed. Please see above clarification on how to bill for inpatient hospital services.**

Follow up: If a patient requires specialized services that need to be done by another facility while in a Swing Bed from our facility, is our facility responsible for paying for that treatment provided by the specialist?

**Answer: Please see above clarification.**

Q5: Do you have to have a physical contract with an outside facility to be considered to have an arrangement?

**A5: No. An arrangement can be verbal.**

Follow up: How does Medicare know if we have an arrangement with another facility?

**Answer: We won't know. But another facility's claim should not be rejected against your 18x.**

Q6: We sometimes have a patient that goes from a Swing Bed to hospital and we have used a patient status of 09, but they sometimes get kicked out. Should we be using a 02?

**A6: You should only be using a 02 patient status if the patient is going to an acute facility. If the patient is admitting into a CAH, the patient status should be a 66.**

Q7: Sometimes our Swing Bed patients go to a doctor's office and we do not have an arrangement with them. So now I can tell the doctor's office they may bill Medicare, but they sometimes don't know how to bill Medicare. What can I tell them?

**A7: They will have to call their A/B MAC or carrier.**



Q8: Sometimes we have an MRI that is done by an outside carrier and we are told by WPS this needs to be billed on an 851 TOB or we will not be paid for it.

**A8: Please see above clarification.**

Q9: We keep hearing that CAHs are not subject to Consolidated Billing. Can you clarify what that means?

**A9: Consolidated Billing is in relation to SNF PPS. Meaning, there are certain services the SNF is responsible for and won't get any additional payment for these services because they are part of Consolidated Billing. CAH Swing Beds are not paid on SNF PPS but at reasonable cost, therefore, you are not paid based on the RUG level being billed as SNF PPS facilities are.**

Follow up: So if we are providing a service for a SNF in our town we still apply the Consolidated Billing rules for them, but we don't apply them for beneficiaries within our own facility?

**Answer: Correct. Please see above clarification.**

Q10: We have 18x bills RTP'ing because they have a 710 and a 964 rev code on the claim. Should we be billing this on a separate bill?

**A10: Yes. Please see above clarification.**

Q11: When we bill a 972 rev code on a 18x TOB we get them returned. Is this not billable on a 18x bill type?

**A11: Please send us an example of this for us to review. Answer: A 972 revenue code is not billable on a 18x TOB, but is billable on a 85x TOB.**

Q12: We have billed claims with surgery codes on a 18x TOB and have had them returned saying they don't accept the revenue code on this type, so we have always separated them out on a 85x. So you are telling us this is no longer correct?

**A12: Please see above clarification.**

Q13: We bill x-rays, etc., on a 18x TOB, however, there is another SNF in the area and we often bill services for them. Am I understanding correctly that when we bill for our own Swing Bed patients we bill the services on a 18x, but when we do services for the SNF we would have to bill that to the SNF?

**A13: It would have to go back to the SNF if the service is included in SNF Consolidated Billing. Now if the service is excluded from Consolidated Billing, then it would be billed under the CAH's provider number. Please see above clarification on how to bill for services provided for CAH Swing Bed patients.**

Follow up: If we bill a service we believe should be excluded from Consolidated Billing and it is denied, can we call you up?

**Answer: You may always call our Customer Service area if you have a question, but make sure you are using the Consolidated Billing exclusion list to verify the HCPC you are billing is listed as an exclusion.**

Q14: In regards to the CRNA services, are we allowed to use revenue code 379 on an 85x TOB?

**A14: We will review this and put the answer in the minutes.**

**Answer: Revenue code 379 is allowed on an 85x TOB. Please see above clarification on how to properly bill for CRNA services.**

Q15: We want to verify that anything on the Consolidated Billing exclusion list should be billed separately.



- A15:** There are always conditions when it comes to Consolidated Billing. When you are looking at the exclusion list, you need to remember that if the service is an outpatient surgery or therapy code and it is on the list, the service would be included in Consolidated Billing. You also have place of service exclusions. For example, if you are billing a service considered to be Major Category I (CTs, MRIs, etc.), this service is only excluded if it was provided in the outpatient department of a hospital or CAH. On the Website there is a link that will guide you to the General Explanation of the Major Categories (<http://www.cms.hhs.gov/SNFConsolidatedBilling/Downloads/08MajorCatExpl.pdf>). I recommend everyone take a look at this because it explains all the rules regarding Consolidated Billing. So everyone knows, we will be holding a Consolidated Billing ACT in the future. Please keep checking our Website for any future ACTs WPS will be holding.
- Q16: In regards to previous questions, am I understanding correctly that we are suppose to go to the exclusion list for services that are included in Consolidated Billing?
- A16:** If a service is not listed as an exclusion on the exclusion list, then that service would be considered an extended care service and not separately billable. Please note that surgery and therapy services listed on the exclusion list are INCLUSIONS. There are so many outpatient surgeries that are beyond the scope of the SNF, CMS only listed the ones they believe should be SNF responsibility. If it is an inclusion, the file will state "INCLUSION" in the far right hand column of the list.
- Q17: Is there a condition or occurrence code we need to use on the 12x claim when we are billing for ancillary charges for a beneficiary who has exhausted his or her benefits?
- A17:** There are no additional codes you need to use. You do need to make sure, however, you are also sending in your Swing Bed benefit exhaust claims prior to sending in your Part B 12x.
- Follow up: Is there a code we need to put on our benefit exhaust claim?
- Answer: No. When benefits exhaust, you are going to send in your claim as normal with all days/charges listed as covered.**
- Follow up: The Part B claim is a 12x not an 85x?
- Answer: That is correct. If the patient is inpatient of your Swing Bed but benefits have exhausted, you will send any ancillary charges in on a 12x TOB.**
- Q18: I am having issues billing revenue codes 360, 379, and 761 on a 18x TOB, has this issue been resolved?
- A18:** We are currently working on the CAH revenue file. We hope to have this done by the end of next week, but we can't give a definite date.
- Answer: Please see above clarification.**
- Q19: Our question is regarding treatment rooms. My understanding is I am suppose to bill the SNF for the treatment room and the SNF will be reimbursed for this if the patient is using his or her Medicare days. The SNF doesn't believe they are the one who is to be billing this service. Do you have any clarification for me?
- A19:** To know for sure who would be responsible for this service, I would need a HCPC code to see if it was on the exclusion list.
- Follow up: I did look to see if the code was on the exclusion list, and it was not listed so I went ahead and billed it to the SNF. Would that be correct?
- Answer: If this HCPC was not on the exclusion list, then yes the SNF would be responsible for this service.**



- Q20: If a patient was in a Swing Bed and they no longer meet criteria or are out of benefits, but remain in a Medicare-certified bed, are they breaking their spell of illness or not?  
**A20: This depends on if they are at a skilled or non-skilled level of care.**  
Follow up: They are at a non-skilled level of care.  
**Answer: Then as long as you are billing your last skilled claim with a 22 occurrence code, and the patient was at a non-skilled level of care for 60 consecutive days, this should break their spell of illness. Remember, also, you need to send us a No-Pay claim to show us when they discharged from the Medicare-certified bed.**
- [Providers were informed WPS would be holding an ACT on SNF Benefit Exhaust and No-Pay billing later the same afternoon. Another Outreach Analyst gave the time and dial-in information if any provider wished to call in and participate.](#)
- Q21: When a patient is in a Swing Bed but is sent to a different facility for a test, do we need to discharge and readmit the beneficiary?  
**A21: As long as the patient was not admitted as an inpatient to the other facility, you will not need to discharge and readmit the patient.**  
Follow up: If they come back a different day, then we would need to discharge and readmit them?  
**Answer: That all depends on if the other facility is admitting them as an inpatient or not.**
- Q22: Does the 3-day Qualifying Hospital Stay (QHS) have to be an acute stay?  
**A22: It has to be an inpatient hospital stay, whether acute or CAH.**  
Follow up: It can't be a skilled stay?  
**Answer: No, it has to be a 3 day hospital stay.**
- Q23: We had a patient that went to skilled for one hour, then had a decline in health and had to be readmitted to acute. Are we able to bill for this one hour?  
**A23: You would be able to bill this as a same-day transfer claim. If you have questions on how to bill for a same-day transfer claim, you may always contact me for direction.**
- Q24: A patient is a SNF resident and comes to our CAH for a doctor's visit (510 revenue code), is this excluded or not?  
**A24: Professional services should be excluded from SNF Consolidated Billing.**  
Follow up: This is for the room charge, not for the physician's professional fee.  
**Answer: It would then depend on the HCPC code being used for the room charge. If the HCPC is not an exclusion, then the SNF would be responsible.**

The teleconference was ended at approximately 11:03 AM Central Time.

The references included in this presentation are for informational purposes only. The current Medicare regulations will prevail.

There were 271 participants on 120 lines for the teleconference.