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**Skilled Nursing Facility Consolidated Billing Ask-the-Contractor Teleconference (ACT)
Minutes
December 17, 2009
Chairperson: Janet Mateo**

The Northeast Region ACT call was conducted by Janet Mateo, Medicare Outreach Analyst for the Northeast Region in Chicago, IL, at 10:00 a.m. Central Time. The topic was Skilled Nursing Facility Consolidated Billing (SNF CB)

The teleconference began with welcoming remarks to Legacy and J5 providers on the call. Legacy providers are Former Mutual of Omaha Part A providers who joined WPS in November 2007. J5 MAC providers are Part A providers in Iowa, Kansas, Missouri, and Nebraska who were formerly served by another Medicare contractor prior to joining WPS Medicare in late 2007 or early 2008. Janet was joined by members of the Provider Outreach and Education (POE) team and representatives from the Customer Service Department to assist during the question and answer session.

Legacy and J5 providers who registered for the teleconference were e-mailed the SNF CB PowerPoint presentation, along with three (3) handouts. The handouts included a Centers for Medicare & Medicaid Services (CMS) publication entitled "Skilled Nursing Facility Prospective Payment System Fact Sheet"; Change Request 6669 entitled "2010 Annual HCPCS Code for SNF CB"; and the CMS handout entitled, "General Explanation of the Major Categories for Skilled Nursing Facility (SNF) Consolidated Billing."

The topic for the SNF CB teleconference call was selected based on provider inquiries from Legacy and J5 providers and feedback received from the Provider Outreach and Education Advisory Group members. The SNF CB presentation included information about providers and suppliers who were affected by SNF CB, the importance of communication between all parties as well as an explanation of the major categories of services that are excluded from consolidated billing. The exclusion list was also reviewed. After the presentation, the lines were opened for questions and answers.

SNF CB Question/Answer Session

Q1. Why are PET Scans not excluded from CB?

A1. CMS is looking at PET Scan as a possible exclusion, but it has not been added to the list of exclusions yet.

Q2. Can Skilled Nursing Facilities bill for therapy services under Part B when a patient is in a certified bed?

A2. Yes. If a beneficiary is in a Medicare certified bed and not eligible for coverage under Part A, therapy may be billed by the SNF on a 22x type of bill (TOB).

Remember, Physical Therapy, Occupational Therapy, and Speech and Language Pathology services are always subject to consolidated billing when the beneficiary is in a Medicare certified bed. Also, residents who have exhausted their Part A benefits, but continue to receive services at a Medicare skilled level of care, cannot be moved to a non-certified bed or unit.

Q3. Is a wheelchair transport ever subject to consolidated billing?

A3. Medicare does not provide any coverage at all under Part A or Part B for any non-ambulance forms of transportation, such as ambulette, wheelchair van, or litter van. Please see MLN Matters Number SE0433 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0433.pdf> titled “Skilled Nursing Facility Consolidated Billing As It Relates to Ambulance Services” for more information.

Q4. Is chemotherapy that is provided in an outpatient hospital setting always excluded from consolidated billing?

A4. Certain chemotherapy drugs and their administration are excluded from consolidated billing. Even though a type of service is excluded from consolidated billing, providers still need to check whether the specific HCPCS code is on the exclusion list. If a HCPCS code for a chemotherapy drug a Part A resident is receiving is not on the list, then it is considered part of consolidated billing and covered under the prospective payment rate. Only certain specific services identified by HCPCS codes are excluded.

Q5. If a hospice patient is receiving a skilled level of care under Medicare Part A, is it necessary to report the hospice diagnosis code on the claim along with the condition code 07?

A5. You should report all applicable diagnosis codes on the claim. If the reason you are providing skilled services is unrelated to the beneficiary’s terminal illness, append condition code 07 to the claim. Condition code 07 states your claim is unrelated to the beneficiary’s terminal illness. (CMS Internet Only Manual (IOM), Publication 100-04, Chapter 6, Section 20.2.2)

Q6. Can you bill for an ambulance transport when a patient is admitted to the SNF facility or is discharged from the SNF?

A6. Yes. Please see MLN Matters Number SE0433 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0433.pdf> titled “Skilled Nursing Facility Consolidated Billing As It Relates to Ambulance Services” for more information.

Q7. One of our beneficiaries was prescribed Procrit by a family physician not affiliated with our facility. Before returning to our facility, the beneficiary had the prescription filled at a pharmacy and Medicare Part D covered it. Do we need to report the drug on our claim? Our facility did administer the drug to the beneficiary.

A7. Situations similar to this should not happen often. Remember, 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 (CMS IOM, Publication 100-04, Chapter 6, Section 10.1). In this instance, since Medicare Part D paid for the drug without the SNF’s prior knowledge, do not include the charge for the drug on your Part A claim. You may, however, include the charge for the administration.

Q8. What recourse do hospitals have when a skilled nursing facility refuses to pay for services that are rendered to Part A residents?

A8. Medicare does not prescribe the actual terms of the SNF’s relationship with its suppliers (such as the specific amount or timing of payment by the SNF), which are to be arrived at through direct negotiation between the parties to the agreement. However, in order for a valid “arrangement” to exist, the SNF must reach a mutual understanding with its supplier as to how the supplier is to be paid for its services. Documenting the terms of the arrangement confers the added benefit of providing both parties with a ready means of resolution in the event that a dispute arises over a particular service. This type of arrangement has proven to be effective in

situations where suppliers regularly provide services to facility residents on an ongoing basis; e.g., laboratory and x-ray suppliers, DME supplies, etc.

If an SNF elects to utilize an outside supplier to furnish medically appropriate services that are subject to consolidated billing, but then refuses to reimburse that supplier for the services, then there is no valid arrangement as contemplated under §1862(a)(18) of the Act. Not only would this potentially result in Medicare's noncoverage of the particular services at issue, but an SNF demonstrating a pattern of nonpayment would also risk being found in violation of the terms of its provider agreement. Under §1866(a)(1)(H)(ii) of the Act (and 42 CFR 489.20(s)), the SNF's provider agreement includes a specific commitment to comply with the requirements of the consolidated billing provision. Further, §1866(g) of the Act imposes a civil money penalty on any person who knowingly and willfully presents (or causes to be presented) a bill or request for payment inconsistent with an arrangement or in violation of the requirement for such an arrangement. (CMS IOM, Publication 100-04, Chapter 6, Section 10.4.1)

Q9. Should we bill for wound care (HCPCS 97602) with revenue code 761 or 521? We were told by a hospital providing wound care services to our Part A resident that we needed to reimburse them for the services they provided to our patient because the claim submitted to Medicare Part B by the hospital was denied.

A9. We cannot tell you which revenue code to use. HCPCS 97602 is part of consolidated billing, so the SNF would be responsible for this service. Please go to <http://www.cms.hhs.gov/SNFConsolidatedBilling/> to find a list of exclusions from SNF consolidated billing.

Q10. As a hospital, we report revenue code 761 whenever wound care services are provided to Part A residents and the physician writing the order is not involved in the plan of care. We only report revenue code 521 when the physician is involved in the care of the patient. Is this correct?

A10. We cannot tell you how to code your claims.

Q11. Can we charge a SNF Part A resident for transportation provided when they leave the facility?

A11. If the patient is discharging from the SNF, then any medically necessary ambulance charge may be billed to Part B. Please see MLN Matters Number SE0433 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0433.pdf> titled "Skilled Nursing Facility Consolidated Billing As It Relates to Ambulance Services" for more detailed information.

Q12. Should a physician's visit outside the facility that is not part of the plan of care be included in the SNF PPS payment?

A12. 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, and for all physical, occupational and speech-language pathology services received by residents under Part B. (CMS IOM, Publication 100-04, Chapter 6, Section 10.1) Physician's and other practitioner's professional services are excluded services and can be billed directly to the carrier.

Q13. What should we do when a hospital insist that we are responsible for paying for services provided to a Part A resident, simply because Part B denies their claim.

A13. First check the HCPCS code in the CMS SNF quarterly and annual updates to ensure that the services are excluded from consolidated billing at <http://www.cms.hhs.gov/SNFConsolidatedBilling/>. If the HCPCS code is on the list of exclusions,

you can refer the administrator of the hospital to Publication 100-04, Medicare Claim Processing Manual, Section 20.1 – Services Beyond the Scope of the Part A SNF Benefit. Also, remember there are “place of service” exclusions. You may also refer to <http://www.cms.hhs.gov/SNFConsolidatedBilling/Downloads/09MajorCatExpl.pdf> for “General Explanation of the Major Categories for Skilled Nursing Facility (SNF) Consolidated Billing.”

Q14. Please clarify the website where we can download the Annual SNF Consolidated Billing HCPCS code list

A14. You can find the 2010 Annual SNF Consolidated Billing HCPCS codes at the link listed below.

http://www.cms.hhs.gov/SNFConsolidatedBilling/72_2010Update.asp

Providers were encouraged to submit topics for future ACT calls to janet.mateo@wpsic.com. The ACT call ended at 11:35 a.m.

There were 249 participants on the call from 100 facilities across the country.