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**Consolidated Billing
 Computer Based Training**



What Will I Gain?

- Utilize guidelines to determine when services are the responsibility of the Skilled Nursing Facility
- Identify which services are “excluded” from Consolidated Billing
- Determine who is responsible for billing or payment of services
- Recognize potential problem situations

Background

- In the Balanced Budget Act of 1997, Congress mandated that payment for the majority of services provided to beneficiaries in a Medicare covered Skilled Nursing Facility stay be included in a bundled prospective payment made through the Fiscal Intermediary to the Skilled Nursing Facility.
- Consolidated billing requires the Skilled Nursing Facility to bill the entire package of care that residents receive during a covered Part A Skilled Nursing Facility stay, and physical, occupational and speech therapy services provided during a non-covered stay, with the exception of a limited number of exclusions.

Outside Providers Affected by Consolidated Billing

- Outpatient hospitals/rehabilitation facilities
- Physicians/professionals
- Clinics
- Freestanding labs/x-ray companies
- Ambulance
- Suppliers
- Contracted therapist

How Are Outside Providers Affected by Consolidated Billing?

- **The outside provider must look to the Skilled Nursing Facility (rather than to Medicare Part B) for payment for services that are included in Consolidated Billing.**
- **If an outside provider submits a claim to Medicare for services that should be included in Consolidated Billing, the claim will be denied.**
- **Common Working File currently has edits in place for claims received for beneficiaries in a Part A covered Skilled Nursing Facility stay as well as for beneficiaries in a non-covered stay.**

Skilled Nursing Facility Has First Level of Responsibility

- It is very important for Skilled Nursing Facilities to notify outside providers when they are treating a resident covered under Consolidated Billing to ensure the services are billed properly.
- Since the Skilled Nursing Facility is responsible for all care provided to a Part A resident, the Skilled Nursing Facility also has the first level of responsibility for the notification.
- Skilled Nursing Facilities should also establish agreements with outside providers to pay for Part A services not excluded from the Consolidated Billing provision to help insure that neither party is surprised.
- The Skilled Nursing Facility needs to keep a current copy of the required certificates for all contracted laboratory and radiology providers. If you have a lab or radiology unit, you must obtain the necessary certifications prior to billing for the services.
- All services and charges need to be submitted to the Part A Fiscal Intermediary in the appropriate, i.e., UB-04 or electronic billing system.

How Can a Skilled Nursing Facility Prepare an Arrangement?

- Although a formal, legal contract is not required, all Skilled Nursing Facilities should have a written agreement with the outside entities that may provide services to their Part A Skilled Nursing residents. An "arrangement" could be any written agreement between the Skilled Nursing Facility and the outside provider that specifies which services the Facility would be responsible for, and the manner in which they would pay for those services.
- Prepare a document that accompanies the resident. For example, if the SNF refers a Part A resident to an offsite clinic to receive certain bundled procedures, such as diagnostic tests, the document could notify the clinic of the following:
- Medicare Part A is covering the resident's Skilled Nursing Facility stay, so that the clinic must bill the Skilled Nursing Facility rather than Part B for any bundled services that it furnishes to the resident.
- The particular bundled services that the beneficiary is being sent to receive, and the terms of the Skilled Nursing Facility's payment to the clinic.
- Before furnishing any bundled services beyond those specified, the clinic must first contact the Skilled Nursing Facility.
- By furnishing services to the beneficiary, the clinic agrees to the terms set forth in the agreement by the Skilled Nursing Facility.

Are There Sample Arrangement Forms?

- "Under Arrangement" agreement:
 - Skilled Nursing Facility and supplier
- Request for ambulance transport
- Notice to physician treating beneficiary
- Notice to outpatient hospital treating beneficiary
- Weekly Part A beneficiary service log

What Happens in the Absence of an Agreement?

- Skilled Nursing Facility has overall responsibility to
 - Furnish services directly or
 - Make arrangement
- Skilled Nursing Facility refuses to reimburse
 - Inconsistent with Medicare agreement to participate

When Does Consolidated Billing Apply?

- Applies to a Medicare Part A stay
 - Beneficiary meets coverage criteria
- Does not apply to a Medicare non-covered (Part B) stay
 - Beneficiary no longer meets coverage criteria

What Is Always Subject to Consolidated Billing?

- Physical Therapy, Occupational Therapy, and Speech Language Pathology Services
- Applicable to residents in:
 - Covered Part A stay
 - Non-covered Part B Skilled Nursing Facility stay

What Does "Excluded" Mean?

- Means that "excluded" services may be separately billable by outside provider
- Does not mean "excluded" services *are not covered*

What Services Are Covered in Consolidated Billing?

- All services except exclusions
- Know exclusions:
 - If the service is not on the list of exclusions, it is included in Consolidated Billing

List of General Exclusions

- Professional component (technical component is not excluded)
 - Physician
 - Physician Assistant
 - Nurse Practitioner
 - Certified Nurse-midwives
 - Qualified Psychologists
 - Certified Registered Nurse Anesthetists
- Home dialysis supplies and equipment

General Exclusions (Continued)

- Epogen for certain dialysis patients
- Hospice care
- Services beyond the scope of a Skilled Nursing Facility
- Medically necessary ambulance transportation
 - To the Skilled Nursing Facility upon admission
 - From the Skilled Nursing Facility upon final discharge
 - Major Categories I & II

General Exclusions Hospital's "Facility Charge"

- Physician's services are billed to the Part B carrier
- Hospital's "Facility Charge" in connection with clinic services of a physician are billed to the FI
 - Represents solely overhead expenses
 - 13x or 85x bill types
 - Revenue code 0510 (clinic visit)
 - E&M HCPCS codes 99201-99245

Four Major Categories of Excluded Outpatient Services

- Services that are beyond the scope of a Skilled Nursing Facility:
 - Divided into four major categories
 - Excluded services identified by HCPCS code

Major Category I Beyond the Scope

- *Must be provided at a hospital or critical access hospital:*
 - CT scan
 - Cardiac catheterization
 - Magnetic Resonance Imaging (MRI)
 - Radiation therapy
 - Angiography, lymphatic, venous and related procedures
 - Outpatient surgery and related procedures
 - Emergency services
 - Medically necessary ambulance for services within this list

Major Category I Outpatient Surgery and Related Procedures

- Inclusions, rather than exclusions, are listed
- The following services are also excluded when billed with excluded outpatient surgeries
 - Anesthesia, drugs, supplies & lab (revenue codes 037x, 025x, 027x 062x & 030x)

Major Category I Emergency Services

- Emergency Room (ER) services are billed by the hospital to the FI
 - Revenue code 045x
 - Line item date of service for the ER encounter is the date the patient entered the ER
 - All other services reported the date the service was rendered
 - “ET modifier” for related services performed on subsequent dates

Major Category II ESRD/Hospice

- Dialysis services and supplies (including Epogen) when rendered and billed by:
 - A Renal Dialysis Facility
 - For ESRD patients
- Home dialysis supplies/equipment, self-care home dialysis support services and institutional dialysis services *not provided by a SNF*
- Ambulance transportation to Renal Dialysis Facility for dialysis services

Major Category III Provided by Any Entity Except Skilled Nursing Facility

- Identified by HCPCS code
 - Certain specific chemotherapy drugs
 - Certain chemotherapy administration services
 - Certain radioisotope services and their administration
 - Certain customized prosthetic devices

Major Category IV Preventive/Screening

- Mammography screening
- Vaccines and administration: pneumonia, influenza and Hepatitis B
- Screening pap smear and pelvic exams
- Colorectal screening
- Prostate cancer screening
- Glaucoma screening
- Diabetes screening
- Cardiovascular screening

Major Category V Services Must Be Billed By Skilled Nursing Facility

- Part B services *included* in Skilled Nursing Facility consolidated billing for residents in a certified bed:
 - Physical therapy
 - Occupational therapy
 - Speech-language pathology

“Place of Service” Exclusions

- Place of service criteria:
 - Major Category I
 - Hospital Outpatient Department or Critical Access Hospital
 - Major Category II
 - Renal Dialysis Facility (RDF)
 - Major Category III
 - Any licensed Medicare provider *except a SNF*
- If exclusion does not meet the “place of service” criteria, it is included in the SNF PPS payment

Is All Ambulance Transport Covered?

- Ambulance transport is generally paid as part of the SNF PPS Part A daily rate
- Medically necessary ambulance claims for Part A patients will be denied for:
 - Transportation to or from a diagnostic or therapeutic site other than a hospital

How Can a Skilled Nursing Facility Determine Responsibility ?

- Check HCPCS code
 - Quarterly/annual updates
- Service is site specific
- Determine payment
- Process bill

Questions to Ask Yourself

- Is the resident in a Part A stay?
 - Meet coverage criteria?
 - Part A days remaining?
- Is the provided outside service an “exclusion”?
 - Considered a professional component?
 - HCPCS code on the exclusion list?

Questions to Ask Yourself

- Are the outside services “place of service” exclusions?
 - Provided in the appropriate setting?
- If not excluded, do you have an “under arrangement” agreement with the outside entity?

Where Can We Find SNF Consolidated Billing Updates?

- Discrepancies in the SNF Help File
 - SNF Help File discontinued
- Redesigned update file:
 - “Annual and Quarterly Updates” section:
 - www.cms.hhs.gov/SNFConsolidatedBilling/75_2007_FI_Update.asp#TopOfPage

References

- Consolidated Billing
 - Medicare Claims Processing Manual (100-4), Chapter 6, Section 10.1
- Exclusions
 - Medicare Claims Processing Manual (100-4), Chapter 6, Sections 20.1-20.3
- HCPCS Updates
 - www.cms.hhs.gov/SNFCConsolidatedBilling/75_2007_FI_Update.asp#TopOfPage
- Best Practices
 - www.cms.hhs.gov/SNFPPS/08_BestPractices.asp

Summary

- Providers other than Skilled Nursing Facilities are affected by consolidated billing
- Part B residents subject to consolidated billing for therapy services only
- Four major categories of “excluded” services
- Some services are only excluded based on “place of service”
- Included services need to be provided “under arrangement”

Thank You

This program is presented for informational purposes only. The current Medicare regulations will prevail.

Test Your Knowledge

“Consolidated Billing” means that all services provided to a SNF resident must be billed on the Part A claim unless they are “excluded” services.

- A. True
B. False

Skilled Nursing Facility does not have any responsibility to notify outside providers if they are treating a SNF Part A resident.

- A. True
B. False

If a service falls within the major category but the HCPCS for that service is not listed, then the service would not be an “exclusion”.

- A. True
B. False

There are a very few services that are specifically “excluded” from Consolidated Billing, but the Skilled Nursing Facility must furnish all other services either directly or under a formal arrangement with an outside entity.

- A. True
B. False

Consolidated Billing only affects Skilled Nursing Facilities.

- A. True
B. False

Test Your Knowledge

Congress enacted Consolidated Billing because of duplicate billing, added expenses and the lack of accountability.

- A. True
B. False

If an outside provider submits a claim to Medicare for services that should be included in consolidated billing, the claim will be denied.

- A. True
B. False

Residents who are in a non-certified beds are ALWAYS subject to consolidated billing requirements.

- A. True
B. False

Outside providers must look to the Skilled Nursing Facility for payment (rather than to Medicare Part B) for payment for services included in Consolidated Billing.

- A. True
B. False

If exclusions do not meet the “place of service” criteria, they are included in the Skilled Nursing Facility’s Prospective Payment Rate.

- A. True
B. False