Consolidated Billing in Nursing Homes

CMS Clarifies Requirements

The Centers for Medicare and Medicaid Services (CMS) has issued instructions to clarify consolidated billing rules that require a Skilled Nursing Facility (SNF) to have a valid written arrangement with outside suppliers of services, including speech-language pathologists and audiologists.

CMS states that when a SNF arranges to use outside entities to provide services, there must be a written agreement between the facility and the provider. This agreement should state that the SNF will reimburse the provider for Medicare-covered services that are subject to consolidated billing requirements. Without a written agreement in place, the provider may have difficulty in obtaining payment from the SNF, according to CMS.

The transmittal is part of a CMS effort to clarify consolidated billing requirements, which require the SNF to bill Medicare directly for Part A patients, and to submit Part B claims for physical therapy, occupational therapy, and speech-language pathology services. For Part B services only, audiologists would directly bill the carrier. CMS states that without a written arrangement billing errors may occur, such as an outside provider submitting Part B claims for services rendered to a SNF Part A resident, rather than directly billing the SNF.

CMS is interested in hearing from providers who have questions or comments regarding consolidated billing rules. The agency's Transmittal 183 can be found on the CMS Web site at **www.cms.hhs.gov/manuals/pm_trans/R183CP.pdf**. If you would like to express your concerns, ASHA will compile responses and forward them to CMS. Please e-mail your concerns to Ingrida Lusis at ilusis@asha.org.

SNF Consolidated Billing Service Furnished Under Arrangement with an Outside Entity

DC/DE, MD, TX, VA, IHS Service Areas

Change Request No. 3592
Transmittal No. 412

This notification alerts providers who render a Medicare-covered service that is subject to consolidated billing to a skilled nursing facility resident.

This article is informational only and clarifies the instruction contained in Change Request (CR) No. 3248, issued May 21, 2004. It explains that an "arrangement" between a Medicare Skilled Nursing Facility (SNF) and its supplier is validated not by the presence of specific supporting written documentation but rather by their actual compliance with the requirements governing such "arrangements." However, supporting written documentation delineating the "arranged-for" services for which the SNF assumes responsibility and the manner in which the SNF will pay the outside entity for those services can help the parties arrive at a mutual understanding on these points.

Under the SNF consolidated billing provisions of the Social Security Act (the Act) the Medicare billing responsibility is placed with the SNF for most of its residents' services. (See Sections 1862(a)(18), 1866(a)(1)(H)(ii) and 1888(e)(2)(A)). The SNF must include on its Part A bill submission to its Medicare intermediary almost all of the services a resident receives during a covered stay, excluding those services that are not covered under the SNF's global Prospective Payment System (PPS) per diem payment for the particular stay.

These excluded services (e.g., those provided by physicians and certain other practitioners) continue to be separately billable to Part B directly to the Medicare carrier by those "outside entities" that actually provide the service. Also, Part B consolidated billing makes the SNF itself responsible for the submission of Part B bills for any **physical, occupational or speech-language therapy services** received by a resident during a **non-covered** stay.

In addition, the SNF must provide any Part A or Part B service that is subject to SNF consolidated billing either directly with its own resources or through an outside entity (e.g., a supplier) under an "arrangement," as set forth in Section 1861(w) of the Act. If an outside entity provides a Medicare-covered service that is subject to SNF consolidated billing to an SNF resident during a covered stay, the outside entity must look to the SNF for payment (rather than billing their carrier under Part B). The reason is because under an arrangement, Medicare's payment to the SNF represents payment in full for the arranged-for service, and the SNF in turn is responsible for making payment to outside entities if the service provided is subject to the SNF's global PPS per diem payment.

Problem Situations

Since the start of the SNF PPS, problematic situations have arisen when the SNF resident receives services that are subject to consolidated billing from an outside entity, such as a supplier. These problems are usually connected with either of two scenarios, namely:

- An SNF does not accurately identify services as being subject to consolidated billing when ordering such services from a supplier or practitioner; or
- A supplier fails to ascertain a beneficiary's status as an SNF resident when the beneficiary (or other individual acting on behalf of the beneficiary) seeks to obtain such services directly from the supplier without the SNF's knowledge.

In this context, the term "supplier" can also include those practitioners who, in addition to performing their separately billable professional services, essentially act as a supplier by also furnishing other services that are subject to the consolidated billing requirement.

Documenting Arrangements

SNFs should document, in writing, arrangements with suppliers that render services on an ongoing basis (e.g., pharmacies, laboratories and X-ray suppliers). Documentation of a valid arrangement, including mutually agreeable terms, should help avoid confusion and friction between SNFs and their suppliers. Suppliers need to know which services fall under the CB provisions so they do not improperly bill Medicare carriers under Part B or other payers (like Medicaid and beneficiaries) directly for services.

It is also important that when ordering or providing services "under arrangement," the parties reach a mutual understanding of all the payment terms, e.g., how to submit an invoice, how payment rates are determined, and the "wait" time between billing and payment.

SNF's Responsibility

However, the absence of a valid arrangement (written or not) does not nullify the SNF's responsibility to pay suppliers for services "bundled" in the SNF PPS global per diem rate. The SNF must be considered the responsible party (even in cases where it did not specifically order the service) when beneficiaries in Medicare Part A stays receive medically necessary supplier services, because the SNF has already been paid under the SNF PPS. Examples of this obligation occur when:

- The physician performs additional diagnostic tests during a scheduled visit that had not been ordered by the SNF.

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SNF CONSOLIDATED BILLING SERVICE FURNISHED UNDER ARRANGEMENT WITH AN OUTSIDE ENTITY (CONTINUED)

Or,

- A family member arranges a physician visit without the knowledge of SNF staff and the physician bills the SNF for "incident to" services.

Establishing a valid arrangement prior to ordering services from a supplier minimizes the likelihood of a payment dispute between the parties. However, occasional disagreements between the parties that result in non-payment of a supplier claim may occur. When patterns of such denials are identified, there are potentially adverse consequences to SNFs. The reason is because all SNFs, under the terms of their Medicare provider agreement, must comply with program regulations. These regulations require a valid arrangement to be in place between the SNF and any outside entity providing resident services subject to consolidated billing. Moreover, in receiving a bundled per-diem payment under the SNF PPS that includes such services, the SNF is accepting Medicare payment and financial responsibility for the service.

Under Section 1862(a)(18) of the Act, there is no valid "arrangement" if an SNF obtains services subject to consolidated billing from an outside supplier but refuses to pay the supplier for said services. This situation could result in the following consequences:

- The SNF is found in violation of the terms of its provider agreement.
  And/or,
- Medicare does not cover the particular services at issue.

The SNF's provider agreement includes a section requiring a specific commitment to comply with the requirements of the CB provision (see Section 1866(a)(1)(H)(ii) of the Act and the regulations at 42 CFR 489.20(s)). Also Section 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.

Additional Guidance

In the absence of a valid "arrangement" between an SNF and its supplier, the problems that arise tend to fall into one of the following problem scenarios.

Problem Scenario 1

An SNF elects to use an outside supplier to furnish a type of service that would be subject to Part A CB, but then fails to inform the supplier that the resident receiving the service is in a covered Part A stay. This causes the supplier to conclude mistakenly that the service it furnishes to that resident is not subject to CB.

Based on the inaccurate impression that the resident's SNF stay is non-covered, the supplier inappropriately submits a separate Part B claim for the service and may also improperly bill other insurers and the resident. Then the supplier only learns of the actual status of the resident's Medicare-covered SNF stay when that Part B claim is denied.

In this scenario, even though the supplier made reasonable efforts to ascertain from the SNF both the beneficiary's status as an SNF resident and the specific nature of the beneficiary's SNF stay, the information from the SNF (on which the supplier relied) proved to be inaccurate.

The Centers for Medicare & Medicaid Services (CMS) realizes that unintentional mistakes occasionally may occur when furnishing such information. However, the SNF is responsible for making a good faith effort to provide accurate information to its supplier and to pay the supplier once the error is pointed out. If in Scenario 1 above the SNF refuses to pay the supplier even after the accuracy of its initial information is called to its attention, the SNF would risk being in violation of its provider agreement by not complying with CB requirements. As stated previously, supporting written documentation for the disputed service would provide a basis for resolving the dispute and aid in ensuring compliance with the CB requirements.

By ensuring that it sends accurate and timely information to its supplier regarding a resident's covered stay, the SNF can often prevent disputes such as those described in Scenario 1 from arising. The communication of accurate and timely resident information by the SNF to the supplier is especially important when a portion of an otherwise "bundled" service remains separately billable to Part B (e.g., the professional component representing a physician's interpretation of an otherwise "bundled" diagnostic test).

Problem Scenario 2

A resident temporarily departs from the SNF on a brief leave of absence, typically accompanied by a relative or friend. While briefly offsite, the resident (or the relative or friend, acting on the resident's behalf) obtains services that are subject to the CB requirement, but fails to notify the SNF. The SNF refuses to pay for the offsite services and the supplier bills the beneficiary/family member directly.

As in the previous scenario, the SNF remains responsible for any services included in the SNF "bundle" of services subject to CB that are furnished to the resident by an outside entity, **even in the absence of a valid arrangement with the SNF.**

The SNF can take steps to prevent problems like this from occurring by making sure that the resident or his representative fully understands the applicable requirements. For example, under Section 1802 of the Act, Medicare law

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guarantees to a beneficiary the right to choose any qualified entity willing to provide services to him. By selecting a particular SNF, the beneficiary has in effect exercised this right of choice regarding the entire array of services for which the SNF is responsible under the CB requirement and agrees to use only those outside suppliers the SNF selects or approves to provide services.

The staff of the SNF should explain these rights and requirements to the beneficiary and his family members or representative(s) during the admission process, periodically throughout each resident's stay, and upon the resident's temporarily leaving the facility.

The supplier in this scenario also retains responsibility for preventing problems from arising by understanding and complying with the CB requirements. Therefore, before providing beneficiary services, the supplier should determine whether that beneficiary currently receives any comprehensive Medicare benefits (e.g., SNF or home health), which could include the supplier's services. If the beneficiary is a resident of an SNF with which the supplier does not have a valid "arrangement," the supplier should consult with the SNF before actually furnishing any services that may be subject to the CB provision. Further, the supplier should know that the beneficiary cannot be charged for the bundled service in accordance with the regulations at 42 CFR 489.21(h).

The complete article is available on the *CMS Medlearn Matters...Information for Medicare Providers* Web page at:

www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3592.pdf

Addition of CLIA Edits to Codes for Mohs Surgery

DC/DE, MD, TX, VA, IHS Service Areas

Change Request No. 3458
Transmittal No. 434

Effective for dates of service on or after July 1, 2005, claims submitted to Medicare for Mohs surgery will require a Clinical Laboratory Improvement Amendment (CLIA) certificate number. The applicable CPT procedures are:

17304©	1 stage mohs, up to 5 spec
17305©	2 stage mohs, up to 5 spec
17306©	3 stage mohs, up to 5 spec
17307©	Mohs addl stage up to 5 spec
17310©	Mohs any stage > 5 spec each

The Mohs micrographic surgical treatment for skin cancer requires the trained physician to serve as pathologist and surgeon. The above CPT codes include the physician microscopic exam and interpretation of tissue specimens. Both the microscopic examination and interpretation of tissue specimens are categorized as high complexity tests under the CLIA in the specialty of histopathology. Thus, these CPT codes will be subject to CLIA edits. Medicare will deny payment if a CLIA number is not submitted on claims by facilities for CPT codes 17304, 17305, 17306, 17307 and 17310.

CLIA requires a facility to be appropriately certified for each test performed. To ensure that Medicare pays only laboratory tests performed by certified facilities, each code that includes a laboratory test is currently edited at the CLIA certificate level.

The Mohs surgery procedure usually includes the following steps:

- A physician generally removes the visible cancer, along with a thin layer of additional tissue.
- The removed tissue specimen is cut into sections, stained and marked on a detailed diagram.
- The tissue is frozen on a cryostat; very thin slices are removed from the entire edge and undersurface and these slices are then placed on slides and stained for examination under the microscope.
- The physician examines the entire undersurface and complete edge of the tissue specimen, and all microscopic "roots" of the cancer are precisely identified and pinpointed on the Mohs map.
- Upon microscopic examination, if residual cancer is found, the physician utilizes the Mohs map to direct the removal of additional tissue.

The process is repeated as many times as necessary to locate any remaining cancerous areas within the tissue specimen. When the microscopic examination reveals there is no remaining tumor, the surgical defect is repaired.

The following types of facilities will **not** be permitted to bill for the above noted tests:

- Those without a valid current CLIA certificate.
- Those with a current CLIA certificate of waiver (certificate type code 2).
  Or,
- Those with a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4).

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