SNF Consolidated Billing

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SNF Consolidated Billing

Basic Requirement

- The skilled nursing facility (SNF) consolidated billing provisions place with the SNF itself the Medicare billing responsibility for most of its residents' services.
- Part A consolidated billing requires that an SNF must include **on its Part A bill [UB-04]** almost all of the services that a resident receives during the course of a *Medicare-covered* stay, other than those services that are specifically *excluded* from the SNF's global prospective payment system (PPS) per diem payment for the covered stay.

Legislative History

SNF Consolidated Billing

- Section 4432(b) of Balanced Budget Act [BBA]
  - Pub Law 105-33 - August 5, 1997
  - SNF must bill all services [Both A & B] the patient receives
  - With limited exceptions
- Interim final rule 63 FR 26252 – May 12, 1998
  - Implemented with beginning of first Medicare cost report
  - On or after July 1, 1998
- Section 103 of Balanced Budget Refinement Act [BBRA]
  - Pub Law. 106-113 Appendix F – November 29, 1999
  - Excluded "high-cost, low probability services"
  - Chemotherapy, radioisotopes, customized prosthetic devices

Legislative History
SNF Consolidated Billing

- Section 313 of Benefit Improvement & Protection Act [BIPA]
  - Pub Law 106-554 – December 21, 2000
  - Repealed Part B except PT, OT, ST
- Section 410 Medicare Modernization Act [MMA]
  - Pub Law 108-173 – December 8, 2003
  - Aides Add-on of 128%
  - Excluded services provided by RHC & FQHC from SNFCB
- Section 149 Medicare Improvements for Patients and Providers Act [MIPPA]
  - Pub Law 110-275 - July 15, 2008
  - Section 149 allowed SNF to be telehealth originating site
  - SNF receives separately payable Part B facility fee
  - This is paid outside the SNF PPS bundled rate

SNF CB Today
SNF Consolidated Billing

- Requirement that all Medicare covered services rendered to the SNF Part A resident be billed by the SNF [bundled] unless they are specifically excluded
- Requirement that PT, OT and ST services identified by CPT code and provided to Part B patients in a Medicare certified bed of the SNF be billed by the SNF
- Basic principle has not changed since 1998

Why SNF CB?

- Why did Congress enact SNF Consolidated Billing?
- Prior to 1998
  - Duplicate billing from both SNF and ancillary provider
  - Beneficiary paid additional co-insurance
  - No accountability
  - CMS could not easily identify cost of Part A inpatient

What has Changed?

Common Working File Edits

- CMS Implemented 1st CWF edits in 2003
- Numerous program memorandum and clarifying instructions

What has Changed?

*Office of Inspector General [**OIG**]*

- March 27 ,2000 – SNF CB Compliance
- May 28, 2004 – Improper Part B Payments
- August 28, 2009 - Ambulance Transport
- December 17, 2010 – Ambulatory Surgery Centers
- SNF consolidated billing is still part of OIG work plan

Consolidated Billing related Issues

- SNFs have not signed **Under Arrangement Agreement** with outside providers
- Physician, clinics and hospitals are receiving denied claims and recoupments based on RAC audits
- SNFs are being billed at prices above the Medicare allowable fee schedule
- SNFs are being billed for non-covered Medicare services
- SNFs are being billed for items that are excluded from the SNF bundle
- Providers are billing SNFs for both technical and professional component
- SNFs are either paying way too much or not at all

Entities Impacted by C.B.

- What entities are affected by Consolidated Billing for Part A SNF residents?
  - Outpatient Hospitals, CORFS, ORFS
  - Clinics
  - Freestanding Labs & XRAY Companies
  - Ambulance Companies
  - Suppliers
  - Contracted Therapists
  - Physician Offices

Which Residents Are Affected?

- Medicare Part A residents in a SNF beginning with facility cost report year beginning on or after 7/1/98
- MEDICARE beneficiaries enrolled in risk HMOs are NOT governed by C.B
  - But, these may be tied in contractually!

Under Arrangement Provision

CMS Pub 100-05

Chapter 5 Sec 10.3 – 10.4

Under Arrangement Agreement
Transmittal 412

- SNF must either provide services directly with its own resource
  - Or, obtain services from an outside supplier under an arrangement
- CMS expects that the SNF have an "under arrangement" agreement with outside providers
- SNF must reimburse the outside entity for those Medicare covered services that are subject to consolidated billing
  - Not mention regarding level or reimbursement

Under Arrangement Agreement
Transmittal 412

- CMS expects that SNFs document the under arrangement agreement in writing, particularly with common suppliers
- SNF can effect an "arrangement" through any means that specifies—
  - the arranged-for services for which the SNF assumes responsibility, and
  - the manner in which the SNF will pay the supplier for those services

Under Arrangement Agreement
CMS Pub 100-05 Chapter 5 Sec 10.3, 10.4

- SNF cannot merely act as billing mechanism
- SNF must exercise professional responsibility over the arranged for services
  - Same quality controls
  - Complete timely clinical record
    - diagnosis, medical history, physician orders, progress notes
- The SNF's failure to reimburse the supplier places the SNF in violation of its Provider Agreement

Under Arrangement Agreement

Our Recommendation

1. Agreement should be in writing
2. SNF is responsible only for certain Medicare covered services clearly bundled to the SNF
3. Services provided by the 3rd party should be authorized by the SNF prior to be provided
4. SNF needs to assume responsibility for
   - Quality & timeliness
5. Agreement should specify how supplier will be paid
   - When
   - At what rate [Medicare allowable fee schedule]

Under Arrangement

CBSI Recommendation

6. Supplier claim to SNF must be on CMS 1500 or UB-04 as appropriate and show:
   - CPT or HCPCS code
   - Date of service
   - Diagnosis code
7. Supplier must provide to SNF:
   - physician order
   - Diagnosis
   - medical history
   - progress notes
9. Supplier must bill SNF within 6 months or DOS
10. The SNF should not refuse to pay the suppier of services. Rather, the SNF should pay at it standard rate thus avoiding issues with its provider agreement.

SNF's Mission

CMS Pays the SNF for A Bundle of Services, Let's Learn to Manage the Money.

General Principle

The SNF is responsible for all

Medicare covered services

Rendered to

RESIDENTS of the SNF,

Unless the item has been

Specifically excluded

From the SNF bundle

Step 1: What Is a Medicare Covered Service?

Medicare Covered Services

Medicare services covered in a SNF include:

- Bed / board in semi-private room
- Drugs & biologicals
  - must be FDA approved
  - Or, used in hospital prior to admission
- Diagnostic x-rays
- Diagnostic lab
- X-ray, radium & radioactive isotope therapy

Medicare Covered Services
Continued

- Surgical dressings, splints, casts
- Prosthetic devices
- Leg, arm, back and neck braces, trusses, artificial legs, arms and eyes, including adjustment, repairs and replacements
- PT, OT, SLP
- Hemophilia clotting factors
- Social Security Act 1888(e)(A)

Medicare Non-covered Services

- Private duty nurse
- Bed / board in private room
- Services that are not reasonable and necessary for the patient's illness or injury
- Transportation by other than ambulance
- Ambulance transportation that is not medically necessary

What Is Reasonable & Necessary?

- If the service or supply had been billed directly to Medicare for payment,
  - Would the item or service be covered?
  - Would Medicare have paid the claim?
- Is the service or supply excluded in the Medicare National Coverage Determination Manual, CMS 100-3?
- Current SNF CB, CWF edits implement prior to Medical necessity edits

Drugs – Off Label Use

- Medicare pays for off label use in certain circumstances[CR 6191 – 10/24/08
- Use is listed on authoritative compendia:
  - American Hospital formulary
  - NCCN drugs and biologicals
  - Thomson Miromedex DrugDex
  - Clinical Pharmacology
- Contractors shall recognize medically accepted indication as those that:
  - Are favorably listed in one or more of the above
  - Or, contractor determines from a review of peer reviewed literature it is medical accepted
  - Unless; CMS determines use is not accepted

Step 2: When is a Patient NOT a Patient for SNF Consolidated Billing

Resident Status as Inpatient

- Starts when patient is physically admitted to skilled nursing facility Medicare Part A inpatient
- Ends when patient is admitted as an Inpatient to:
  - A Medicare participating hospital
  - A Critical Access Hospital (CAH)
  - As a resident of a different SNF

Note: Patient remains a resident of SNF until admitted to new facility

Resident Status as Inpatient

- Ends when:
  - Patient is formally discharged
  - Or, otherwise departs from the SNF (LOA)
  - And, is not readmitted or does not return to that or any other SNF by midnight of the day of departure

Resident Status as Inpatient

- Ends When:
  - Patient receives certain limited outpatient services from a Medicare participating acute care hospital or CAH which:
  - Are "Exceptionally Intensive", and,
  - That lie "well beyond the scope of care that a SNF would ordinarily furnish", or,
  - Are "Emergency Services"
- Ends When:
  - Patient receives services, under a plan of care from a Medicare participating Home Health Agency

Leave of Absence

- Part A beneficiaries **not** in the SNF at midnight are on a 'Leave of Absence'
- SNF PPS payment is not made to SNF
- SNF Part A benefit bay is **not** applied
- CB regulations do **not** apply
  - Services provided outside the SNF can be billed directly to Medicare (Carrier, FI or DMERC - depending on the service) on any day designated a LOA
  - LOA days may occur for *medical or social reasons*

Step 3: Services Excluded From SNF Bundle

Consolidated Billing

Excluded Items – 5 Ways

1. Items provided by outpatient hospital and "Lie well beyond the SNF Scope of Care" [Cat 1]
2. Services when rendered to specific beneficiaries [Cat II]
3. Additional items rendered by certified Providers [Cat III]
4. Items that are not covered under Part A because they are preventive or screening and are therefore excluded from the SNF bundle [Cat IV]
5. Federal Law Exclusions - professional services not covered in SNF

Hospital Outpatient

Major Category I

- Provided by Hospital Outpatient Department
  - Computerized Axial Tomography (CT Scans)
  - Cardiac Catherization
  - Magnetic Resonance Imaging (MRI)
  - Radiation Therapy
  - Angiography, Lymphatic and Venous Procedures
  - Ambulatory Surgery Involving the Use of an operating room
  - Emergency Services

NOTE: This is a place of service exclusion [must be provided in Hospital Outpatient or CAH]

Hospital Outpatient

Major Category I

- In addition to items identified by code, most items are excluded from the SNF if they are directly related to category I services and billed with the same:
  - Place of Service (POS) and,
  - Line Item Date of Service (LIDOS)
  - This may include anesthesia and drugs (revenue codes 037x, 0255, 027x, and 062x) when billed with exclude procedure

What Is Hospital Outpatient?

- Place of Service = 22 on CMS Form 1500
- TOB = 13x, 14x or 85x on CMS Form UB-04
- Meaning:
  - Person not admitted by hospital as inpatient
  - And, is registered on the hospital records as an outpatient
  - And, receives services and not just supplies
    - May be either diagnostic or therapeutic
    - Diagnostic services may be furnished by hospital "under an arrangement"

Services to Specific Patients

Major Category II

- Services provided to specific beneficiaries by Renal Dialysis Facility [ESRD]
  - Provided in renal dialysis facility
  - Provided in SNF, SNF may not be paid for supplies
  - EPO or Aranesp are excluded when provided by ESRD
  - Must be billed by RDF on TOB 72x
- Beneficiaries who have elected Hospice
  - Must be billed using TOB 81x or 82x

Beyond Scope of SNF Care

Major Category III

- Services excluded when rendered by certified provider [Not a SNF]
  - Chemotherapy Items
  - Chemotherapy Administration Services
    - These codes are only excluded if they occur with the same LIDOS as excluded chemotherapy agent
  - Radioisotope and their administration
    - These codes are excluded when used in cancer treatment
    - New codes added 1/1/04
  - Selected Customized Prosthetic Devices
    - **New codes (L5673, L5679) added effective 1/1/04 – Trans 191**

Not in Part A Rate

Major Category IV

- Certain preventive & screening services billed separately from Part A PPS Rate
  - Must be billed by SNF on TOB 22X to be excluded
  - Mammography
  - Vaccination for pneumococcal, Flu or hepatitis B
  - Vaccine administration
  - Screening Pap smear and pelvic exam
  - Colorectal screening services
  - Prostate cancer screening
  - Glaucoma screening
  - Diabetes screening
  - Cardiovascular screening

Federal Law - Exclusions

- Social Security Act 1888(e)(2)(iii)
  - Ambulance for renal dialysis [Cat I.H]
  - Chemotherapy items [Cat III.A]
  - Chemotherapy Administration [Cat III.B]
  - Radioisotope services [Cat III.C]
  - Customized Prosthetic devices [Cat III.D]
    - Provided during stay in SNF
    - Intended to be used after discharge from SNF
- Statue identifies range of code
- Gives Secretary authority to add codes

Federal Law - Exclusions

- Other Excluded Services:
  - Home Dialysis supplies & equipment [Cat II]
  - Self-care home dialysis support services [Cat II]
  - Institutional dialysis services and supplies [Cat II]
  - Erythropoietin (EPO) / Aranesp for ESRD patients [Cat II]
  - Hospice care related to a patients' terminal condition [Cat II.B]

Professional Services

Excluded Items

- Exempt Practitioner Services:
  - Physicians' services
    - (which include anesthesia per AB-99-90)
  - Physicians' assistants working under a physician's supervision
  - Nurse Practitioners & Clinical Nurse Specialists working in collaboration with a physician
  - Certified Nurse-Midwives
  - Qualified Psychologist
  - Certified Registered Nurse Anesthetists

Ambulance Services

Ambulance Bundling
Overview

- CMS considers ambulance transportation to be part of the SNF bundle for an inpatient of the SNF
- Only covered ambulance transportation is part of the bundle
- Other forms of transportation are not the responsibility of the SNF under SNF CB.
- SNF is not responsible for ambulance when the person is not an inpatient or if the service has been excluded as Cat I A-E & G

Ambulance Bundling
Not an Inpatient

- The SNF is NOT Responsible for:
  - Initial Transport to the SNF of admission
  - Final discharge from the SNF
    - Except when transferring to another SNF
  - Transport to inpatient hospital admissions
  - Transport to hospital for Category I excluded services
  - Transport to/from Dialysis Services became an exclusion on 4/1/00

Ambulance Bundling
SNF Is Responsible

- SNFs ARE Responsible for:
  - Medically necessary ambulance transport for services provided outside the SNF
    - When that service is excluded by statute
    - E.G. Physician visit
    - Cancer center
  - Transfers to another SNF that require ambulance transport

Ambulance

Transmittal #163

- Established new edits effective 10/1/04
- For resident in a Part a stay
  - Assure only ambulance transport to/from hospital is paid under Part B
  - Will reject transport to/from
    - Diagnostic testing facility
    - Cancer treatment center
    - Radiation therapy center
    - Wound care center

Routine Transportation

- Transportation by ambulance in not medically necessary under 42 CFR 409.27
  - "Other means of transportation is contraindicated"
- These forms may include:
  - Wheelchair vans
  - Ambulettes
  - Facility van
- SNF may charge patient or Medicaid may cover
  - Give patient NEMB if they are responsible for payment

SNF Responsibilities

CMS on SNF CB

- **Clarification:** The SNF CB requirement makes the SNF itself responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These "excluded" services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their Medicare durable medical equipment regional carrier (DMERC.)

SNF Responsibilities

- The SNF must bill for all Part A services provided "Under Arrangement"
  - Supplies
  - Enteral and Parenteral Nutrition
  - Services "Incident to" a Professional Service
  - Ambulance Services - Unless Excluded
  - Labs and X-ray Services
  - Orthotics and Prosthetics - Unless Excluded
  - Drugs and Biologicals
  - Any Service Received in an ER that is NOT an for Emergency Treatment

SNF System Set-Up

- Make arrangements to provide the entire bundle of services to inpatients. [Preferred Provider]
  - Only need to make arrangement with one entity for each service
- Notify providers if you do NOT want to have an arrangement
- Amend your admission package to notify residents and their family of those providers where the SNF has an arrangement for services
  - Provide notice that if they choose another (Non-Approved) provider that they will be responsible

SNF Resident Management

- Notify outside Providers they are treating a Part A SNF resident for services that may be "Bundled" back to the SNF
- Determine medical necessity of services
- Pay outside Providers for services rendered to SNF Part A residents
- Report services and charges to Part A Intermediary on HCFA 1450 (UB04) claim
- Communicate between departments!

Common Working File Edits

CB Edits - Purpose

- Intermediaries and Carriers are to Insure that Duplicate Payments are Not paid to multiple Providers for the same service
- Part A claim will always take priority over Part B claim - regardless of which claim is paid and posted to CWF history first
- Part B claim will be auto-cancelled if a covered Part A claim is received after the Part B claim was paid

CB Edits - Contractor Action

- Return to Provider (RTP)
  - for correction any duplicate claim that has allowable and non-allowable services billed
  - for correction any overlapping claim that has allowable and non-allowable services billed
- Reject
  - Any claim that must be billed ONLY by the SNF

Pitfalls, Pratfalls & Real Life Examples

Ambulatory Surgery Center

Facility Fee

- The facility fee portion of the professional service is bundled to the SNF
- The professional code is used by the ASC
  - This appears to the SNF as a professional service
  - It is not
- See OIG report December 17, 2010

Hospital Facility Fee

- The facility fee portion of the professional service is bundled to the SNF
- The Hospital generally expects payment based on OPPS
  - Not the physician or other fee schedule
- The professional code is used by the Hospital
  - This appears to the SNF as a professional service
  - It is not

No HCPCS or CPT Code

- We have seen numerous instances where a physician, supplier, hospital or clinic bills the SNF without including an HCPCS or CPT code
- If billed by the Hospital [TOB = 13X]
  - They may be excluded with other Category I excluded services
  - Some are excluded based on revenue code and LIDOS
- If billed by supplier
  - HCPCS code is required code in order to determine status
  - We suggest returning all claims missing CPT or HCPCS for non-payment

Codes Missing Fee Schedule

- Medicare fee schedules come from seven different sources
- Even if the SNF has all seven sources, there are still codes that are not subject to the fee schedule because
  - They are bundled with other costs
  - Paid on reasonable charge basis
  - Paid on reasonable cost basis
- Your under arrangement provision should dictate payment amount.

Services Provided Are Not Reasonable Necessary

- Medicare only covers “reasonable and necessary” services for the patients illness or injury
- It is possible to deny payment to the supplier if you believe Medicare would not have covered services if they had billed directly to Medicare
- This is not official guidance from CMS but rather our opinion

Vision Services

- Covered service under SNF 260.4
- Included in Part A bundled rate

Blood Products

- Extremely expensive
- Bundled back to SNF
- E.G
  - Factor VII
  - Factor XIII
  - Factor IX

New Codes Not Properly Excluded

- Stereotactic Body Radiation Therapy
  - CPT 77373 & 77435
  - On July 9,2015, CMS excluded these codes retro for 2014.
  - Still not listed in CMS Help Files
  - Changed website only
  - SNF Billed at $4,990 / unit
  - www.SNFCB.com shows $150,000 in correctly bundled to SNF

CMS Claims Processing Manual is *Incorrect*

- Category I.F codes should allow all other services billed with
  - Same LIDOS
  - Same POS
  - Regardless of revenue code
- To be excluded from SNF CB
- CMS Pub 100-04, Chap 6, Section 20.1.2.1 is outdated

Office of the Inspector General May 28, 2004

OIG Report May 28, 2004

- OIG Identified SNF CB as vulnerable area
- Reviewed claims for 1999 & 2000
- CMS paid twice for same service
  - Improper payments = $108.3 million
  - Beneficiaries co-pay = $33.1 million
- Supplier paid by both CMS and SNF

OIG Report - Causes

- Controls are not established at SNFs
- Controls are not established at suppliers
- CMS was late in establishing edits

OIG Report – Recommendations

- Recover improper payments
- SNF / Suppliers to enhance billing controls
- Identify “best practices” for communicating that SNF resident is in Part A stay
- Education
- Delineate SNFs’ responsibility
- Identify SNFs and Suppliers that are non-compliant

OIG – Billing Controls

- Timely and accurate communication regarding SNF's Part A status
- SNF review of supplier bills to ensure that all supplier services subject to C.B. are properly billed
- Written agreement between SNFs and suppliers regarding compliance responsibilities

Office of the Inspector General December 17, 2010

OIG Report Dec 17, 2010

- OIG Identified Ambulatory Surgery Centers as a vulnerable area
- ASC should have billed SNF for facility Fee
- Reviewed claims for 2006 to 2008
- CMS paid twice for same service
  - Improper payments = $102,879
  - 100 services at 88 ASCs

OIG Report – Recommendations

- Recover improper payments of $102,879
- Review 20,806 services not reviewed by OIG
- Recover estimated over payments of 6.5 million
- Provide guidance to ASC on SNF CB
  - Timely and accurate communication
- Establish CWF edit to prevent improper payment

CMS SNF CB Forms

CMS SNF CB Sample Forms

1. Beneficiary Service Log
2. Request for Ambulance Transport
3. Notice to Physician
4. Notice to Physician
5. Notice to Physician
6. Notice to Hospital – Outpatient
7. Notice to Hospital – Outpatient

Regulatory Update

Hospital Outpatient

Change to CWF Edits

- Correct and update to CWF edit for DOS effective 4/1/01
- Corrected edits will allow pharmacy services (rev code 25x) to bypass when billed with
  - Excluded surgery
  - Emergency room service
- Implementation date is 10/4/04

Common Working File Edits

Critical Access Hospitals

- Pub 100-04
- Claims Process Manual
- Trans 429
- CR 3561
- Date: 1/14/05
- Effect: 7/1/01
- Imp: 7/5/05

- Directs CWF to bypass SNF CB edits for critical access hospitals
- Applies to CAH billing revenue codes 96x,97x and 98x
- Claim type is 85x

Common Working File Edits

Partially non-covered claims

- Pub 100-04
- Claims Process Manual
- Trans 1009
- CR 5220
- Date: 7/28/06
- Effect: 10/1/05
- Imp: 7/1/07

- Directs CWF SNF CB edits to bypass SNF 22x bill types
- Therapy services
- Dates of service fall within non-covered periods on SNF inpatient bills.
- Allows 22x therapy bills to process when resident is not a SNF inpatient

Common Working File Edits

Hospital ER Services

- Pub 100-04
- Claims Process Manual
- Trans 1151
- CR 5389
- Date: 1/11/07
- Effect: 10/1/05
- Imp: 4/2/07

- Replaces Trans 1109
- ER services are excluded from SNF bundle
- Hospitals use rev code 045x
- LIDOS = date patient entered ER
- Claims with subsequent service dates are rejecting
- Hospital should use modifier ET for line items related to the ER encounter

Common Working File Edits

- Pub 100-04
- Claims Process Manual
- Trans 1289
- CR 5624
- Date: 7/13/07
- Effect: 4/1/01
- Imp: 1/7/08

- Identify periods where SNF CB should not be applied
- Compares therapy 22x against SNF 21x
  - Bypass edits 7258, 7259
  - Allowing 22x claims in span code 74 to pay.
- Compares Other Part B 22x against SNF 21x
  - Bypass edits 7260 & 7261
  - Allows 22x claims in span codes 74,76,77,79 or M1 to pay

Common Working File Edits

- Pub 100-04
- Claims Process Manual
- Trans 1289
- CR 5624
- Date: 7/13/07
- Effect: 4/1/01
- Imp: 1/7/08

- Compares Ambulance Part B 22x against SNF 21x
  - Bypass edits 7275
  - Allows 22x claims in span codes 74,76,77,79 or M1 to pay
- Clinical social workers
  - Bypass edit 7269
  - Allows 22x claims in span codes 74,76,77,79 or M1 to pay

Change in Covered Codes

- Pub 100-04
- Claims Process Manual
- Trans 1301
- CR 5665
- Date: 7/20/07
- Effect: 1/28/05
- Effect: 1/1/08
- Imp: 1/7/08

- Medicare does not cover
  - Code 78609 [pet for brain perfusion imaging]
  - It is incorrectly listed in 60.3.2 as a covered code Eff 1/05
- Tracer code for PET scan
  - A4641 [radiopharmaceutical, diagnostic] is not a tracer code
  - Effective 1/1/08

Non Coverage Decision

Autologous PRP - Non-healing wounds

- Pub 100-03
- National Coverage Determinations
- Trans 83
- CR 6043
- Date: 5/2/08
- Effect: 3/19/08
- Imp: 6/2/08

- Use of autologous platelet rich plasma (PRP) is not covered for the treatment of acute wounds where PRP is applied directly to the closed incision site.
- Effective 3/19/08 CMS maintains its current non-coverage determination
- This should not bundled to the SNF under SNF CB.

New SNF CB Edits for ASC

- Pub 100-04
- Claims Processing
- Trans 1911
- CR 6702
- Date: 2/5/10
- Effect: 1/1/10
- Imp: 7/6/10

- Creates anew edit for facility costs billed by ASC
  - Provider type 49
  - Service is type of service F
  - Patient is in Part A SNF Stay
- Does not change policy
- Facility Fee is therefore bundled to SNF

July 2011 SNF CB

Quarterly Update

- Pub 100-04
- Claims Processing
- Trans 2184
- CR 7345
- Date: 3/25/11
- Effect: 1/1/11
- Imp: 7/5/11

- Changes SNF CB Edits
  - CT Scan codes
  - 74176,74177,74178
  - Cat 1.A
- Other Code changes as well
- If Billed prior to 7/5 may incorrectly be listed as bundled when it is not.

October 2011 SNF CB

Quarterly Update

- Pub 100-04
- Claims Processing
- Trans 2300
  - Updated 2237
- CR 7444
- Date: 9/13/11
- Effect: 1/1/11
- Imp: 10/3/11

- Code J0894 should be included in Category III.A & carrier code file 1
- Code J9033 should be included in Category III.A & carrier code file 1
- This may not be changed until October 3, 2011.

SNF CB Annual update 2012

- Pub 100-04
- Claims Processing
- Trans 2286
- CR 7552
- Date: 8/26/11
- Effect: 1/1/12
- Imp: 1/3/12

- Annual update to carrier and FI consolidated billing files.
- Removes deleted codes no longer valid
- Updates new codes

Revision to Physician Services

Excluded from Part A PPS

- Pub 100-04
- Claims Processing
- Trans 2377
- CR 7658
- Date: 12/30/11
- Effect: 1/31/12
- Imp: 1/31/12

- Clarified that physician professional services are excluded regardless of whether they are employed by the SNF.
- This is a clarification of existing policy
- Chapter 6, Sec 20.1.1

October 2012 SNF CB

Quarterly Update

- Pub 100-04
- Claims Processing
- Trans 2492
  - Updated 2284
- CR 7856
- Date: 6/8/12
- Effect: 1/1/12
- Imp: 10/1/12

- Code J9033 should be included carrier code file 1
- MAC will reprocess claims only when brought to their attention

SNF CB Annual update 2013

- Pub 100-04
- Claims Processing
- Trans 2542
- CR 8037
- Date: 9/7/12
- Effect: 1/1/13
- Imp: 1/7/13

- Annual update to carrier and FI consolidated billing files.
- Removes deleted codes no longer valid
- Updates new codes

SNF CB Annual update 2014

- Pub 100-04
- Claims Processing
- Trans 2802
- CR 8474
- Date: 10/25/13
- Effect: 1/1/14
- Imp: 1/6/14

- Annual update to carrier and FI consolidated billing files.
- Removes deleted codes no longer valid
- Updates new codes

October 2014 SNF CB

Quarterly Update

- Pub 100-04
- Claims Processing
- Trans 2991
- CR 8829
- Date: 7/18/14
- Effect: 1/1/14
- Imp: 10/6/14

- Code Q2050 should be included in carrier code file 1 & Cat III.A
- Code G0461 & G0462 should be included in code file 2
- Code G0463 when billed with TOB 13x & 85x Rev Code 510 are excluded
- Code 97610 is no longer included in Cat V.A
- Claims must be brought to attention of MAC.

SNF CB Annual update 2015

- Pub 100-04
- Claims Processing
- Trans 3088
- CR 8943
- Date: 10/3/14
- Effect: 1/1/15
- Imp: 1/5/15

- Annual update to carrier and FI consolidated billing files.
- Removes deleted codes no longer valid
- Updates new codes

SNF CB Annual update 2016

- Pub 100-04
- Claims Processing
- Trans 3349
- CR 9340
- Date: 9/11/15
- Effect: 1/1/16
- Imp: 1/4/16

- Annual update to carrier and FI consolidated billing files.
- Removes deleted codes no longer valid
- Updates new codes

July 2016 SNF CB

Quarterly Update

- Pub 100-04
- Claims Processing
- Trans 3473
- CR 9561
- Date: 3/4/16
- Effect: 7/1/16
- Imp: 7/5/16

- The contractor shall add HCPCS code 93600, 93602, 93603, 93609, 93610, 93612, 93613, 93615, 93616, 93618-93624, 93631, 93640 - 93642, 93644, 93650, 93653, 93654, 93655, 93656, 93657, 93660, 93662 to the Major Category 1.B Coding List for SNF Consolidated Billing.
- Claims with DOS on or after 1/1/16 must be brought to attention of MAC.

October 2016 SNF CB

Quarterly Update

- Pub 100-04
- Claims Processing
- Trans 3546
- CR 9688
- Date: 6/17/16
- Effect: 10/1/16
- Imp: 10/3/16

- For claims processed on or after the implementation of the October 2016 release on October 3, 2016, the CWF shall add HCPCS code 10030 to File #1
- Claims must be brought to attention of MAC.

SNF CB Annual update 2017

- Pub 100-04
- Claims Processing
- Trans 3603
- CR 9735
- Date: 8/26/16
- Effect: 1/1/17
- Imp: 1/3/17

- Annual update to carrier and FI consolidated billing files.
- Removes deleted codes no longer valid
- Updates new codes

October 2017 SNF CB

Quarterly Update

- Pub 100-04
- Claims Processing
- Trans 3825
- CR 10163
- Date: 8/4/17
- Effect: 10/1/17
- Imp: 10/2/17

- Add certain radiology codes in range 77014-79445 to carrier code #1 to them the 26 modifier to process. Effective is retro to 1/1/15
- Add certain radioisotope codes to category III.c to allow them to by SNFCB CWF edits. Effective date is 12/31/15 or 12/31/16

SNF CB Annual update 2018

- Pub 100-04
- Claims Processing
- Trans 3857
- CR 10262
- Date: 9/8/17
- Effect: 1/1/18
- Imp: 1/2/18

- Annual update to carrier and FI consolidated billing files.
- Removes deleted codes no longer valid
- Updates new codes

10 Steps to Managing
Consolidated Billing

1. **Set-up arrangements with outside providers**
2. Update admission information giving residents notice of preferred providers
3. Establish fair payment rate
   - At or Below Medicare fee schedule
   - SNF will only pay Technical Component
4. Screen potential admissions
5. Know where resident goes when they leave the facility
6. Require pre-authorization by SNF
7. Track and communicate services received outside facility
8. Conduct training on SNF CB Exclusions
9. Review all claims from outside suppliers carefully
10. Include all bundled services on UB-04

Questions????