

# MEDICARE PART A BULLETIN

June 12, 1998

SNF Medicare Bulletin S-19

TO: All Participating Skilled Nursing Facility Providers

FROM: Program Relations

SUBJECT: **CONSOLIDATED BILLING FOR SKILLED NURSING FACILITIES (SNFS)**

**ATTENTION MEDICARE BUSINESS OFFICE:** Please distribute to the appropriate health care facility personnel.

The purpose of this bulletin is to formally publish instructions to SNFs on the changes associated with consolidated billing.

## **CONSOLIDATED BILLING - GENERAL**

Section 4432(b) of the BBA requires consolidated billing for SNFs. Under the consolidated billing requirement, the SNF must submit **ALL** Medicare claims for **ALL** the services that its residents receive (both Part A and Part B services), except for certain excluded services listed below. A SNF resident is defined as a beneficiary who is admitted to a Medicare-participating SNF (or to the nonparticipating portion of a nursing home that also includes a Medicare-participating SNF), regardless of whether Part A covers the stay. Whenever such a beneficiary leaves the facility, the beneficiary's status as a SNF resident for consolidated billing purposes (along with the SNF's responsibility to furnish or make arrangements for needed services) ends when one of the following events occurs:

- The beneficiary is admitted as an inpatient to a Medicare-participating hospital or critical access hospital (CAH), or as a resident to another SNF;
- The beneficiary receives services from a Medicare-participating home health agency under a plan of care;
- The beneficiary receives outpatient services from a Medicare-participating hospital or CAH (but only with respect to those services that are not furnished pursuant to the SNF's required resident assessment or comprehensive care plan; or
- The beneficiary is formally discharged (or otherwise departs) from the SNF, unless the beneficiary is readmitted (or returns) to that or another

SNF within 24 consecutive hours.

**NOTE:** This instruction only applies to Medicare fee-for-service beneficiaries residing in a participating SNF or in the nonparticipating remainder of a nursing home that also includes a participating distinct part SNF.

These claims shall be submitted to the Part A intermediary on the HCFA-1450 (UB-92) claims format. All services billed by the SNF (including those furnished under arrangements with an outside supplier) for a resident of a SNF in a covered Part A stay are included in the SNF's inpatient bill (i.e., type of bill 21X). If a resident is not in a covered Part A stay (Part A benefits exhausted, posthospital or level of care requirements not met), the SNF still bills for all the services not specifically excluded. The provision requires that effective for services and items furnished on or after July 1, 1998, payment is to be made directly to the SNF. SNFs will no longer be able to "unbundle" services to an outside supplier that can then submit a separate bill directly to the Part B carrier. Instead, the SNF must furnish the services either directly or under an arrangement with an outside supplier in which the SNF (rather than the supplier) bills Medicare. Medicare does not pay amounts that are due a provider to any other person under assignment, or power of attorney, or any other direct payment arrangement. As a result, the outside supplier must look to the SNF (rather than to the Part B carrier) for payment.

**In Terms of Facilities, Consolidated Billing Applies To:**

- A participating SNF;
- **Any part** of a nursing home that includes a participating distinct part SNF. In this situation, place of service must always be coded as "SNF" even if the beneficiary was in a nursing facility (NF) for part of the time;

**But Does Not Apply To:**

- A nursing home that has no Medicare certification, such as:
  - A nursing home that does not participate at all in either the Medicare or Medicaid programs; and
  - A nursing home that exclusively participates only in the Medicaid program as a nursing facility.

**In Terms of Services, Consolidated Billing Applies To:**

All services furnished to a SNF resident (other than the excluded service categories described below). Examples of services that are subject to consolidated billing include:

- Physical, occupational, and speech-language therapy services, regardless of whether they are furnished **by (or under the supervision of) a physician or other health care professional.**
  - Psychological services furnished by a clinical social worker; and
  - Services furnished as an "incident to" the professional services of a physician or other

excluded category of health care professional described below.

**But Does Not Apply To:**

- The excluded service categories listed below.

**SERVICES EXCLUDED FROM CONSOLIDATED BILLING**

- Physician's services furnished to SNF residents are not subject to the consolidated billing requirement and are still billed separately to the Part B carrier. Section 4432 (b)(4) of the BBA requires bills for these particular services to include the SNF's Medicare provider number;
- Physician assistants working under a physician's supervision;
- Nurse practitioners and clinical nurse specialists working in collaboration with a physician;
- Certified nurse-midwives;
- Qualified psychologists;
- Certified registered nurse anesthetists;
- Home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies;
- Erythropoietin (EPO) for certain dialysis patients, subject to methods and standards for its safe and effective use (see 42 CFR 405.2163(g) and (h));
- Hospice care related to a beneficiary's terminal condition;
- An ambulance trip that transports a beneficiary to the SNF for the initial admission or from the SNF following a final discharge; and
- **FOR 1998 ONLY** - The transportation costs of electrocardiogram equipment for electrocardiogram test services (HCPCS code R0076) furnished during 1998. This reflects §4559 of the BBA which temporarily restores separate Part B payment for the transportation of portable electrocardiogram equipment used in furnishing tests during 1998.

**GENERAL BILLING INFORMATION FOR ALL CONTRACTORS - TRANSITION**

**SNFs Not on PPS Prior to January 1, 1999**

**A transition period from July 1, 1998 through December 31, 1998 is available for those SNFs that will not have the systems and billing capability to submit claims to the intermediary for all the services that their residents receive effective for services and supplies rendered on or after July 1, 1998. However, beginning January 1, 1999, suppliers will no longer be permitted to bill the Part B carrier or the DMERC for supplies and services rendered to residents of a SNF. The SNF must bill the intermediary. This is not a "phase in" period where SNFs may gradually begin billing for those services usually billed to the DMERC or the Part B carrier, e.g., additional services beginning to come to the intermediary in October and gradually more billed in November and so on. For those SNFs utilizing the transition period, all claims for all services and supplies rendered on or after January 1, 1999, that the resident of a SNF receives, must be billed to the intermediary. There will be no extensions beyond January 1, 1999.**

**During this transition period, suppliers may continue to bill the Part B carrier or the DMERC as appropriate for the services and supplies rendered to the residents of a SNF not in a covered**

**Part A stay ( Part A benefits exhausted or level of care requirements not met) and to residents in a Part A stay if the stay is not yet reimbursed under the prospective payment system (PPS) and only if the SNF is not currently billing for these services and supplies to the intermediary.**

**These services and supplies include prosthetics and orthotics, surgical dressings and supplies, ostomy and miscellaneous supplies, parenteral and enteral nutrition (PEN), and independent laboratory and independent radiology services. In the case of PEN, the SNF may not bill these to the intermediary until January 1, 1999. HCFA will check for duplicate billings and payments during this transition period.**

### **SNFs on PPS Prior to January 1, 1999**

#### **Part A Stay**

**SNFs that go on PPS prior to January 1, 1999 must submit line item billing to the best of their ability for all of the ancillaries that the resident receives. Suppliers may not bill the DMERC or the Part B carrier for ANY service or supply rendered to residents in a Part A inpatient stay (21X bill type) because payment for the ancillaries is included in the PPS rate.**

#### **Inpatient Part B**

**If a resident of a SNF is no longer in a covered Part A inpatient stay (Part A benefits exhausted or level of care requirements not met — 22X bill type) the billing guidelines stated on the prior page for SNFs not on PPS prior to January 1, 1999 are to be followed during the transition period.**

### **General Information Effective July 1, 1998**

- SNFs are responsible for assuring that all Medicare medical necessity guidelines are followed for services rendered to their residents and for obtaining all the necessary orders. All items of DMEPOS require a doctor's order in the file.
- The SNF will **not** have to obtain a bond to bill durable medical equipment (DME). DME is not covered for residents of an SNF under Part B.
- A SNF may contract with an outside entity to perform on the SNF's behalf the actual tasks involved in completing and submitting the bill; however, the SNF may not "assign" to any other entity the legal responsibility for the claim or the right to receive Medicare payment. Payment from Medicare must be issued to the SNF itself.

#### **Effective January 1, 1999**

- The SNF is responsible for having the necessary certifications to provide the services, e.g., certificate of medical necessity for PEN. The SNF can either assemble the required documentation itself, or can obtain it from an outside supplier with which the SNF elects to make arrangements.

## **HCPCS Coding Requirement**

Section 4432(b)(3) of the BBA requires HCFA Common Procedure Coding System (HCPCS) coding on all SNF Part B outpatient bills when Part A inpatient benefits are exhausted or the patient does not have Part A coverage (22X bill type). HCPCS includes CPT-4 codes. HCPCS coding is not required on SNF Part A inpatient bills (21X bill type). SNFs will report HCPCS codes in Form Locator (FL) 44, "HCPCS/Rates." This requirement enables you to identify individual items and services more readily on the claim and to limit the amount you pay the SNF to any applicable fee schedule amounts that carriers pay suppliers for comparable items and services. In the event that no fee schedule is in place for a specific item or service, you are to pay according to the current payment methodology and to apply the appropriate caps.

### **Applicable Bill Types on the HCFA-1450**

The appropriate bill types for consolidated billing are:

21X

22X

### **Providers do not use bill type 23X for consolidated billing.**

Effective July 1, 1998, bill type 23X is used only for patients who reside elsewhere (not anywhere within the facility) but are coming to the SNF for supplies or services.

For claims submission purposes, when a resident of a SNF has been discharged from a Part A inpatient stay because the level of care requirements are no longer met, but the beneficiary remains a resident of the SNF/NF, a bill type 22X must be submitted for the service dates for which the patient is still a resident. This includes when a resident is transferred from a certified portion of the SNF to a non-certified bed. As long as a patient who initially was receiving a skilled level of care and subsequently is moved to a non-certified portion within a facility that has a portion Medicare certified, the status (FL 22) of the resident must be a "30" (still patient).

### **Spell of Illness**

To code a claim properly for a resident whose Medicare Part A coverage is ending due to a change in the skilled level of care (or benefits exhausted) when the beneficiary continues to reside in the facility, the discharge status code (FL 22) **must** be 30 (still patient). For the purpose of breaking a spell of illness, those residents who have changed to a non-skilled level of care must have their Part A inpatient claim (TOB 21X) coded with an Occurrence Code 22 (FL 32) and the date of the last medically covered day. A benefits exhausted situation does not automatically break a spell for a Medicare beneficiary; therefore, Occurrence Code 22 should not be coded in a benefits exhausted situation unless there is medical justification for doing so. For a resident who changes to a non-skilled level of care after Part A reimbursement ends, Occurrence Code 22 and date of last medically covered day may be coded on a non-covered still patient claim. When properly applied, Occurrence Code 22 (and date) will enable the Common Working File (CWF) to track the spell of illness properly.

### **Applicable Revenue and HCPCS Codes for:**

#### Chemotherapy and Anti-Emetic Drugs

SNFs are to use the appropriate HCPCS codes in FL 44 “Applicable HCPCS Code” with revenue code 636 in FL 42 “Revenue Code” for oral cancer drugs and bill type 22X for residents not in a covered Part A stay. Intravenous chemotherapy codes are listed in the J9000 - J9999 series. These codes are entered in FL 44 with revenue code 636 in FL 42.

If the patient is in a covered Part A stay, the SNF should use revenue code 250 and no HCPCS code.

### **Immunosuppressive Drugs**

HCPCS codes for these drugs are currently listed in the DMERC Manual. These codes are entered in FL 44 with revenue code 636 in FL 42 and bill type 22X for residents not in a covered Part A stay.

If a patient is in a covered Part A stay, the SNF should use revenue code 250 and no HCPCS code.

### **Parenteral and Enteral Nutrition (PEN)**

Parenteral and enteral nutrition systems (i.e., parenteral and enteral nutrients, supplies, pumps, and kits) or any of the parenteral and enteral nutrition systems components used by residents under a Part B stay in a Medicare participating SNF are covered as a prosthetic device under the Prosthetic Device Benefit. HCPCS codes for PEN are currently listed in the DMERC Manual. SNFs may not bill you for PEN until January 1, 1999.

### **Surgical Dressings and Supplies**

These codes are entered in FL 44 with revenue codes 270 or 620 as appropriate in FL 42.

### **Prosthetics and Orthotics**

These codes are entered in FL 44 with revenue code 270 in FL 42.

### **Physical, Speech, and Occupational Therapy**

As a result of §4541(a)(2) of the BBA, which is effective for services provided on or after April 1, 1998, SNFs are required to report HCPCS codes for outpatient rehabilitation services. A previous instruction has just been released and will be published shortly outlining the appropriate codes.

### **Independent Laboratory and Independent Radiology**

During the transition period, SNFs are to utilize their current billing methodology.

## **Ambulance**

Effective July 1, 1998, as long as a beneficiary's status as a resident of a SNF continues, even when the beneficiary temporarily leaves the facility for a period of time, the SNF is responsible for billing the intermediary for the ambulance. This requirement does not apply to an ambulance trip that transports a beneficiary to the SNF for the initial admission, or from the SNF following a final discharge. These codes are entered in FL 44 with revenue code 540 in FL 42.

## **Modifier Reporting**

Occasionally modifiers are required with HCPCS coding. Where appropriate, modifiers will be assigned with the HCPCS codes.

## **Line Item Dates of Service Reporting**

SNFs are required to report line item dates of service per revenue code line for all items and services that its residents receive (both Part A and Part B services). Line item date of service reporting is effective for claims with dates of service on or after October 1, 1998.

## **Service Units Reporting**

SNFs are required to report the number of units for consolidated billing in FL 46 "Service Units" based on the procedure or service, e.g., based on the HCPCS codes reported instead of the revenue code for bill type 22X. Units are to be reported based on the number of times the procedure, as described in the HCPCS code definition, is performed. When reporting service units for HCPCS codes where the procedure is not defined by a specific time frame, report "1" in FL 46. Visits should no longer be reported as units for these services. Since providers may perform a number of procedures or services in a single visit, the number of units may exceed the number of visits. SNFs are required to report on bill type 21X, the number of units for consolidated billing in FL 46 "Service Units" based on the procedure or service.

## **Total Charges Reporting**

SNFs are required to report in FL 47 "Total Charges" the actual charge for each line item. This requirement applies to all services (Part A and Part B services) rendered to the resident of a SNF.

## **EXAMPLE OF LINE ITEM REPORTING:**

This example is for physical therapy services provided twice during a billing period.

For the UB-92 flat file, report as follows:

<u>Record Type</u>	<u>Revenue Code</u>	<u>HCPCS</u>	<u>Dates of Service</u>	<u>Units</u>	<u>Total Charges</u>
61	42X	97001	05-05-98	1	\$80.00
61	42X	97001	05-29-98	2	\$160.00

For the hard copy UB-92 (HCFA-1450), report as follows:

<u>FL 42</u>	<u>FL 44</u>	<u>FL 45</u>	<u>FL 46</u>	<u>FL 47</u>
42X	97001	05-05-98	1	\$ 80.00
42X	97001	05-29-98	2	\$160.00

Questions regarding this bulletin may be addressed by calling the Medicare Part A Customer Service Department at (904) 355-8899.