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COMPLIANCE ALERT

TO: Compliance Alert Distribution List

FROM: Maryann C. Palmeter, CPC, CENTC
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SUBJECT: Medicare and Consolidated Billing Rules

DATE: December 10, 2014

The Office of Compliance was recently was alerted to some Medicare overpayment demand letters issued as a result of an audit performed by the Comprehensive Error Rate Testing contractor (the "CERT"). The reason given for the overpayments was, "Based on Medicare Policy, services within a Skilled Nursing Facility (SNF) period are subject to consolidated billing and should not be paid separately."

What is Consolidated Billing?

When Congress enacted the Balanced Budget Act of 1997, the law contained Consolidated Billing (CB) requirements for SNFs. Under the CB requirement, a SNF must submit all Medicare claims for the services that its residents receive (except for specifically excluded services like physician services).

The SNF CB requirement is similar to the bundling requirement for inpatient hospital services where the hospital is assigned the responsibility for billing Medicare for virtually the entire package of services that a hospital patient receives, except for certain services that are specifically excluded (like physician services).

SNFs can no longer "unbundle" services that are subject to CB rules to an outside supplier. Instead, the SNF must furnish the services, either directly, or under an "arrangement" with an outside supplier, and in turn the SNF (rather than the outside service supplier) bills Medicare. The service supplier must look to the SNF (rather than to Medicare Part B) for payment.

Why did this happen?

Although physician services are excluded from the SNF CB rules, many physician services include both a professional and a technical component. This exclusion applies only to the professional component while the technical component must be billed to Medicare by the SNF. Diagnostic tests are examples of services that may have both a professional component (the interpretation and report) and a technical component (covers cost of equipment, supplies, and personnel needed to perform the study). The technical component is subject to CB. When a patient is registered as an inpatient in a Skilled Nursing Facility (SNF), the technical component of a diagnostic test is included in Medicare Part A's reimbursement to the SNF – just like it would be if the patient was an inpatient in a hospital.

If the faculty practice bills Medicare Part B for the technical component of a diagnostic test (or bills the global fee which includes both the professional and technical components) for a SNF patient, Medicare should deny the technical part of the fee and only allow the professional component. Some carriers will deny the entire fee if billed globally. In this case, the professional component piece could be rebilled to Medicare Part B. The service may need to be billed with a "-26" modifier appended (or appropriate interpretation only procedure code) so Medicare Part B pays only for the professional component.

Overpayments may occur when the Medicare Part B contractor pays the physician practice for both components of the service.

How can this be prevented?

The faculty practice may not bill Medicare Part B for the technical component of tests but rather must look to the SNF for reimbursement for this part of the study.

Patients scheduled for diagnostic tests in locations designated as non-facility (e.g., physician office) should be queried. The patient should be asked if they reside in a Skilled Nursing Facility and if so, which one. Sometimes the patient demographic information includes the name of the SNF, at times the patient's history will contain this information, and yet at other times, the service is actually being provided in office space located within the walls of a SNF (e.g., Brooks Rehabilitation at Bartram Crossing).

It would be beneficial to make this determination before the patient presents for the study (if the reason for the encounter is to have the study) so as not to inconvenience the patient if the test must be postponed until alternate financial arrangements with the SNF can be made. At times,

the SNF will provide the patient with paperwork instructing the clinic to bill the SNF for the technical piece of the study.

If the study is ordered as part of the provider's management plan for the patient, then the patient should be queried before the study is performed. The SNF should be contacted for a form or written agreement to pay for the technical component of the study.

If the charge has both a professional and a technical component, the charge will have to be split into its separate components with the professional component billed to Medicare Part B and the technical component billed to the SNF (SNF as guarantor).

The charge for the technical component must not be billed to Medicare Part B.

The Centers for Medicare and Medicaid Services (CMS) issued some best practices guidelines on this issue. CMS advises the following:

> While entering into a formalized legal contract may well be a routine business practice with regard to those suppliers with which an SNF has a routine, ongoing relationship, this may be less feasible in connection with other entities that serve the SNF's residents on only an occasional or irregular basis. For example, an SNF may occasionally refer one of its Part A residents to an offsite clinic to receive certain bundled procedures, such as diagnostic tests. Rather than executing a formalized contract with the clinic in advance, the SNF may instead prepare a document that accompanies the resident. For example, the document could notify the clinic of the following:
>
> that Medicare Part A is covering the resident's SNF stay, so that the clinic must bill the SNF (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 SNF's payment to the clinic for those services;
>
> that before furnishing any bundled services beyond those specified (or referring the beneficiary to any other entity to receive such services) the clinic must first contact the SNF; and

that by furnishing services to the beneficiary, the clinic agrees to the terms set forth in the agreement by the SNF.

Here is a link to some Consolidated Billing educational information published by CMS:

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/ConsolidatedBilling.html

The Office of Compliance would appreciate it if you would share this information with relevant faculty and clinical staff as well as billing and operational staff. Feel free to contact me if you have any questions about the Medicare regulations.

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