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Making Cents of Consolidated Billing

Facilities can minimize financial liability by deepening their understanding of the complex and often misunderstood world of consolidated billing.

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Failure to understand consolidated billing (CB) rules and take appropriate steps to review invoices prior to paying them can cost the long-term care industry thousands of dollars. Although CB has been required since the inception of the Prospective Payment System (PPS), many long-term care providers have been faced with the brutal reality of these requirements over the past year and a half and still have difficulty understanding their responsibility under the current regulations.

Congress enacted the CB requirements by passing the Balanced Budget Act (BBA) of 1997. Essentially, it states that a skilled nursing facility (SNF) itself must submit all Medicare claims for the services that its residents receive, except for specifically excluded services. Prior to CB, most services provided by outside suppliers to residents in a Medicare Part A SNF stay were billed directly to Medicare Part B without any involvement by the SNF. This practice created several problems that were to be

addressed by the implementation of the CB regulations, such as:

1. Potential duplicate billing by the SNF and outside provider
2. An increased out-of-pocket liability by the beneficiary
3. A dispersal of responsibility for resident care among various outside suppliers adversely affecting quality and the integrity of the Medicare program.

Under the CB regulations, a SNF is financially responsible for all of the care and services a resident receives, except for those that are specifically excluded by regulation. In addition to the professional services (professional component) of physicians, nurse practitioners, clinical nurse specialists, and qualified psychologists, additional services have been excluded from CB provisions. Consolidated billing exclusions are listed by Healthcare Common Procedure Coding System (HCPCS) codes and grouped into major category types.[1]

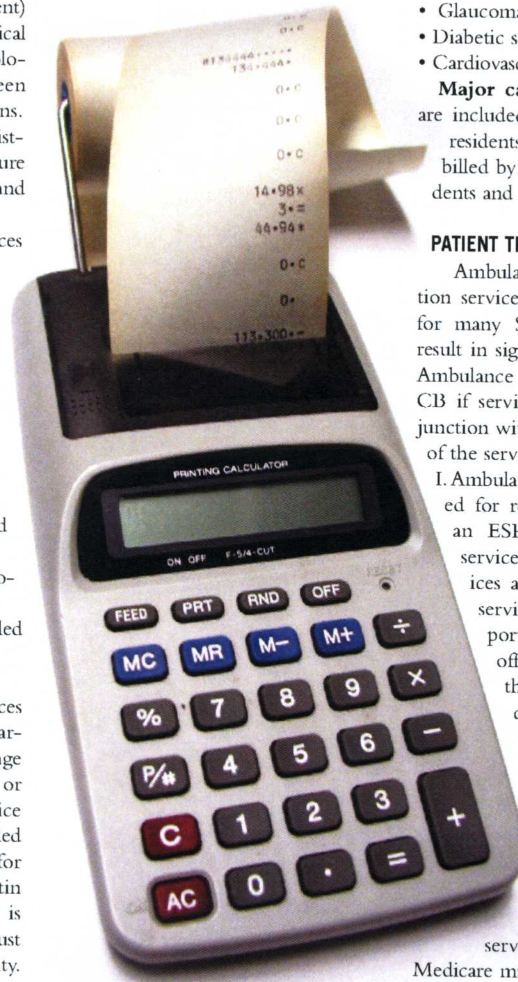
Major category I. These services must be provided on an outpatient basis at a hospital, including a critical access hospital (CAH). Services excluded are:

- Computed tomography imaging (CT scans)
- Cardiac catheterizations
- Magnetic resonance imaging (MRI)
- Radiation therapy
- Angiograph, lymphatic, venous, and related procedures
- Outpatient surgery and related procedures
- Emergency services (must be billed using revenue code 045x)
- Ambulance services.

Major category II. These services must be provided to specific beneficiaries, in 2 different categories: end-stage renal disease (ESRD) beneficiaries or beneficiaries who have elected hospice from specific Medicare providers. Skilled nursing facilities will not be paid for services, such as dialysis, erythropoietin (EPO), and aranesp, when the SNF is the place of service. These services must be provided in a renal dialysis facility. Hospice services are excluded from CB when billed directly by the hospice provider.

Major category III. These services may be provided by any Medicare provider licensed to provide them, except a SNF. Services excluded from CB include:

- Chemotherapy (select chemotherapeutic agents only)
- Chemotherapy administration (only if used in conjunction with an excluded chemotherapeutic agent)
- Radioisotopes and their administration
- Customized prosthetic devices.



Major category IV. These preventative and screening services are covered as Part B benefits and are not included in the SNF PPS. The following services must be billed by the SNF for beneficiaries in a Part A Medicare stay with Medicare Part B eligibility:

- Mammography
- Vaccines (pneumococcal, flu, or hepatitis B)
- Vaccine administration
- Screening Pap smear and pelvic exams
- Colorectal screening services
- Prostate cancer screening
- Glaucoma screening
- Diabetic screening
- Cardiovascular screening.

Major category V. Therapy services are included in SNF PPS and CB for residents in a Part A stay and must be billed by the SNF for its Part B residents and non-residents.

PATIENT TRANSPORT COVERAGE

Ambulance and other transportation services continue to be confusing for many SNF providers, which can result in significant costs to the facility. Ambulance services are excluded from CB if services were rendered in conjunction with the resident receiving any of the services listed in major category I. Ambulance services are also excluded for round-trip transportation to an ESRD treatment for dialysis services. Because ambulance services are not a Medicare-covered service if the resident is transported to and from a physician's office, using an ambulance for this type of transportation can create a significant financial liability to the facility. Furthermore, ambulance transportation for SNF-to-SNF transfers, if medically necessary, is the financial responsibility of the transferring SNF. All ambulance services to be covered under Medicare must be reasonable and med-

ically necessary for the resident's current clinical condition.

Since non-ambulance transportation is not a Medicare-covered service, it is not included under the CB regulations. This type of transportation includes medi-vans, ambu-lettes, stretch vans, taxis, and public transportation. The cost for some of these services may be charged to the state Medicaid plan, if covered, or charged back to the resident (as long as he or she was notified in advance of the anticipated costs).

It is important to point out that CB regulations only pertain to residents who are considered "residents" of a SNF at the time the services are rendered. A beneficiary's status as a resident, along with the SNF's responsibility to furnish or make arrangements for needed services, ends when 1 of the following events occurs:[2]

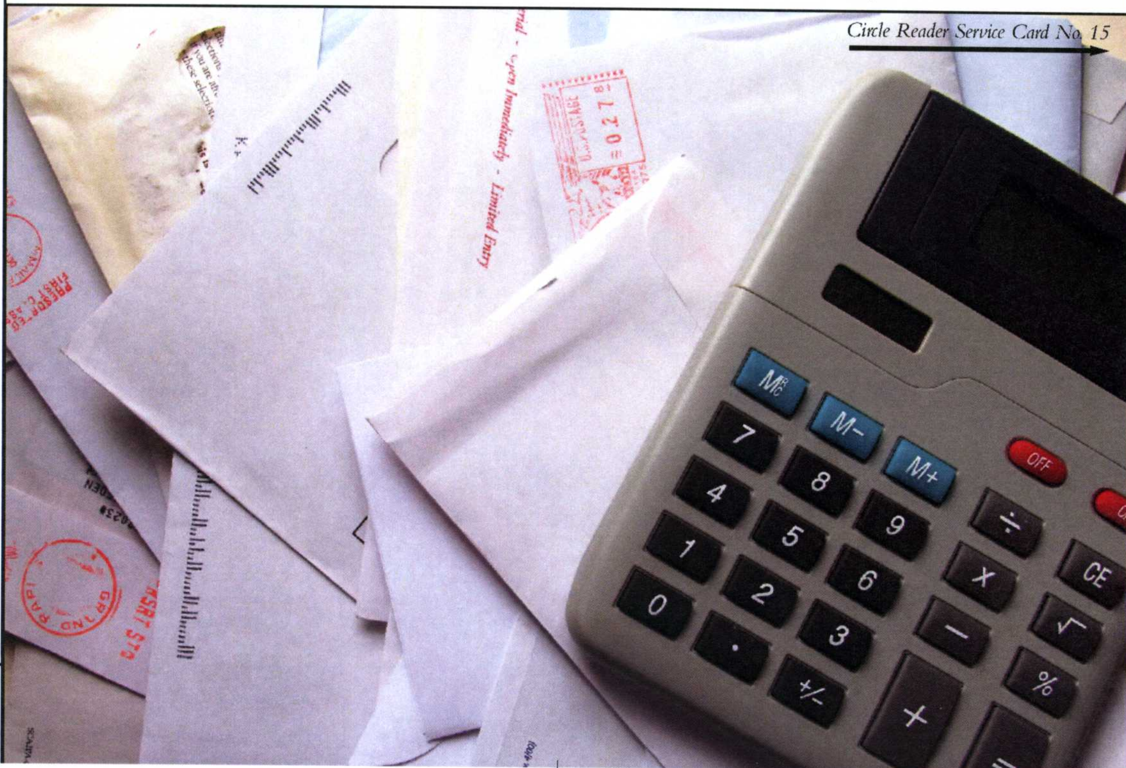
1. The beneficiary is admitted as an inpatient to a Medicare-participating hospital or CAH, or as a resident to another SNF
2. The beneficiary has been discharged from the SNF and receives services from a Medicare-participating home health agency under a plan of care
3. The beneficiary receives emergency or other excluded outpatient services
4. The beneficiary is formally discharged or otherwise departs from the SNF, such as in a Leave of Absence (LOA). However, if the beneficiary is readmitted or returns to that or another SNF before midnight of the same day, the beneficiary will still be considered to be in a SNF stay.

INCLUSIONS AND EXCLUSIONS

Knowing what services are included or excluded from CB is only the first step in minimizing your financial liability under these regulations. The Centers for Medicare and Medicaid Services (CMS) issues annual and quarterly updates to CB when codes of the HCPCS are revised, added to, or deleted from the list of excluded services. In addition, SNFs must take the appropriate steps to know which services are required of the resident, where these services will be performed, and how much the facility can expect to be charged for these services. All of the information should be known prior to the resident receiving ordered services.

Many long-term care facilities have incurred significant expenses related to CB, because many of the questions that needed to be asked prior to services being rendered were asked after the fact. Major category I, for instance, requires that these services be performed on an outpatient basis at a hospital or CAH. Services performed at a free-standing clinic, such as a MRI or CT scan, do not fall under the provision of excluded services, so the SNF would be responsible for any and all charges associated with these services.

Looking at the chemotherapy exclusion under major category III, these services would not meet the exclusionary requirement if provided by the SNF. Therefore, it would prove financially beneficial to ensure that any chemotherapy services provided that are listed as exclusions to CB are provided at the appropriate outside approved Medicare provider. Conversely, for those chemotherapy agents not excluded under CB, it may be beneficial for the SNF to make appropriate arrangements to procure the chemotherapeutic agent and administration services in house, if clinically appropriate to do so, rather than sending the resident out to receive



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