Dermatology Coding Alert

Consolidated Billing: 3 Simple Steps Put You on the Path to Capturing Payment for Your Nursing Facility Services

Determining whether a patient is in a Part A or Part B stay is your key to proper reimbursement when dealing with consolidated billing.

Most practices deal with a patient who is staying in a nursing facility at some point.

When that time comes and your physician sees a nursing facility patient in your office for conditions such as dermatitis or rashes, your challenge is collecting proper reimbursement for those services.

The problem: A patient's nursing facility NF status -- whether he is in a Part A-covered stay or a Part B-covered stay -- determines how you should be billing for your physician's services, and if you're not following consolidated billing rules you'll continue to sacrifice part of your fees.

Good news: If you follow three steps, you'll be well on your way toward proper billing and payment every time.

1. Understand Consolidated Billing and How It Affects Your Practice

Before you can start billing for services your physician performs for nursing facility patients, you need to figure out what consolidated billing really is and why it matters to your billing process.

How it works: "Medicare's 'consolidated billing' is a payment methodology that reimburses nursing facilities in a lump sum payment for all facility services the patient may need during the course of a Part A nursing facility stay," explains **Joan Gilhooly PCS, CPC, CHCC,** a coding expert and president of Medical Business Resources in Lebanon, Ohio. "In addition to paying for the bed and nursing services the patient receives, the payment also covers other 'facility-type' services the patient may need to receive. The lump sum payment rate is the same whether the patient receives these additional services or not."

Here's why it matters: Because Medicare Part A typically covers nursing facility patients and consolidated billing rules apply, you can only report certain services to Medicare. When patient visits your office, if the patient is in a covered Part A stay, the facility is liable for the payment for the technical component services. These services include medications, lab work, x-rays (the technical portion, not the interpretation), the technical portion of EKGs, billable supplies, DME dispensed from office, etc.

"Obviously, Medicare doesn't want to pay for those services twice -- once to the nursing facility in that lump sum payment and second to the physician on an ala carte basis," Gilhooly says. "As a result, if the patient is currently in the nursing facility covered under a Medicare Part A stay, the physician can onlybill Medicare for his/her professional services. Any technical or 'facility' services you need to perform during that office visit must be billed directly to the nursing facility, requesting reimbursement for billable supplies and/or technical component expenses your practice incurred during the encounter."

Example: Your dermatologist sees a nursing facility patient with severe blistering; he interprets a Tzanck smear of fluid samples of the blisters. You may bill the interpretation of the Tzanck smear to the Part B carrier with 87207-26 (Smear,primary source with interpretation; special stain for inclusion bodies or parasites [e.g., malaria, coccidia, microsporidia, trypanosomes, herpes viruses]; Professional component).

Note: To receive payment for the expenses you incurred for the technical aspects of services your physician performs, you may need to have a set contract with the SNF. 2. Check the Patient's Status To properly bill and collect for nursing

facility patient services is to actually contact the facility to confirm whether the patient is in a Part A or Part B stay. If he is not covered by Part A, you may bill your Part B carrier for all the services you provide.

But if his nursing home stay is covered by Part A, you are about to enter the world of consolidated billing. "This really should start, not during billing, but with appointment scheduling," Gilhooly says. She advises practices to contact the nursing facility on the day of the appointment to confirm whether the patient is in a Part A or Part B stay.

Warning: There is no way to guess if a patient is in a Part A or Part B stay, Gilhooly stresses. Even if a nursing facility has certain floors for "skilled nursing care," assuming a patient is a Part A admit is still a bad idea, for example. "Check with the individual at the nursing home who maintains the SNF/NF's census," Gilhooly explains. "They will know, on a day-by-day basis, whether the patient is in a Part A stay versus a Part B stay (which can vary from one day to the next)."

3. Leave the Professional Portion to Medicare

For services with both a technical and a professional component that your physician performs for a nursing facility patient in your office, you should report only the professional component -- such as the written interpretation of an x-ray -- to your Medicare carrier/MAC.

And for many of the medications your physician might administer to a nursing home patient in a Part A stay, Medicare Part B will not reimburse you in the usual manner. Instead, you must submit a claim to, and seek payment from, the nursing facility itself for reimbursable expenses for medications, supplies, the technical components of diagnostic services, etc. as explained in step one.

Example: A dermatologist sees a nursing facility patient in the office due to severe dermatitis. The doctor evaluates the patient and injects Kenalog 40.

You're unaware that the patient is an SNF resident in a Part A stay, so you report the office visit, the injection code, and the medication to the patient's Medicare Part B carrier. Since this patient is a nursing facility resident in a Medicare Part A stay, the carrier will deny part of your claim, likely using denial code 190 (Payment is included in the allowance for a Skilled Nursing Facility [SNF] qualified stay). Since Medicare is paying to cover some of these under consolidated billing, Medicare will not pay again for the medication used in the injection.

For a Part A-covered patient in this scenario, you should report the office visit (for example, 99213, Office or other outpatient visit for the evaluation and management of an established patient ...) and the injection (11900 Injection, intra-lesional; up to and including 7 lesions) to your Part B carrier. You should seek reimbursement from the nursing home directly for the Kenalog supply (J3301, Injection, triamcinolone acetonide, not otherwise specified, 10 mg).