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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 4 Tips Ensure You Don't Forfeit Pay When Treating SNF Payments

Hint: Make sure you have the right POS for consolidated billing.

You perform services for a patient and bill your Medicare contractor, but instead of collecting reimbursement, you get a denial due to the fact that your MAC sent the payment directly to the patient's skilled nursing facility (SNF). Now it's up to you to negotiate with the SNF to get your money back.

If this scenario sounds familiar, it's because consolidated billing has been a constant headache for medical practices. "Medicare will pay a claim, take back the funds, and we are left trying to get payment from the SNF who doesn't want to pay us," says **Lynde Bledsoe**, business office manager with Midlands Orthopaedics. "They lose our claims, they never receive our claims, excuse after excuse to wear down the provider to just stop billing for the service."

If you're facing the same frustrations as Bledsoe, follow these four steps to successfully ensure that you don't forfeit your income when treating SNF patients.

1. Study What Consolidated Billing Means

Before you can start billing for services that 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: Under consolidated billing, a SNF receives a basic per diem rate per level of care for each resident, which covers all costs (routine, ancillary and capital) related to the services furnished to beneficiaries. The bundled services are billed by the SNF to the Part A MAC in a consolidated bill. "The outside supplier must look to the SNF (rather than to Medicare Part B) for payment," according to CMS's 2015 Consolidated Billing guidelines.

Tip: In the situation quoted above, your doctor is the "outside supplier."

The SNF bills Medicare for services provided to resident patients, but Medicare excludes some categories of services from consolidated billing because they are costly or require specialization. So in order for your practice to be reimbursed for any of the excluded services, you can contact Medicare Part B directly--but for any services included in SNF consolidated billing, your practice has to work with the facility.

CMS also includes physical and occupational therapy as part of consolidated billing. "Therapy services must be provided and billed under arrangement with the SNF," CMS says about these services.

2. Confirm Patient Status

To properly bill and collect for services provided to SNF patients, you should contact the facility on the day of the patient's appointment 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.

Other actions that practices should perform include:

- Confirm the patient's status as a SNF resident at the time the appointment is scheduled.
- If SNF status was not confirmed at the time of the appointment, call the SNF prior to rendering services to verify that the patient is truly considered a SNF resident and to let them know what services the practice will be providing.

- Alert the SNF to charges for services included in consolidated billing before the services are provided.
- Make sure that the practice has established an agreement or contract with the local SNF to establish a reimbursement process for services included in consolidated billing.
- Educate patients, their families, and staff at local SNFs about the need to inform the practice about the patient's status when making an appointment.

Warning: There is no way to guess if a patient is in a Part A or Part B stay. In addition, this information can even vary from one day to the next, so be sure you confirm the status with the facility.

3. Set up a Contract

In order to be paid for the expenses that your physician incurs while treating SNF patients, you should create a contract with the SNF. "The 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," CMS says in its Consolidated Billing Best Practices fact sheet.

It is in your practice's best interest to meet face-to-face with local SNF administrators to review technical charges and establish a direct contract or agreement for payment of the technical services as part of the consolidated reimbursement.

The contract should also list your billing information and include a disclaimer stating that you expect payment for services rendered regardless of the nursing facility's reimbursement status with the Medicare carrier. Provide an executed copy of the contract to the facility, and keep one for your records.

Protect yourself: Have an attorney review any agreement or contract you plan to use before you obtain the signatures to ensure the contract is in fact legal and binding. Make sure that attorney is competent in Stark law compliance. While you can start with a sample contract, you should consult an attorney before presenting it to the nursing facility.

Don't miss: Even if your practice doesn't deal often with nursing facility patients, you should still have a contract just in case. You never know when one of your patients will be admitted for a Part A stay, and unless the facility has a doctor on staff for temporary transfers of care, your physician could end up caring for the patient.

If the patient is referred to you by the SNF and you don't have a contract in place, the SNF can send a document along with the SNF resident that clarifies the financial relationship, CMS says in its Consolidated Billing Best Practices fact sheet. "Rather than executing a formalized contract with the clinic in advance, the SNF may instead prepare a document that accompanies the resident," CMS says.

4. Deal With Denials

In some cases, you'll face erroneous denials from your MAC for claims that shouldn't be included in consolidated billing, such as office visits. For example, some MACs have been paying SNFs for E/M visits provided in private offices, even though those payments should be separately covered under Part B and not subject to consolidated billing. In this situation, you should appeal the claim to the MAC with a letter from the doctor stating that E/M services are not to be paid under consolidated billing and that the MAC should pay you directly.

In addition, you can prevent future denials by listing the appropriate place of service (POS) code on your claim. Although many practices believe that SNF patients must be billed under POS 31 (SNF) even when they visit your office for a service, that belief is incorrect. MLN Matters article MM7631 notes that you should use the POS code that reflects the location where the services were administered which in this case would be 11 (Office).

In black and white: "For all services with two exceptions paid under the Medicare Physician Fee Schedule, the POS code to be used by the physician and other supplier will be assigned as the same setting in which the beneficiary received the face-to-face service," CMS says. The two exceptions are when the doctor treats a "registered inpatient or outpatient of a hospital," billed under POS codes 21 and 22.

Consider This Example

Example: A physician sees a nursing facility patient in the orthopedic office due to severe hip pain. The doctor evaluates the patient and performs an x-ray. When the physician determines there's no fracture, he decides to schedule the patient for a hip injection.

You're unaware that the patient is a SNF resident in a Part A stay, so you report the office visit and the global x-ray code to the patient's Medicare Part B carrier. However, since this patient is a resident in a Medicare Part A nursing facility 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). Medicare will not reimburse you for the technical component of the x-ray, because it will pay the nursing facility for that under the consolidated billing guidelines.

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 professional component of the x-ray service using modifier 26 (Professional component) to your Part B carrier. You'll report the technical component of the x-ray to the SNF directly.