Eli's Rehab Report

Bill SNF Patients' Therapy Directly to Nursing Facility

Don't risk losing $80 or more per claim: follow consolidated billing rules

When skilled nursing facility (SNF) patients present to your PM&R practice for E/M services or customized prosthetic devices, you may be tempted to thank your lucky stars that you don't have to worry about consolidated billing requirements -- but don't get smug yet.

The Balanced Budget Act of 1997 requires SNFs to consolidate their billing for Medicare Part A (and some Part B residents), making SNF patients' reimbursement a huge challenge for PM&R practices. If your practice reports every single service for SNF patients directly to Medicare, be ready for consistent problems.

Report Technical Portion to SNF

Suppose an SNF patient presents to your practice for electromyography (EMG) of four extremities (95864, Needle electromyography; four extremities with or without related paraspinal areas). The physiatrist performs the service and submits the claim directly to the patient's Medicare carrier.

Medicare will probably deny the claim, leaving the physiatrist short the approximately $200 that he normally collects for four-extremity EMG services.

According to CMS Program Memorandum B-00-67, "Medicare carriers will no longer make payment to physicians and suppliers for technical components of physician services furnished to beneficiaries in the course of a Medicare Part A covered stay."

Solution: You can still collect your EMG reimbursement, but it will take a little more footwork than usual. Report your professional component directly to the Medicare carrier (95864-26, Professional component), which allows you to collect the $115 or so allotted for the professional portion.

And you don't have to write off the $80 that Medicare allots for the technical portion of the claim. Instead, you should collect it directly from the SNF. Medicare will pay the SNF for the technical portion, so you should develop a relationship with the SNFs in your area and remind them that you will bill them directly for such services.

Most of the time, this will mean that you report the claim to the SNF exactly as you would bill it to Medicare. In our example, you would report **CPT 95864** -TC (Technical component) to the SNF, along with the appropriate ICD-9 code.

Establish System Before Patient Visits Your Office

But don't wait until after you see the patient to coordinate your efforts with the SNF, says **Deb Hudson, CCS-P**, coder at the Mason City Clinic, a 35-physician multispecialty practice in Iowa.

When the SNF calls your practice to set the appointment, Hudson says, your receptionist should put a note on the patient's fee ticket indicating that she resides in an SNF.

"When the fee ticket gets to the coder, he or she should create another, separate fee ticket," Hudson says. "The fee ticket for professional services will go to the patient's Medicare carrier, and the other fee ticket, for technical services, will go to the SNF with modifier -TC."

Hold SNFs Responsible for Global Therapy Fees

Unfortunately, PM&R practices are subject to one big consolidated billing caveat: Although most consolidated billing rules apply only to residents of Part A stays, therapy services for Part B residents are also subject to the rule.

So you must bill the SNF directly for physical, occupational and speech therapy services that you render to SNF Part B residents. In addition, some muscle and range-of-motion testing codes also fall under this caveat to the basic consolidated billing rule.

If a Part B SNF resident presents to your practice for a physical therapy evaluation, you should bill 97001 (Physical therapy evaluation) directly to the SNF. Otherwise, you could lose the approximate $80 that Medicare reimburses for this service.

Note: See the article "Report These Codes Directly to the SNF" on page 29 to determine which services are subject to the consolidated billing requirements.

The Good News: E/M Services Are Safe

Your physiatrist's E/M services do not fall under consolidated billing rules, says **Paula Roland**, office manager for Michael Pushkarewicz, MD, in West Grove, Pa. The standard E/M rules still apply, however, so if you perform an E/M service with another procedure, you should append modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to your E/M code (99201-99215 for outpatient E/M services).

Suppose an SNF resident whom your physiatrist has seen before presents to your practice complaining of arm and wrist pain. Your physiatrist performs a level-three office visit and a motor nerve conduction study. He diagnoses the SNF patient with carpal tunnel syndrome and splits the bill between the patient's Medicare carrier and the SNF.

Your practice should submit the following codes to the patient's Medicare carrier:

1. 95900-26 -- Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study
2. 99213-25 -- Office or other outpatient visit ...
3. 354.0 -- Carpal tunnel syndrome.

Send the SNF a separate claim listing 95900-TC as the procedure and 354.0 as the diagnosis.