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MDS Alert

Medicare: Consolidated Billing: Prevent Major Fiscal Woes By Being In The Know

Cover these 4 bases and your SNF won't be paying unnecessarily.

Ineffective Part A consolidated billing management can blindside a SNF with huge unexpected bills or cause it to routinely pay invoices that should not be coming out of the SNF's pocket. And while consolidated billing can be tricky, these expert strategies will keep your facility on the right billing track.

1. Know What You Really Owe. "SNFs are still losing money ... because they don't understand exactly what's included in and excluded from Part A consolidated billing," says **Ron Orth, RN, NHA, CPC, RAC-CT**, president of **Clinical Reimbursement Solutions LLC** in Milwaukee. Consultant **Cindy Fronning, RN**, finds SNFs sometimes don't recognize that consolidated billing doesn't apply when the resident isn't in the bed at midnight and the SNF thus cannot bill for that day. If consolidated billing isn't in effect, those services should be paid through Medicare Part B, she adds.

Don't lose sleep over this: Due to the midnight rule, Part A consolidated billing would not apply to an overnight sleep study, said a CMS representative at a recent SNF/LTC Open Door Forum.

Another trap: A bill you don't want your SNF to receive is one for a resident's MRI, CT scan or radiation that would have been excluded if it had been provided in a hospital outpatient department. If a resident gets an MRI, for example, in a freestanding clinic, the facility has to pay for it, cautions **Elizabeth Malzahn**, manager, **FR&R Healthcare Consulting** in Deerfield, IL.

Blood transfusions are, however, not excluded from consolidated billing even if they are administered as part of an excluded service, such as chemotherapy, adds Malzahn. Nursing home providers in Illinois were confused about that, she notes, because state law prohibits them from providing blood transfusions.

2. Discuss Big-Ticket Services With Providers Up Front. Fronning sees SNFs not looking up HCPCS and J codes to see if a service or chemotherapy medication is excluded before the resident's admission or before he receives treatment.

"Medicare facilities can't deny access to a Medicare beneficiary based on cost but they should go into it with their eyes open and be prepared for the cost," she says. The SNF may have an opportunity to work with the physician to see if an equally effective, less costly alternative would work, she notes. The SNF might ask the physician if a particular diagnostic study that will come out of the facility's per diem is really needed at that point as a service that will affect the resident's health; or perhaps it might even be more safely postponed until the resident is no longer acutely ill, Fronning adds.

"Perhaps the person could have the study after the SNF Part A stay when his Part B insurance will pay for it," Fronning suggests.

Resource: Check the coding updates for consolidated billing at http://www.cms.hhs.gov/snfconsolidatedbilling/74_2008_update.asp#Topofpage.

3. Consolidate and Case Manage Appointment Scheduling. Having too many people scheduling residents' healthcare appointments can make staying on top of consolidated billing very difficult. For example, "a medical secretary, ward clerk or floor nurses may do the scheduling" and be unaware that a service isn't included in consolidated billing or what to watch out for, Malzahn notes.

Proactive strategies: As part of case management, the MDS coordinator can take the lead with scheduling or overseeing scheduling of ancillary and physician services for consolidated billing purposes, suggests Malzahn. The person doing the

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scheduling can provide the Medicare team a list of scheduled appointments a week in advance -- or attend the weekly Medicare meeting and share the information with everyone then.

"Oversight is the issue," Malzahn emphasizes. "Oftentimes, one person is doing the scheduling, and another person is paying the bills. Someone needs to look at the process and big picture."

4. Create a Billing Safety Net. Designate someone in the patient accounts department to systematically ensure that the SNF isn't paying physician invoices for the professional component of services.

Under Part A consolidated billing, SNFs only owe the technical component of a service performed in a physician's office -- for example, for an X-ray that's included in consolidated billing. The physician should bill the professional component (for interpreting the X-ray) to the carrier or Medicare Administrative Contractor (MAC).

Costly problem: The physician offices often don't split out the professional component from the technical component for services when they bill Medicare for it, Malzahn says. And if the carrier denies a service because it overlaps with the patient's Part A SNF stay, the physician office often bills the nursing facility the entire amount rather than just the technical component, she says. "So the SNF may receive a $500 bill for a $17 X-ray -- and if billing isn't aware that the bill includes the professional component too, which is excluded from consolidated billing -- it may pay the entire amount," Malzahn cautions.

Real-world practice: As part of managing Part A consolidated billing, **Isabella Geriatric Center**'s patient accounts department looks up the HCPCS codes for everything the facility is billed to see if it's owed, says **Carole Stoll**, director of patient accounts for the facility in New York, NY. "We also check the date of service to make sure the resident went out on that date."

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