PUBLICATION

Selected CMS Guidance for Billing for Skilled Nursing Facility Services [Ober|Kaler]

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Skilled nursing facilities (SNFs) should take note of the updates and clarifications set forth in Medlearn Matters article 8997, issued by the CMS on March 13, 2015. Medlearn Matters article 8997 updates the chapters in the Medicare Benefit Policy Manual and the Medicare Claims Processing Manual that apply to SNF providers.

Medicare Benefit Policy Manual

The Medicare Benefit Policy Manual section 20.2.3 is amended to address situations in which a Part A SNF stay is interrupted and then resumes within a 30-day period. Such an interruption may involve a transfer from one SNF to another during that 30-day period, for example, when an individual transfers from a hospital to a hospital transitional care unit that houses SNF beds, and then moves to a community SNF for the balance of rehabilitation. The Medlearn article and manual revision clarify that CMS policy permits coverage of services provided to a beneficiary for whom covered Part A services are interrupted when custodial care rather than Part A skilled services are provided for a period, and then Part A services are resumed within the same SNF during the same 30-day stay. The beneficiary need not incur an intervening hospital stay or be transferred from one SNF to another.

Medicare Claims Processing Manual

Chapter 6, Section 20.1.1.2 (Hospital's Facility Charge in Connection with Clinic Services of a Physician)

A beneficiary receiving Part A SNF services may choose to go to a hospital clinic for a physician (or nonphysician practitioner) visit rather than to a freestanding medical office. In addition to the physician claim in this situation, the hospital may submit a facility charge claim for its overhead. Per CMS, hospitals bill for “facility charges” under the physician Evaluation and Management (E&M) codes in the range of 99201–99245 and G0463 (for hospitals paid under the Outpatient Prospective Payment System). The hospital charge is excluded from consolidated billing because it is billed using an E&M code; therefore, the hospital may bill Part B rather than billing the SNF.

SNFs still must be mindful, however, of when a diagnostic test is subject to consolidated billing under Part A and therefore must be billed to the SNF and not billed separately to Part B by the outside medical office or supplier.

Chapter 13, Section 90.5 (Transportation of Equipment Billed by a SNF to a MAC)

When a SNF resident receives a portable x-ray service during the course of a Medicare-covered stay in the SNF, only the service's professional component (representing the physician's interpretation of the test results) is a separately billable physician service under Part B (see section 20 of Chapter 6). However, the technical component representing the procedure itself, including any associated transportation and setup costs, would

be subject to consolidated billing and must be included on the SNF's Part A bill for the resident's covered stay (Bill Type 21x) rather than being billed separately under Part B.

Chapter 6, Section 30.1 (Health Insurance Prospective Payment System (HIPPS) Rate Code)

The HIPPS rate code consists of the three-character resource utilization group (RUG) code that is obtained from the "Grouper" software program followed by a two-digit assessment indicator (AI) that specifies the type of assessment associated with the RUG code obtained from the Grouper. The Manual update provides a link that providers may use to access HIPPS code information online, using the Resident Assessment Instrument (RAI) manual.

Chapter 6, Section 30.2 (Coding PPS Bills for Ancillary Services)

Per CMS, PPS bills coded for ancillary services associated with a Part A inpatient stay must continue to show the traditional revenue codes in conjunction with the appropriate entries in Service Units and Total Charges. SNFs must report the number of units based on the procedure or service. For therapy services (i.e., revenue codes 042x, 043x, and 044x), units represent the number of calendar days of therapy provided. For example, the date on which a beneficiary received physical therapy, occupational therapy or speech-language pathology would be considered one calendar day and would be billed as one unit. SNFs must report the actual charge for each line item, in Total Charges.

Chapter 6, Section 30.5.1 (Adjustment Requests)

Adjustment requests based on corrected assessments must be submitted within 120 days of the service "through" date on the bill. The through date indicates the last day of the billing period for which the HIPPS code is billed and will be used to calculate the period during which adjustment requests may be submitted based on corrected RAI assessments. Providers must append a condition code D2 on their adjustment claim for HIPPS changes resulting from an MDS correction.

Medlearn 8997 indicates that CMS expects that most HIPPS code corrections will be made during the course of the beneficiary's Medicare Part A stay. Therefore, providers that routinely submit corrections after the beneficiary's Part A stay has ended may be subject to focused medical review.

Adjustment requests to change a HIPPS code may not be submitted for any claim that has already been medically reviewed. This applies whether or not the medical review was performed either pre- or post-payment. All adjustment requests submitted are subject to medical review.

Chapter 6, Section 40.3.5.2 (Leave of Absence)

Leave of absence (LOA) days are shown on the bill with revenue code 018X and LOA days as units. However, charges for LOA days are shown as zero on the bill, and the SNF cannot bill the beneficiary for them except as specified in Chapter 1, section 30.1.1.1 of the Medicare Claims Processing Manual. LOA from and through dates should be reported using occurrence span code 74. CMS instructs that providers should review the RAI manual to clarify situations in which an LOA is not appropriate, for example observation stays in a hospital lasting greater than 24 hours.

Ober | Kaler's Comments

The MedLearn 8997 updates apply to those sections of the Medicare Benefit Policy Manual and the Medicare Claims Processing Manual that address policy and billing for SNF services to Medicare beneficiaries. SNF providers will be well-served to review the updated policies and ensure that their coding and billing staff are aware of and understand the changes, particularly as they apply to SNF residents' travel outside the facility for

services rendered in other settings, including whether in a hospital or non-hospital setting, where consolidated billing requirements may or may not apply.