SKILLED NURSING FACILITY (SNF)
CONSOLIDATED BILLING

Presented by
Palmetto GBA
Provider Outreach and Education
Disclaimer

The information provided in this presentation is current as of January 7, 2019. Any changes or new information superseding this information is provided in articles with publication dates after January 7, 2019 on our website at:

www.PalmettoGBA.com

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Agenda

• SNF Coverage
• SNF Consolidated Billing (CB)
• MDS Resource Utilization Groups (RUGs)
• Documentation
• Medical Review Common Errors
SNF COVERAGE
Part A SNF Coverage

- Coverage criteria -
  - Beneficiary is entitled to Medicare Part A benefit
  - Require daily skilled level of care services
  - Daily skilled services can only be provided on an inpatient basis in a SNF
  - Must be medically reasonable and necessary for treatment of the patient’s illness or injury
Part A SNF Coverage

- Qualifying hospital stay of at least 3 consecutive days of inpatient care for related illness/injury
  - Not counting day of discharge or time in observation
  - Stay can be in one or more Medicare participating hospital
    - Or institution that meets at least the conditions of participation for emergency service hospital
  - Admitted to SNF within 30 days of hospital discharge
Qualifying Stay Exception

• Exception to the 3 day qualifying hospital stay
  • Disenrollment from a Medicare Advantage (MA) plan due to termination when there is no 3 day hospital stay before SNF admission
    • If admitted to SNF prior to effective date of disenrollment
Transfer Requirement

• 30 day transfer requirement
  • Must be transferred to a participating SNF within 30 days after discharge from hospital
  • Unless patient’s condition makes it medically inappropriate to begin active treatment in a SNF immediately after hospital discharge and;
  • It is medically predictable at time of hospital discharge that patient will require covered care within a predetermined time
SNF Readmissions

- If patient is discharged from skilled level of care (LOC) and subsequently is readmitted at a skilled LOC to same or another facility within 30 days, a new qualifying stay is not required.
  - If readmission occurs more than 30 days after discharge, a new qualifying stay is required unless there’s a medically appropriate delay.
  - Care must be related to prior hospital or SNF stay.
Benefit Period

- May be more than one benefit period in a calendar year or one benefit period may overlap a calendar year
  - Diagnoses do not affect benefit period determination
  - Renewed every 60 days if there is no inpatient hospitalization
Benefit Period

• Begins with first day patient is furnished inpatient hospital or extended care services by a qualified provider in a month for which patient is entitled to hospital insurance benefits
  • Midnight to midnight method of counting
Benefit Period

• Ends when patient has not been inpatient in a hospital, SNF or Swing Bed (SB) for 60 consecutive days
  • Count begins with day patient was discharged
  • For benefit period purposes, SNF/SB inpatient status ends when patient no longer meets daily skilled care requirements
Benefit Period

- SNF/SB = 100 post-hospital days
  - 20 days paid in full by Medicare
  - 80 days coinsurance ($170.50 for 2019)
  - Lifetime Reserve Days do not apply in a SNF/SB

- Date of discharge, death or leave of absence are not counted as SNF days
SNF CONSOLIDATED BILLING
SNF CB - Background

• BBA 1997 mandated payment for majority of services provided to patients in a Medicare covered Part A SNF stay be bundled in PPS
  • Excluded services not subject to CB

• Bundled services required to be billed by SNF/SB
  • Entities that provide services for patients in a SNF stay cannot bill separately for those services
Facilities Subject to CB

- Medicare participating SNFs
  - Short term hospitals, long term hospitals, and rehabilitation hospitals certified as SB - except CAH SB

- All Part A and B physical, occupational and speech therapy services must be provided directly or indirectly, and billed by SNF
  - Includes covered and non-covered stays
SNF CB - Requirements

- Requirement makes SNF responsible for billing almost all services during a Medicare stay
  - Services must be furnished directly by SNF resources or obtained under arrangement with an outside entity

- SNF must reimburse entity for services subject to CB whether agreement is in place prior to services or after
SNF CB - Requirements

• Exception to specifically excluded services

• Excluded services are separately furnished and billed to Part B by outside sources

http://www.cms.gov/SNFConsolidatedBilling/
Under Arrangement

• Private agreement/contract between SNF and outside entity is recommended
  • Both parties should reach common understanding on terms of payment
  • Absence of a valid arrangement does not invalidate SNF responsibility to reimburse outside entity
• CMS sample agreement forms at:
  https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/BestPractices.html
SNF CB – Major Categories

• CMS divides services affected by SNF CB into major categories
  • General Explanation of Major Categories for SNF CB

• Must understand these major categories to apply CB principles correctly to billing
# Five Major Categories for CB

<table>
<thead>
<tr>
<th>I - Exclusion of services beyond SNF Scope</th>
<th>II - Add. excluded services when rendered to specific patients</th>
<th>III - Add. excluded services rendered by certified providers</th>
<th>IV - Add. excluded preventive and screening services</th>
<th>V - Part B services included in SNF CB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broken into sub-categories Note: F. Outpatient Surgery and Related Procedures - Inclusion</td>
<td>SNF TOB 22x SB TOB 12x</td>
<td></td>
<td>PT, OT, and SLP included in CB for patients in Part A stay</td>
<td></td>
</tr>
</tbody>
</table>
Major Category I

- Computerized Axial Tomography (CT) Scans
- Cardiac Catheterization
- Magnetic Resonance Imaging (MRIs)
- Radiation Therapy
- Angiography, Lymphatic, Venous, related procedures
- Outpatient Surgery and related procedures (inclusion)
- Emergency Services
- Ambulance Transportation
Major Category II

- Dialysis – Home dialysis supplies/equipment and self-care home dialysis support services

- Institutional dialysis services and supplies

- Erythropoietin (EPO) and Darbepoietin (DPA),

- Hospice Care for a Beneficiary’s Terminal Illness
Major Category III

• Additional Excluded Services Rendered by Certified Providers
  • Chemotherapy
  • Chemotherapy Administration
  • Radioisotopes and their Administration
  • Customized Prosthetic Devices
Frequency of Billing

- SNF claims are billed to Medicare monthly
  - Submit claims to Palmetto GBA monthly
    - Submit in sequence for patient
    - Current claim must finalize before next claim is submitted
  - Upon discharge of the patient
  - When patient’s benefits have exhausted
  - Patient no longer needs skilled care
Major Category IV

Additional excluded preventive, screening services

Mammography
Vaccines – Pneumococcal, Flu or Hepatitis B
Vaccine Administration
Screening - Pap Smear and Pelvic Exams
Colorectal Screening Services

Prostate Cancer Screening
Glaucoma Screening
Diabetic Screening
Cardiovascular Screening
Initial Preventative Physical Exam (IPPE)
Abdominal Aortic Aneurysms (AAA) Screening
Major Category V

Therapies billed with revenue codes:

- 42x (physical therapy)
- 43x (occupational therapy)
- 44x (speech-language pathology)

SNFs bill for therapy services for patients in certified bed in a non-covered stay on 22x TOB
CB Inclusions

- SNF must bill for all services provided to Part A residents covered in a Part A stay
- Psychological services furnished by a clinical social worker
- Services “incident to” the professional services of a physician or other health care professional
CB Exclusions

• A number of services excluded from SNF CB
  • These services are outside the PPS bundle
  • They remain separately billable to Part B when furnished to an SNF resident by an outside supplier

CB Exclusions

• Excluded RHC/FQHC Physician Services
  • Physician/Non-Physician Practitioner services included within the scope of RHC and FQHC services

• Only this subset of RHC/FQHC services may be covered and paid separately during Part A stay
Incident to Services

• CB excludes professional services a practitioner performs personally

• Exclusion does not apply to physician "incident to" services furnished by someone else as "incident to" practitioner's professional service
  • These "incident to" services furnished by others to SNF residents are subject to CB
  • HCPCS for services subject to SNF CB editing
## Excluded Services

<table>
<thead>
<tr>
<th>Excluded Services</th>
<th>Excluded ‘Incident to’</th>
</tr>
</thead>
</table>
| Physician services - Physician, PA, NP, certified nurse midwife, CRNA, qualified psychologist | Cardiac catheterizations  
Certain lymphatic and venous procedures                                                  |
| Home dialysis supplies/equipment, self-care home dialysis support services and Institutional dialysis services/supplies | Ambulatory surgery; involves use of operating room  
Emergency services                                                                   |
| EPO and DPA for certain dialysis patients                                          | CT scans, MRIs, angiography and custom prosthetic devices                              |
| Hospice care                                                                      | Chemotherapy items and administration                                                 |
| Ambulance trip                                                                    | Radiation therapy, radioisotope services                                              |
Ambulance Exclusions

- Initial trip to SNF admission
- Trip home after discharge not followed by readmission to same or another SNF by midnight
- Trip for inpatient admission to hospital/CAH
- Trip to/from hospital/CAH for ER services or other outpatient exclusions
- Trip home for services under HHA plan of care
- Trip for Part B dialysis services
MINIMUM DATA SET (MDS)
Listing of Skilled Nursing Facility (SNF) Resource Utilization Groups (RUGs)

To view the listing for the Resource Utilization Groups (RUGs) for skilled nursing facilities (SNFs) for federal fiscal year (FFY) 2019, effective October 1, 2018, open the 'SNF RUGS 100118' Excel spreadsheet below. **Please note there are separate tabs for urban and rural locations.**

Use the pick list in the top left corner to find the appropriate Core Based Statistical Area (CBSA).

SNF_RUGS_100117.xlsx (XLSX, 340 KB)
SNF_RUGS_100118.xlsx (XLSX, 337 KB)
Resource Utilization Groups

- Classification of patients into specific resource utilization groups (RUGs) for payment purposes
  - Measurement of characteristics and health status information to determine type, amount and intensity of services needed to provide appropriate care
  - Determines per diem reimbursement
  - Scores determined by Minimum Data Set (MDS)
Minimum Data Set (MDS)

- Primary purpose is to identify resident care problems addressed in individualized care plan
  - Capture care and services
  - Tracking tool for changes in patient condition
  - Must be completed and submitted to repository
    - All scheduled assessments

PDPM is Effective October 1, 2019

- SNF PPS Patient Driven Payment Model (PDPM) will improve payments made under SNF PPS
  - Improves payment accuracy and appropriateness by focusing on the patient, rather than the volume of services provided
  - Significantly reduces administrative burden on providers
  - Improves SNF payments to currently underserved beneficiaries without increasing total Medicare payments

- RUG-IV & PDPM Functional Score Differences
MDS Changes: Assessment Schedule

• Both RUG-IV and PDPM utilize the MDS 3.0 as the basis for patient assessment and classification
• Assessment schedule for RUG-IV includes both scheduled and unscheduled assessments with a variety of rules governing timing, interaction among assessments, combining assessments, etc.
  • Frequent assessments are necessary, due to the focus of RUG-IV on such highly variable characteristics as service utilization
# RUG-IV Assessment Schedule

<table>
<thead>
<tr>
<th>Scheduled Assessment</th>
<th>Assessment Reference Date</th>
<th>Assessment Reference Date Grace Days</th>
<th>Applicable Standard Medicare Payment Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare MDS Assessment Schedule Type</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5-day</td>
<td>Days 1-5</td>
<td>6-8</td>
<td>1 through 14</td>
</tr>
<tr>
<td>14-day</td>
<td>Days 13-14</td>
<td>15-18</td>
<td>15 through 30</td>
</tr>
<tr>
<td>30-day</td>
<td>Days 27-29</td>
<td>30-33</td>
<td>31 through 60</td>
</tr>
<tr>
<td>60-day</td>
<td>Days 57-59</td>
<td>60-63</td>
<td>61 through 90</td>
</tr>
<tr>
<td>90-day</td>
<td>Days 87-89</td>
<td>90-93</td>
<td>91 through 100</td>
</tr>
<tr>
<td>Unscheduled Assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start of Therapy Other Medicare-Required Assessment (OMRA)</td>
<td>5-7 days after</td>
<td>start of therapy</td>
<td>Date of the first day of therapy through the end of the standard payment period</td>
</tr>
<tr>
<td>End of Therapy OMRA</td>
<td>1-3 days after</td>
<td>end of therapy</td>
<td>First non-therapy day through the end of the standard payment period</td>
</tr>
<tr>
<td>Change of Therapy OMRA</td>
<td>Day 7 (last day) of Change of Therapy (COT) observation period</td>
<td></td>
<td>The first day of the COT observation period until end of standard payment period, or until interrupted by the next COT-OMRA assessment or scheduled or unscheduled PPS Assessment</td>
</tr>
<tr>
<td>Significant Change in Status Assessment</td>
<td>No later than 14 days after</td>
<td>significant change identified</td>
<td>Assessment Reference Date (ARD) of Assessment through the end of the standard payment period</td>
</tr>
</tbody>
</table>
## PDPM Assessment Schedule

<table>
<thead>
<tr>
<th>Medicare MDS Assessment Type</th>
<th>Assessment Reference Date</th>
<th>Applicable Standard Medicare Payment Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Five-day Scheduled PPS Assessment</td>
<td>Days 1-8</td>
<td>All covered Part A days until Part A discharge (unless an IPA is completed)</td>
</tr>
<tr>
<td>Interim Payment Assessment (IPA)</td>
<td>Optional Assessment</td>
<td>ARD of the assessment through Part A discharge (unless another IPA assessment is completed)</td>
</tr>
<tr>
<td>PPS Discharge Assessment</td>
<td>PPS Discharge: Equal to the End Date of the Most Recent Medicare Stay (A2400C) or End Date</td>
<td>N/A</td>
</tr>
</tbody>
</table>
MDS Changes: New Item Sets

• Interim Payment Assessment (IPA):
  • Optional Assessment: May be completed in order to report a change in patient’s PDPM classification
    • Does not impact the variable per diem schedule
  • ARD: Determined by the provider
  • Payment Impact: Changes payment beginning on the ARD and continues until the end of the Part A stay or until another IPA is completed
MDS Changes: New Item Sets

• Optional State Assessment (OSA):
  • Solely to be used by providers to report on Medicaid-covered stays, per requirements set forth by their state
  • Allows providers in states using RUG-III or RUG-IV models as the basis for Medicaid payment to do so until September 30, 2020, at which point CMS support for legacy payment models will end

SNF PPS: Patient Driven Payment Model

December 11, 2018
DOCUMENTATION
Skilled Documentation

• Physician Order - legible, signed and dated
  • Illegible; send signature log and attestation statement

• Orders for skilled services

• Medications, weight sheets, vital sign records, care plan and treatment plans
Skilled Documentation

• Document look-back period for each MDS billed (may be prior to billing period)
  • Therapy minutes, IV administration, ADLs

• Laboratory tests and reports for billing period
  • Automatic, routine or generic standing orders for labs are not allowable under Medicare
Skilled Documentation

- PT/OT/SLP = Initial evaluation, POC and progress reports on or before every 10th treatment day
  - Treatment encounter notes and discharge summary
  - Overall condition, instability
  - Intervention and patient response
  - Physician involvement and treatment plan modifications
Common Errors

- Minutes on MDS do not match documentation
- Missing orders for therapy and/or therapy minutes not documented
- Missing signature log to validate physician signature
- Documentation doesn’t support the level of RUG billed, but supports a lower level RUG
Certification/Recertification

• Signed and dated by physician
  • Must be legible!

• Continued need for extended care services
  • Estimated period of time
  • Plans for home care
Certification/Recertification

• Missing Physician certification/recertification
  • Refer to MLN SE1428

• Initial certification is due at time of admission
  • First certification must be no later than 14th day
  • Subsequent recertification required every 30 days
  • Delays MUST include an explanation!
Therapy Documentation

• Orders
• Initial therapy evaluations and active written treatment plan for all therapies (every claim)
• Progress notes
• Therapy minute logs
Therapy Minutes

• Actual minutes - do not round!
• Subsequent evaluations
• Only Skilled modalities
  • Require the skill, knowledge and judgement of a qualified therapist
  • Must be part of medical record
Therapy Minutes

• Minutes not to be reported on MDS
  • Non-skilled services
  • Initial evaluation time
  • Refusal or trying to persuade patient
  • Non-therapeutic rest
  • Documentation
  • Not medically necessary
Supporting Documentation

• Hospital information
• Physician involvement
• Medication, treatment and wound care
• Discharge planning or summary
• Activities of Daily Living (ADL) flowsheet
ADLs

• What actually occurred

• Self-Performance coding - Rule of three:
  • ≥ 3 at any level, code that level
  • ≥ 3 at multiple levels, code most depended level
  • ≥ 3 at multiple levels, but not 3 times at one level convert to weight bearing
  • If none of the above met - code supervision
Billing Tips

• Bill in sequence
• Non-utilization days
  • Leave of absence (LOA)
  • Discharged
  • Death
• Discharged, then returns before midnight on the same day is not a discharge!
Billing Tips

• OSC 70 = Qualifying inpatient stay
• Patient status codes; for example:
  • 01 Home
  • 06 Home health
  • 30 Remains in facility
• MDS matches HIPPS rate code
  • Assessment dates and RUG levels entered correctly
MEDICAL REVIEW
COMMON ERRORS
OSC 70

• Error: Claims noted to have incorrect OSC 70 dates that required correction
• Verify the qualifying hospital stay is of at least 3 consecutive days
  • Only inpatient days, no observation
  • Never admitted or less than 3 days; add remarks
Patient Status Code

- Error: Claims billed with incorrect patient status codes that required correction

- Verify patient discharge status
  - Discharge planning process
Incomplete Certification

• Error: late or incomplete certifications
  • Incomplete statements, no date and/or illegible
  • Missing physician signatures

• Support reason for continued need, estimated period of time bene will remain in SNF and any plans for home care
  • Medicare signature requirements
  • Support reasoning, if late
Non-Skilled Modality

- Error: Claims noted to have non-skilled modality minutes captured on MDS
  - Modalities such as electrical stimulation Documentation did not support minutes as skilled

- Only the actual minutes provided for skilled therapy should be recorded on the MDS
  - That required the skill, knowledge and judgement of a qualified therapist and meets all other requirements for skilled therapy
Missed COT-OMRA

• Error: Claims noted to have missed COT OMRA
  • Days denied with provider liability

• Ensure all unscheduled assessments are completed

• Ensure only skilled minutes are counted in evaluating therapy intensity
SNF Change of Therapy Module

Skilled Nursing Facility & Change of Therapy

Start

CMS

PALMETTO GBA

A Celerian Group Company
Therapy Orders

• Error: Claims noted to have missing therapy initial orders or continuation orders

• Ensure submitted documentation contains valid physician orders for all skilled services
  • If orders have through dates, ensure continuation orders
Palmetto GBA Resources

• Skilled Nursing Facilities (SNF) webpage
  • Go to www.palmettогbа.com, choose Articles, then open Skilled Nursing Facilities (SNF)
SNF Basic Training Modules

Palmetto GBA developed a Skilled Nursing Facility (SNF) Basics educational series that consists of seven Web-based Training modules. These training modules provide an overview of SNF Part A and SNF Part B of A eligibility, billing and coverage, consolidated billing, no payment and exhaust billing, as well as when to submit a generic notice versus an Advance Beneficiary Notice (ABN). The following training modules are available:

- Skilled Nursing Facility Basics I: Overview
- Skilled Nursing Facility Basics II: Consolidated Billing
- Skilled Nursing Facility Basics III: Prospective Payment System
- Skilled Nursing Facility Basics IV: General Billing Requirements
- Skilled Nursing Facility Basics V: Part B of A Billing & Coverage
- Skilled Nursing Facility Basics VI: Special Billing Processes
- Skilled Nursing Facility Basics VII: Special Required Notices
This interactive tool provides a closer look at Skilled Nursing Facility (SNF) Extended Care Services. Select the buttons below for more information on each topic.
Stay Connected!

Provider Contact Center
JJA 877-567-7271
JMA 855-696-0705

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Specialty Conferences and Ask the Contractor Teleconferences (ACT)