	Regulatory Compliance Policy	No.	COMP-RCC 4.08
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	SKILLED NURSING FACILITIES CONSOLIDATED BILLING REQUIREMENTS	Effective Date:	07-30-19
		Previous Versions Dated: 07-03-01; 03-15-99	03-23-05;
		Corporate Review Dated:	07-19-19

I. SCOPE:

This policy applies to Medicare certified skilled nursing facilities, including hospital-based skilled nursing units (SNFs), owned or operated by Tenet Healthcare Corporation or its consolidated subsidiaries (Tenet). This policy applies only to Medicare fee-for-services SNF residents.

II. PURPOSE:

Section 4432(b) of the Balanced Budget Act of 1997 (BBA) requires consolidated billing (CB) for SNFs. CB essentially makes the SNF itself responsible for billing Medicare for the entire package of services and supplies that its residents receive under the Part A Medicare benefit (except for certain services discussed below) and for physical, occupational and speech-language therapy services that its residents receive, regardless of whether those residents are in a Part A covered stay.

III. POLICY:

A. Under no circumstances shall services furnished to a resident of a Tenet SNF be scheduled, provided, arranged for, or coded for the purposes of circumventing the CB regulations. Further, no patient shall be discharged from a Tenet SNF and be subsequently readmitted for the purpose of circumventing the Medicare CB regulations.

B. In compliance with CB rules, no Tenet Medicare-certified SNF shall "unbundle" services provided to residents during a Part A stay to an outside supplier/provider that would then submit a separate bill directly to a Carrier. Every Tenet Medicare certified SNF shall have processes and procedures to identify all services, billings, and claims subject to CB. Such processes and procedures must include effective means to prevent inappropriate submission of claims to Medicare for payment.

C. With certain exceptions enumerated within this policy, all Medicare-covered services furnished to a resident during a covered Part A stay, must be

1. Furnished directly by the SNF with its own resources, or

2. Obtained from an outside supplier/provider under an arrangement, as described in §1861(w) of the Social Security Act (Arrangement). This Arrangement must constitute a written agreement that the SNF shall reimburse the outside supplier/provider for Medicare-covered services subject to CB.

D. Any physical, occupational, or speech-language therapy services that a Medicare resident receives, regardless of whether the resident is in a Part A covered stay, and must be furnished directly by the SNF or under arrangements.

IV. PROCEDURE:

A. Definition of a SNF Resident for Consolidated Billing Purposes

A SNF resident is defined as any beneficiary who is admitted to a Medicare-participating SNF or the participating, Medicare-certified, distinct part unit (DPU) of a larger institution. Whenever such a beneficiary leaves the facility (or the DPU), the beneficiary's status as a SNF resident for consolidated billing purposes (along with the SNF's responsibility to furnish or make arrangements for needed services) ends when one of the following events occurs:

1. The beneficiary is admitted as an inpatient to a Medicare-participating hospital or critical access hospital (CAH) or as a resident to another SNF;

2. The beneficiary receives services from a Medicare-participating home health agency under a plan of care;

3. The beneficiary receives one of the types of outpatient hospital services that CMS has designated as being exceptionally intensive; or

4. The beneficiary is formally discharged (or otherwise departs) from the SNF or DPU, unless the beneficiary is readmitted (or returns) to that or another SNF before the following midnight.

B. Services not subject to SNF Consolidated Billing

In general, CB applies to services a SNF resident receives during the course of a covered Part A stay, as well as to any physical, occupational and/or speech-language therapy services received by a SNF resident However, the following services are not subject to consolidated billing (see section 1888(e) (2) (ii) of the Social Security Act and 42 C.F.R. § 411.15(p)(2)):

1. Outpatient hospital services that are considered to fall outside the scope of a typical SNF comprehensive plan of care. Specifically:

   a) emergency services;

   b) cardiac catheterization;

c) computerized axial tomography (CT) scans;

d) magnetic resonance imaging (MRIs);

e) ambulatory surgery involving the use of an operating room;

f) radiation therapy;

g) angiography;

h) lymphatic and venous procedures; and

i) ambulance trips that transport a beneficiary from the SNF to receive any of the above mentioned excluded outpatient services.

Hospitals may only bill for those services and supplies provided to a SNF patient covered by Part A that are directly related and required to complete the outpatient procedure or treat the emergency condition for which the beneficiary came to the hospital (e.g., anesthesia when used during ambulatory surgery involving the use of an operating room). All other services and supplies must be bundled back to the SNF, and the hospital must look to the SNF for payment.

2. The professional component of physicians' services furnished to SNF residents;

3. Physician assistants working under a physician's supervision;

4. Nurse practitioners and clinical nurse specialists working in collaboration with a physician;

5. Certified nurse-midwives;

6. Qualified psychologists;

7. Certified registered nurse anesthetists;

8. Home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies, and ambulance transportation to obtain the dialysis services;

9. Erythropoietin (EPO) for certain dialysis patients, subject to methods and standards for its safe and effective use;

10. Hospice care related to a beneficiary's terminal condition;

11. An ambulance trip that transports a beneficiary to the SNF for the initial admission or from the SNF following a final discharge;

12. A subset of HCPCS codes in the following categories:

    a) chemotherapy and its administration;

    b) radioisotopes and their administration;

    c) however, other services given in conjunction with the above (e.g., other pharmaceuticals, medical supplies, etc.) remain bundled and should be reimbursed by the SNF to the supplier.

13. Specific customized prosthetic devices.

C. Supplier/Provider Arrangements

1. SNFs are solely responsible for assuring the medical necessity of all services rendered to their residents, including any services furnished under arrangement by outside suppliers and providers.

2. In order for a SNF to utilize an outside supplier or provider to furnish services that are subject to CB, the SNF **must have a written agreement** in place with that supplier or provider, which specifies how the supplier or provider is to be paid for its services. The written agreement must also specify that the SNF assumes responsibility for the quality and timeliness of the arranged-for services. The lack of a written agreement could potentially result in Medicare's noncoverage of the particular services, and the SNF could be found in violation of the terms of its Medicare provider agreement and at risk for civil monetary penalties. When services are provided under an arrangement, Medicare's payment to the SNF represents payment in full for the arranged-for service, and the supplier/provider must look to the SNF (rather than to the Carrier) for its payment. The SNF cannot function as a mere billing conduit, but must actually exercise professional responsibility and control over the arranged-for service.

3. The issue of the supplier/provider payment from the SNF is a contractual matter that must be established by the written agreement. Tenet policies governing purchasing and contracting with suppliers/providers must be followed. Operations counsel should be contacted for guidance.

4. For all services provided under arrangement, the SNF must provide the supplier/provider with a copy of the medical order. The SNF must maintain the **original** medical orders on file for billing purposes.

5. A SNF may charge a supplier/provider an administrative fee for billing on behalf of the supplier/provider. This administrative fee must not be charged to Medicare. Rather, the fee must be deducted from the payment to the supplier/provider for the services furnished. The payment of administrative fees must be addressed in the written agreement between the SNF and the supplier/provider.

D. SNF Resident Education

The SNF shall advise each resident, on or before admission and periodically during the stay, of any charges for services not covered by Medicare. In providing such advice periodically throughout each resident's stay, the SNF should take particular care to counsel any resident who is about to leave the facility temporarily, in order to ensure that the resident (and, if applicable, the resident's representative) understands the need to consult the SNF before obtaining any services offsite.

E. No Payment Bills

A SNF is required to submit a bill to Medicare even though no benefits may be payable. A SNF must submit a no-payment bill every month and also when there is a change in the level of care regardless of whether the no-payment days will be paid by Medicaid or a supplemental insurer. (See Medicare Claims Payment Manual, Sect. 40.8).

F. Consolidated Billing Examples

1. Therapy Services

Scenario:

A SNF resident who is a Medicare beneficiary and is not in a covered Part A stay receives physical therapy services from a therapist who is not employed by the SNF.

Analysis:

The therapist and the SNF must have a written agreement and the therapist must look to the SNF for payment and the SNF must bill the services to Medicare under Part B.

Scenario:

A hospital provides outpatient occupational therapy services to a resident of a SNF who is not in a covered Medicare Part A Medicare stay.

Analysis:

Occupational therapy services are subject to SNF CB regardless of whether the Medicare beneficiary is in a covered Part A stay. The SNF and the therapist must have a written agreement for the provision of services. The SNF must bill the services to Medicare under Part B. The hospital may not bill Medicare for the therapy services, but rather must look to the SNF for payment.

2. Surgical Procedures

Scenario:

A SNF resident who is Medicare beneficiary in a Part A covered stay requires a cataract procedure. The patient is transported to a hospital for the procedure. The outpatient surgical procedure is performed in the hospital operating room. The patient returns to the SNF before midnight of the same day.

Analysis:

The procedure qualifies as an exception to CB since it was performed in a hospital outpatient department and required the use of an operating room. Therefore, the hospital must bill Medicare for the procedure.

If the same procedure had been performed in a freestanding ambulatory surgical center (ASC), the procedure would not qualify as an exemption, and the ASC would turn to the SNF for payment of all non-physician services. The SNF must include charges and codes pertaining to the ASC procedure on the SNF's claim to Medicare.

3. Hospital Observation Services

Scenario:

A SNF resident covered under a Part A stay is taken to a hospital and is held in an observation bed past midnight but less than forty-eight hours.

Analysis:

CB would not apply because the patient was away from the SNF past midnight. Thus, the hospital would bill the Medicare program for the services provided.

If the beneficiary were to have returned to the SNF prior to midnight, then his or her status as an SNF resident for CB purposes would continue during the stay in the hospital, regardless of whether the SNF had formally discharged the patient. Thus, the SNF would have to bill Medicare for the services provided at the hospital (except for those services specifically excluded from SNF CB, such as emergency room treatments that are beyond a SNF's typical plan of care).

G. Responsible Person

H. The Tenet Entity's CFO (or equivalent title) is responsible for ensuring that all individuals adhere to the requirements of this policy. If the CFO (or equivalent title) is unable to create adherence to this policy, the CFO (or equivalent title) will immediately report the non-adherence to the Tenet Entity's Compliance Officer.

I. Auditing and Monitoring

Audit Services Department will audit and monitor adherence to this policy in its routine audits.

J. Enforcement

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

V. REFERENCES

1. 63 Federal Register 26252, (5/12/98)

2. 65 Federal Register 46790 (07-31-00)
3. 42 C.F.R. §§ 411.15(p), 424.101, 489.20(s)
4. Medicare Claims Processing Manual Chapter 6