

Historical Questions & Answers on SNF Consolidated Billing

What is consolidated billing?

A requirement in section 1862(a)(18) of the Social Security Act (the Act), effective for services furnished in SNF cost reporting periods beginning on or after July 1, 1998.

Consolidated billing essentially places with the SNF itself the Medicare billing responsibility for the entire package of services that its residents receive during the course of a covered Part A stay--except for those types of services that appear on a short list of statutory exclusions (see "What's excluded?" below), which remain separately billable to Part B by the outside entity that furnishes them. Consolidated billing also applies to physical, occupational, and speech-language therapy services furnished to those SNF residents who are in noncovered stays (e.g., Part A benefits exhausted; no prior qualifying hospital stay).

What were the problems that caused the Congress to enact consolidated billing?

Prior to the introduction of the SNF prospective payment system (PPS), significant problems arose from the unrestricted ability of outside entities to bill Part B directly for services furnished to SNF residents during a covered Part A stay:

Duplicate billing when the SNF billed Part A and the outside entity billed Part B for the same service. This problem was compounded because the Part A and Part B sides of the Medicare claims processing system didn't communicate very well with each other at that time.

Increased out-of-pocket liability for beneficiaries. Even in situations where only the outside entity (and not the SNF) submitted a claim, billing Part B for a service that could have been included on the SNF's Part A bill resulted in increasing the beneficiary's financial liability--by incurring the expense of Part B coinsurance payments and any unmet Part B deductible for the service.

Dispersing responsibility for furnishing and billing services among multiple outside entities diminished the SNF's capacity to meet its own responsibility to oversee, coordinate, and account for the total package of care that its residents received.

What's excluded?

As enacted by section 4432(b) of the Balanced Budget Act of 1997 (BBA, P.L. 105-33), the original list of exclusions (at section 1888(e)(2)(A)(ii) of the Act) carved out entire categories of services from consolidated billing--primarily, those of physicians and certain other types of medical practitioners. These excluded services are separately billable to the Part B carrier.

Subsequently, section 103 of the Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113, Appendix F) enacted a second, more targeted set of exclusions (at section 1888(e)(2)(A)(iii) of the Act), carving out individual "high-cost, low probability" services within a number of broader service categories--such as chemotherapy services--that otherwise remained subject to consolidated billing.

What about diagnostic tests?

Since diagnostic tests don't appear on the list of services that are excluded from consolidated billing, they're included within the comprehensive service package that is subject to the consolidated billing requirement when furnished to an SNF resident during a covered Part A stay. However, as noted above, one of the service categories that the law does exclude from the SNF consolidated billing provision is physician services, which are separately billable to the Medicare Part B carrier.

What happens when a diagnostic test includes both a technical and a professional component?

Basically, the professional component (representing the physician's interpretation of the diagnostic test) is considered a physician service and is separately billable to the carrier. However, the technical component (representing the test itself) is considered a diagnostic test that is subject to consolidated billing and must be billed by the SNF.

The preamble to the interim final rule on the SNF PPS (63 FR 26296-97, May 12, 1998) explains the applicability of the consolidated billing exclusion in the case of certain types of diagnostic procedures that previously were billed to the Part B carrier in conjunction with related physician services and paid under a single, global fee. For example, with regard to diagnostic radiology services, the exclusion of physician services from consolidated billing applies only to the professional component of the diagnostic radiology service, while the technical component of the diagnostic radiology service is considered a diagnostic test that must be billed to Medicare by the SNF, and is included in the SNF's PPS payment for its resident's covered Part A stay.

Because the technical component is already included within Part A's comprehensive per diem payment to the SNF for the covered stay, an outside entity that actually furnishes the technical component would have to look to the SNF, rather than to Part B, for payment.

If SNF consolidated billing has been in effect ever since 1998, why didn't the claims processing system reject separate Part B claims for the technical component until recently?

We advised the Medicare contractors of these policies through the issuance of Program Memorandum (PM) AB-98-18 in April 1998, which discusses the treatment of professional and technical components on page 8. As this discussion indicates, these policies are not new, and have been in effect for a number of years. However, for the first several years, the claims processing system's ability to detect claims that were submitted inappropriately was quite limited (see the "Duplicate Billing" bullet point in "What were the problems that caused the Congress to enact consolidated billing?" above).

What has changed recently, though, is that we have now installed electronic edits that enable the claims processing system to detect automatically any claims that are inappropriately submitted to Part B, for those services (like the technical component of diagnostic tests) that are already included within the SNF's global per diem payment for a resident's covered Part A stay. As discussed above, because these services are already included within the SNF's payment for its resident's Medicare-covered stay, an outside entity that furnishes the services must look to the SNF (rather than to Part B) for payment.