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Information for Medicare Fee-For-Service Health Care Professionals

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Skilled Nursing Facility Consolidated Billing as It Relates to Certain Diagnostic Tests

Note: This article was updated on May 9, 2013, to reflect current Web addresses. All other information remains unchanged..

Provider Types Affected

Skilled Nursing Facilities (SNFs), physicians, suppliers, providers, and radiology centers

Provider Action Needed

This Special Edition is an informational article that describes SNF Consolidated Billing (CB) as it applies to certain diagnostic tests that include both a technical component (representing the test itself) and a professional component (representing the physician's interpretation of the test). These tests commonly include diagnostic radiology procedures (such as x-rays) and laboratory tests, but can also include other types of diagnostic procedures (such as audiology services) as well.

Clarification: The SNF CB requirement makes the SNF itself responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These "excluded" services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their Medicare Durable Medical Equipment Regional Carrier (DMERC).)

Background

When the SNF Prospective Payment System (PPS) was introduced in 1998, it not only changed the way SNFs are paid, but changed the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns the SNF the Medicare billing responsibility for virtually all of the services that the SNF's residents receive during the course of a covered Part A stay. Payment for this full range of services is included in the SNF PPS global per diem rate.

The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service.

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See MLN Matters Special Edition SE0431 at: <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0431.pdf> on the CMS website. It contains a detailed overview of SNF CB and a list of the services excluded from SNF CB.

However, one of the service categories that the law *does* exclude from the SNF CB provision is physician services, which are separately billable to the Medicare Part B carrier.

Since many diagnostic tests include both a technical component and a professional component, suppliers need to generate two bills. For example, with regard to diagnostic radiology services, such as x-rays, the physician service exclusion applies only to the professional component of the diagnostic radiology service (representing the physician's interpretation of the diagnostic test).

The physician service is billed directly to the Medicare Part B carrier.

Because the diagnostic radiology service's technical component is already included within the SNF's global per diem payment for its resident's covered Part A stay, the outside supplier that actually furnishes the technical component would look to the SNF (rather than to their Medicare carrier) for payment.

As indicated in the preceding discussion, these policies are not new, and have been in effect since the implementation of the SNF PPS in 1998. What has changed, though, is that the Centers for Medicare & Medicaid Services (CMS) installed electronic edits in 2002 that enable the claims processing system to detect automatically any claims that are inappropriately submitted to Medicare carriers or intermediaries for those services that are already included within the SNF's global per diem payment for a resident's covered Part A stay (such as the technical component of diagnostic tests).

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 Medicare, for payment.

Additional Information

See MLN Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0440.pdf> on the CMS website.

The CMS MLN Consolidated Billing web site can be found at <http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html> on the CMS website.

It includes the following relevant information:

- General SNF consolidated billing information,
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing),
- Therapy codes that must be consolidated in a non-covered stay, and
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

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Also, the SNF PPS Consolidated Billing web site can be found at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html> on the CMS website.

It includes the following relevant information:

- Background,
- Historical questions and answers,
- Links to related articles, and
- Links to publications (including transmittals and Federal Register notices)

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