



**MEDICARE EDUCATION
AND
TRAINING
DEPARTMENT**



Florida Orthopaedic Society Working Lunch Program
Conference Call Questions and Answers
November 19, 2003
Noon to 1 p.m. (EST)

1. Exactly what charges should be billed to a Skilled Nursing Facility (SNF)? It is our understanding that we bill x-rays and DME (Durable Medical Equipment). We would like a list of procedure codes for which Medicare is not responsible.
 - A. For services furnished to a SNF resident covered under the Part A benefit, the SNF must submit a bill to Medicare for services furnished either directly or under arrangement with an outside provider. The outside provider of the service must look to the SNF for payment. Physicians, non-physician practitioners, and suppliers will continue to bill the Medicare carrier or DMERC (Durable Medical Equipment Regional Contractor) for services excluded from consolidated billing and therefore separately payable. Please reference CMS' Web site at www.cms.hhs.gov/medlearn/snfsectionII.asp for the coding files that identify services that may be billed to the carrier for separate reimbursement.

2. A nursing home told us that a particular patient no longer has Medicare A and has only Medicare Part B. The nursing home also stated that Medicaid is paying the nursing home. In this instance, we were instructed by the nursing home to bill Medicare B for the x-rays, DME, and other services. Is this correct?
 - A. Yes. Medicare beneficiaries can either be in (1) a Part A covered SNF stay which includes medical services as well as room and board, or (2) in a Part B SNF stay in which the Part A benefits are exhausted, but certain medical services are still covered though room and board is not. Services covered by Medicare Part B for SNF residents may be billed to either the intermediary or carrier depending on the provider rendering the service. For Medicare beneficiaries in a Part B SNF stay, only therapy services are subject to consolidated billing. All other covered SNF services can be separately billed to and paid by the carrier.

3. Should we continue to bill Medicare for application of casts (CPT 29075) and cast supplies (HCPCS Q4010), or do these procedures get billed to the nursing home?
 - A. Procedure code 29075 is not subject to SNF consolidated billing and may be billed to the Part B Medicare carrier, as appropriate, for payment consideration. HCPCS code Q4010 is subject to SNF consolidated billing.

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If services are provided under arrangement by an outside provider, the outside provider should seek reimbursement from the SNF.

4. Will Medicare be sending out formal refund request letters for the overpayments they have identified in their recent audits? Can we resubmit the professional component even if the overpayments are from several years ago?
 - A. Yes, First Coast Service Options, Inc. (FCSO) will send out formal requests for any overpayments identified. FCSO was instructed via transmittal AB-02-023 dated February 12, 2002, to demand refunds that were disbursed inappropriately. Providers are given instructions regarding how to refund monies paid in error and their appeal rights. Codes for diagnostic tests may include a technical portion (i.e., the test itself) and a professional component (i.e., the physician's interpretation of the test). To identify the professional components of physician's services for SNF residents that are billable to the carrier, use the information in the Professional Component/Technical Component (PC/TC) indicator field of the Medicare Physician Fee Schedule (MPFS) for payment. For beneficiaries in a Part A covered stay, the physician will be paid for the professional component of physician services that have both technical and professional components or for those physician services that have only professional components. Technical components should be billed by the provider to the SNF for payment.

5. Can physician offices bill the nursing home for 100% of their charge for the technical component, or are we limited by Medicare's fee schedule?
 - A. Financial arrangements made regarding SNF reimbursement to an outside provider must be negotiated between both entities. SNFs are free to establish contracts with outside providers using whatever payment arrangement both parties agree to, as long as those contracts do not violate the anti-kickback statutes.

6. What recourse do we have if the nursing homes do not reimburse us?
 - A. Medicare strongly encourages SNFs and contracting entities to follow CMS instructions regarding financial arrangements between entities or consult with a healthcare attorney.

7. Are the nursing homes required to pay within a certain time frame?

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- A. While Medicare has established timelines for processing claims and adjustments, these timelines do not bind your arrangement with SNF facilities. Reimbursement time frames should be included in your contractual agreement.
8. Currently, we have no way of knowing if a patient is under Part A when they come from a nursing home. How can we identify patients who are in a SNF under Medicare Part A?
- A. Pending
9. Does Medicare have any record of which nursing home should be billed?
- A. A Medicare customer service representative will be able to disclose the name of a SNF facility with which the claim in question overlaps.
10. Should we bill Medicare for x-rays with a 26 modifier and only bill the nursing home with a TC modifier on the same x-ray, or should we bill the nursing home for the entire x-ray?
- A. X-rays provided to a Medicare beneficiary that include a technical and professional component may be billed to the Medicare carrier with modifier 26 when the beneficiary is in a Part A stay. The provider should seek reimbursement for the technical component from the SNF.