CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 183 **Date: MAY 21, 2004**

CHANGE REQUEST 3248

I. SUMMARY OF CHANGES: CLARIFICATION – This instruction clarifies the requirements that must be met in order for a Medicare skilled nursing facility (SNF) to have a valid "arrangement" in effect with an outside supplier.

NEW/REVISED MATERIAL - EFFECTIVE DATE: April 1, 2004
***IMPLEMENTATION DATE: July 1, 2004**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	6/Table of Contents
R	6/10.3/ Types of Services Subject to the Consolidated Billing Requirement for SNFs
N	6/10.4/ Furnishing Services that are Subject to SNF Consolidated Billing Under an "Arrangement" with an Outside Entity
N	6/10.4.1/ Written Agreement
N	6/10.4.2/ SNF and Supplier Responsibilities

***III. FUNDING**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 183	Date: May 21, 2004	Change Request 3248

SUBJECT: Skilled Nursing Facility (SNF) Consolidated Billing: Services Furnished Under an "Arrangement" With an Outside Entity

I. GENERAL INFORMATION

A. Background: The skilled nursing facility (SNF) consolidated billing provisions (at §§1862(a)(18), 1866(a)(1)(H)(ii), and 1888(e)(2)(A) of the Social Security Act (the Act)) place with the SNF itself the Medicare billing responsibility for most of its residents' services. "Part A" consolidated billing requires that an SNF must include on its Part A bill almost all of the services that a resident receives during the course of a *Medicare-covered* stay, other than those services that are specifically *excluded* from the SNF's global prospective payment system (PPS) per diem payment for the covered stay. (These "excluded" services, such as the services of physicians and certain other practitioners, remain separately billable to Part B directly by the outside entity that actually furnishes them.) In addition, "Part B" consolidated billing makes the SNF itself responsible for submitting the Part B bills for any *physical, occupational, or speech-language therapy services* that a resident receives during a *noncovered* stay.

Further, for any Part A or Part B service that is subject to SNF consolidated billing, the SNF must either furnish the service directly with its own resources, or obtain the service from an outside entity (such as a supplier or practitioner) under an "arrangement," as described in §1861(w) of the Act. This "arrangement" must constitute a written agreement to reimburse the outside entity for Medicare-covered services subject to consolidated billing; i.e., services that are reimbursable only to the SNF as part of its global PPS per diem or those Part B services that must be billed by the SNF.

We have become aware of various problematic situations in which an SNF resident receives services that are subject to consolidated billing from an outside entity (such as a supplier), in the absence of a valid arrangement between that entity and the SNF. In some instances, the supplier may have been unaware that the beneficiary was in a Part A stay until its separate Part B claim was denied. In the absence of a written agreement, the supplier may have difficulty in obtaining payment from the SNF, even though the service at issue is a type of service that is Medicare-covered and included in the SNF's global PPS per diem. As discussed in greater detail below, such situations most commonly arise in one of the following two scenarios: 1) An SNF does not accurately identify services as being subject to consolidated billing when ordering such services from a supplier; or 2) A supplier fails to ascertain a beneficiary's status as an SNF resident when the beneficiary (or another individual acting on the beneficiary's behalf) seeks to obtain such services directly from the supplier without the SNF's knowledge.

Whenever a supplier furnishes services that are subject to consolidated billing in the absence of a written agreement with the SNF, the supplier risks not being paid for the services. In addition, the supplier in this situation might improperly attempt to bill Part B directly for the services. The inappropriate submission of a Part B bill for such services could result not only

in Medicare's noncoverage of the services themselves, but also in the imposition of civil money penalties, as explained below. Along with all of the other potentially adverse consequences of such practices, the SNF is also at risk of being found in violation of the terms of the Medicare provider agreement (which, as explained below, requires an SNF to have a valid arrangement in place whenever a resident receives services that are subject to consolidated billing from any entity other than the SNF itself). In order to help prevent these types of problems from arising, we are issuing this instruction as a reminder of the applicable consolidated billing requirements that pertain to SNFs and to the outside suppliers that serve SNF residents.

B. Policy: Under an arrangement as defined in §1861(w) of the Act, Medicare's payment to the SNF represents payment in full for the arranged-for service, and the supplier must look to the SNF (rather than to Part B) for its payment. Further, in entering into such an arrangement, the SNF cannot function as a mere billing conduit, but must actually exercise professional responsibility and control over the arranged-for service (see the online CMS Manual System at www.cms.hhs.gov/manuals/cmsindex.asp ,Publication 100-01 ("Medicare General Information, Eligibility, and Entitlement"), Chapter 5 ("Definitions"), §10.3 ("Under Arrangements")). The long-term care (LTC) facility requirements for program participation further provide that under such an arrangement, the SNF must specify *in writing* that it assumes responsibility for the quality and timeliness of the arranged-for service (see the regulations at 42 CFR 483.75(h)(2)).

Medicare does not prescribe the actual terms of the SNF's written agreement with its supplier (such as the specific amount or timing of the supplier's payment by the SNF), which are to be arrived at through direct negotiation between the parties to the agreement. However, in order for a valid "arrangement" to exist, the SNF *must have* a written agreement in place with its supplier, which specifies how the supplier is to be paid for its services. The existence of such an agreement also provides both parties with a means of resolution in the event that a dispute arises over a particular service.

If an SNF elects to obtain services that are subject to consolidated billing from an outside supplier, but fails to execute a written agreement with that supplier, then there is no valid arrangement for the services as contemplated under §1862(a)(18) of the Act. Not only would this potentially result in Medicare's noncoverage of the particular services at issue, but the SNF would also risk being found in violation of the terms of its provider agreement. Under §1866(a)(1)(H)(ii) of the Act (and the regulations at 42 CFR 489.20(s)), the SNF's provider agreement includes a specific commitment to comply with the requirements of the consolidated billing provision. Further, §1866(g) of the Act imposes a civil money penalty on any person who knowingly and willfully presents (or causes to be presented) a bill or request for payment inconsistent with an arrangement or in violation of the requirement for such an arrangement.

Accordingly, whenever an SNF elects to utilize an outside supplier to furnish a service that is subject to consolidated billing, the SNF must have a written agreement in place with that supplier. Conversely, whenever an outside supplier furnishes such a service to an SNF resident, it must do so under a written agreement with the SNF. Problems involving the absence of a valid arrangement between an SNF and its supplier typically tend to arise in one

of the following two situations. The first problem scenario occurs when an SNF elects to utilize an outside supplier to furnish a type of service that would be subject to Part A consolidated billing, but then fails to inform the supplier that the resident receiving the service is in a covered Part A stay.

This causes the supplier to conclude mistakenly that the service it furnishes to that resident is not subject to consolidated billing. Based on the inaccurate impression that the resident's SNF stay is noncovered, the supplier inappropriately submits a separate Part B claim for the service, and only learns of the actual status of the resident's Medicare-covered SNF stay when that Part B claim is denied. In this scenario, even though the supplier made reasonable efforts to ascertain from the SNF both the beneficiary's status as an SNF resident and the specific nature of the beneficiary's SNF stay, the information from the SNF (on which the supplier relied) proved to be inaccurate.

While we recognize that inadvertent errors may occasionally occur in the course of furnishing such information, an SNF should not only make a good faith effort to furnish accurate information to its supplier, but should have a written agreement in place that provides for direct reimbursement of the supplier once such an error is called to its attention. By contrast, in the scenario at issue, the SNF refuses to pay the supplier for the service even *after* being apprised of the inaccuracy of its initial information. As discussed previously, having a valid arrangement in place for the disputed service would not only ensure compliance with the consolidated billing requirements, but also would provide a vehicle for resolving the dispute itself.

Of course, the SNF can often prevent such disputes from arising to begin with, simply by ensuring that the supplier receives accurate and timely information about the status of a resident's Medicare-covered SNF stay. The SNF's responsibility to communicate accurate and timely resident information to its supplier is especially important in those instances where a particular portion of an otherwise bundled service remains separately billable to Part B (for example, the professional component that represents a physician's interpretation of an otherwise bundled diagnostic test).

The second problem scenario involves a resident who temporarily departs from the SNF on a brief leave of absence, typically accompanied by a relative or friend. While briefly offsite, the resident (or the relative or friend, acting on the resident's behalf) obtains services that are subject to the consolidated billing requirement, but fails to notify the SNF. As in the previous scenario, this results in the services being furnished to the resident by an outside entity in the absence of a valid arrangement with the SNF. In addition, such a practice impedes the SNF from meeting its responsibility to provide comprehensive oversight of the resident's care and treatment.

SNFs can act to prevent such problems from arising by ensuring that each resident (and, if applicable, his or her representative) is fully aware of the applicable requirements. For example, the Medicare law at §1802 of the Act guarantees a beneficiary's free choice of any qualified entity that is willing to furnish services to the beneficiary. However, in selecting a particular SNF, the beneficiary has effectively exercised this right of free choice with respect to

the *entire package* of services for which the SNF is responsible under the consolidated billing requirement, including the use of any outside suppliers from which the SNF chooses to obtain such services.

In addition, the LTC facility participation requirements at 42 CFR 483.10(b)(6) require the SNF to 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 include 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.

Moreover, while the SNF itself should take reasonable steps to prevent such problems from arising, the supplier in this scenario is also responsible for being aware of and complying with the consolidated billing requirements. This means that prior to furnishing services to a Medicare beneficiary, the supplier should routinely ascertain whether the beneficiary is currently receiving any comprehensive Medicare benefits (such as SNF or home health benefits) for which Medicare makes a bundled payment that could potentially include the supplier's services. If the supplier ascertains that a particular beneficiary is, in fact, a resident of an SNF with which the supplier does not have a valid arrangement in place, then the supplier should contact the SNF before actually furnishing services to that beneficiary.

C. Provider Education: A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
3248.1	Intermediaries and carriers shall notify affected providers of the information contained in this document through the methods described in section I.C. above.	Intermediaries and carriers

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: April 1, 2004 **Implementation Date:** July 1, 2004 **Pre-Implementation Contact(s):** Bill Ullman at (410) 786-5667 or BUllman@cms.hhs.gov, or Sheila Lambowitz at (410) 786-7605 or SLambowitz@cms.hhs.gov **Post-Implementation Contact(s):** Appropriate Regional Office	**These instructions shall be implemented within your current operating budget.**

Medicare Claims Processing Manual

Chapter 6 - SNF Inpatient Part A Billing

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(Rev. 183, 05-21-04)

10.3 - Types of Services Subject to the Consolidated Billing Requirement for SNFs

(Rev. 183, 05-21-04)

As previously discussed, the consolidated billing requirement applies to all services furnished to a SNF resident in a covered Part A stay (other than the excluded service categories described below) and for physical, occupational and, or speech language therapy services provided to residents and paid under Part B. Examples of services that are subject to consolidated billing include:

- Physical, occupational, and speech-language therapy services, regardless of whether they are furnished by (or under the supervision of) a physician or other health care professional (see §1888(e)(2)(A)(ii) of the Act). Physical, occupational, and speech-language therapy services (other than audiology services, which are considered diagnostic tests rather than therapy services) furnished to a SNF resident during a noncovered stay must still be billed by the SNF itself.

- Psychological services furnished by a clinical social worker; and

- Services furnished as an "incident to" the professional services of a physician or other excluded category of health care professional described *in §20.1.1* below.

10.4 - Furnishing Services that are Subject to SNF Consolidated Billing Under an "Arrangement" With an Outside Entity

(Rev. 183, 05-21-04)

As discussed in §10.1 and §10.3, the skilled nursing facility (SNF) consolidated billing provisions (at §1862(a)(18), §1866(a)(1)(H)(ii), and §1888(e)(2)(A) of the Act) place with the SNF itself the Medicare billing responsibility for most of its residents' services. "Part A" consolidated billing requires that an SNF must include on its Part A bill almost all of the services that a resident receives during the course of a Medicare-covered stay, other than those services that are specifically excluded from the SNF's global PPS per diem payment for the covered stay. (These "excluded" services, such as the services of physicians and certain other practitioners, remain separately billable to Part B directly by the outside entity that actually furnishes them.) In addition, "Part B" consolidated billing makes the SNF itself responsible for submitting the Part B bills for any physical, occupational, or speech-language therapy services that a resident receives during a noncovered stay.

Further, for any Part A or Part B service that is subject to SNF consolidated billing, the SNF must either furnish the service directly with its own resources, or obtain the service from an outside entity (such as a supplier or practitioner) under an "arrangement," as described in §1861(w) of the Act and in §80.5. This "arrangement" must constitute a written agreement to reimburse the outside entity for Medicare-covered services subject

to consolidated billing; i.e., services that are reimbursable only to the SNF as part of its global PPS per diem or those Part B services that must be billed by the SNF.

Problematic situations sometimes occur in which an SNF resident receives services that are subject to consolidated billing from an outside entity (such as a supplier) in the absence of a valid arrangement between that entity and the SNF. In some instances, the supplier may have been unaware that the beneficiary was in a Part A stay until its separate Part B claim was denied. In the absence of a written agreement, the supplier may have difficulty in obtaining payment from the SNF, even though the service at issue is a type of service that is Medicare-covered and included in the SNF's global PPS per diem. As discussed in greater detail below, such situations most commonly arise in one of the following two scenarios: 1) An SNF does not accurately identify services as being subject to consolidated billing when ordering such services from a supplier; or 2) A supplier fails to ascertain a beneficiary's status as an SNF resident when the beneficiary (or another individual acting on the beneficiary's behalf) seeks to obtain such services directly from the supplier without the SNF's knowledge.

Whenever a supplier furnishes services that are subject to consolidated billing in the absence of a written agreement with the SNF, the supplier risks not being paid for the services. In addition, the supplier in this situation might improperly attempt to bill Part B directly for the services. The inappropriate submission of a Part B bill for such services could result not only in Medicare's noncoverage of the services themselves, but also in the imposition of civil money penalties, as explained below. Along with all of the other potentially adverse consequences of such practices, the SNF is also at risk of being found in violation of the terms of the Medicare provider agreement (which, as explained below, requires an SNF to have a valid arrangement in place whenever a resident receives services that are subject to consolidated billing from any entity other than the SNF itself). Accordingly, in order to help prevent these types of problems from arising, these instructions reiterate the applicable consolidated billing requirements that pertain to SNFs and to the outside suppliers that serve SNF residents.

10.4.1 - Written Agreement

(Rev. 183, 05-21-04)

Under an arrangement as defined in §1861(w) of the Act, Medicare's payment to the SNF represents payment in full for the arranged-for service, and the supplier must look to the SNF (rather than to Part B) for its payment. Further, in entering into such an arrangement, the SNF cannot function as a mere billing conduit, but must actually exercise professional responsibility and control over the arranged-for service (see the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, "Definitions," §10.3, for additional information on services furnished under arrangements). The long-term care (LTC) facility requirements for program participation further provide that under such an arrangement, the SNF must specify in writing that it assumes responsibility for the quality and timeliness of the arranged-for service (see 42 CFR 483.75(h)(2)).

Medicare does not prescribe the actual terms of the SNF's written agreement with its supplier (such as the specific amount or timing of the supplier's payment by the SNF), which are to be arrived at through direct negotiation between the parties to the agreement. However, in order for a valid "arrangement" to exist, the SNF must have a written agreement in place with its supplier, which specifies how the supplier is to be paid for its services. The existence of such an agreement also provides both parties with a means of resolution in the event that a dispute arises over a particular service.

If an SNF elects to obtain services that are subject to consolidated billing from an outside supplier, but fails to execute a written agreement with that supplier, then there is no valid arrangement for the services as contemplated under §1862(a)(18) of the Act. Not only would this potentially result in Medicare's noncoverage of the particular services at issue, but the SNF would also risk being found in violation of the terms of its provider agreement. Under §1866(a)(1)(H)(ii) of the Act (and 42 CFR 489.20(s)), the SNF's provider agreement includes a specific commitment to comply with the requirements of the consolidated billing provision. Further, §1866(g) of the Act imposes a civil money penalty on any person who knowingly and willfully presents (or causes to be presented) a bill or request for payment inconsistent with an arrangement or in violation of the requirement for such an arrangement. Accordingly, whenever an SNF elects to utilize an outside supplier to furnish a service that is subject to consolidated billing, the SNF must have a written agreement in place with that supplier. Conversely, whenever an outside supplier furnishes such a service to an SNF resident, it must do so under a written agreement with the SNF.

10.4.2 - SNF and Supplier Responsibilities

(Rev. 183, 05-21-04)

Problems involving the absence of a valid arrangement between an SNF and its supplier typically tend to arise in one of the following two situations. The first problem scenario occurs when an SNF elects to utilize an outside supplier to furnish a type of service that would be subject to Part A consolidated billing, but then fails to inform the supplier that the resident receiving the service is in a covered Part A stay. This causes the supplier to conclude mistakenly that the service it furnishes to that resident is not subject to consolidated billing. Based on the inaccurate impression that the resident's SNF stay is noncovered, the supplier inappropriately submits a separate Part B claim for the service, and only learns of the actual status of the resident's Medicare-covered SNF stay when that Part B claim is denied. In this scenario, even though the supplier made reasonable efforts to ascertain from the SNF both the beneficiary's status as an SNF resident and the specific nature of the beneficiary's SNF stay, the information from the SNF (on which the supplier relied) proved to be inaccurate.

While we recognize that inadvertent errors may occasionally occur in the course of furnishing such information, an SNF should not only make a good faith effort to furnish accurate information to its supplier, but should have a written agreement in place that

provides for direct reimbursement of the supplier once such an error is called to its attention. By contrast, in the scenario at issue, the SNF refuses to pay the supplier for the service even after being apprised of the inaccuracy of its initial information. As discussed previously, having a valid arrangement in place for the disputed service would not only ensure compliance with the consolidated billing requirements, but also would provide a vehicle for resolving the dispute itself.

Of course, the SNF can often prevent such disputes from arising to begin with, simply by ensuring that the supplier receives accurate and timely information about the status of a resident's Medicare-covered SNF stay. The SNF's responsibility to communicate accurate and timely resident information to its supplier is especially important in those instances where a particular portion of an otherwise bundled service remains separately billable to Part B (for example, the professional component that represents a physician's interpretation of an otherwise bundled diagnostic test).

The second problem scenario involves a resident who temporarily departs from the SNF on a brief leave of absence, typically accompanied by a relative or friend. While briefly offsite, the resident (or the relative or friend, acting on the resident's behalf) obtains services that are subject to the consolidated billing requirement, but fails to notify the SNF. As in the previous scenario, this results in the services being furnished to the resident by an outside entity in the absence of a valid arrangement with the SNF. In addition, such a practice impedes the SNF from meeting its responsibility to provide comprehensive oversight of the resident's care and treatment.

SNFs can act to prevent such problems from arising by ensuring that each resident (and, if applicable, his or her representative) is fully aware of the applicable requirements. For example, the Medicare law at §1802 of the Act guarantees a beneficiary's free choice of any qualified entity that is willing to furnish services to the beneficiary. However, in selecting a particular SNF, the beneficiary has effectively exercised this right of free choice with respect to the entire package of services for which the SNF is responsible under the consolidated billing requirement, including the use of any outside suppliers from which the SNF chooses to obtain such services.

In addition, the LTC facility participation requirements at 42 CFR 483.10(b)(6) require the SNF to 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 include 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.

Moreover, while the SNF itself should take reasonable steps to prevent such problems from arising, the supplier in this scenario is also responsible for being aware of and complying with the consolidated billing requirements. This means that prior to furnishing services to a Medicare beneficiary, the supplier should routinely ascertain whether the beneficiary is currently receiving any comprehensive Medicare benefits

(such as SNF or home health benefits) for which Medicare makes a bundled payment that could potentially include the supplier's services. If the supplier ascertains that a particular beneficiary is, in fact, a resident of an SNF with which the supplier does not have a valid arrangement in place, then the supplier should contact the SNF before actually furnishing services to that beneficiary.