Mastering SNF Billing: Don't Leave Money on the Table

ECS SOLUTIONS
A Division of HW&Co.

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Conversations That Change Everything℠

Your Presenters

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Overview of Today's Session

- Staying up to date with Beneficiary Notices
- Managing Medicare as Secondary Payer
- Medicare Credit Balance Reports
- Compliant Billing with Medicare Informational Claims
- Where we are with the Targeted Probe and Educate Audit and other audit news
- Managed Care Tips – New CMS Mandates for managed care plans and other managed care news
- Cleaning up bad habits Post Pandemic
- Consolidated Billing Tidbits – Don't Pay What you Don't Owe
- Vaccine Billing

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Staying Up to Date with Medicare Beneficiary Notices

The Importance of Medicare Beneficiary Notices

- In order to shift liability to the beneficiary, Medicare says that a provider MUST notify a beneficiary in advance when the provider believes that items or services will likely be denied because they no longer meet coverage criteria under Medicare guidelines.
- If PROPER notice is not given, providers may not shift financial liability for the services to the beneficiary which can result in significant financial penalty to the facility.

Preventing Provider Liable Days

- A provider will likely have financial liability for items or services provided if:
  - The provider knew, or should have known, that Medicare would not pay and fails to issue the appropriate notice when required
  - The Provider issues a defective form:
    - Missing Signature
    - Signed but not dated
    - No box checked
    - Incomplete sections
    - Use of Medicare number vs medical record number
    - Alters the form

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Notice of Medicare Non-Coverage (NOMNC) & Provider Liable Days

- If the QIO determines that a provider did not deliver a valid NOMNC to a beneficiary, the provider is financially liable for continued services until two days after the beneficiary receives a valid notice; or until the effective date of the valid notice, whichever is later.

When to Provide NOMNC & DENC

- **Generic Notice/Expedited Review – CMS 10123-NOMNC**
  - For Traditional Medicare Part A, Part B, and Medicare Managed Care plans
  - Should be issued at least 2 days prior to cut date
  - Not used in benefit exhaust situations
- **Detailed Notice/Expedited Review – CMS 10124-DENC**
  - Used if beneficiary chooses to appeal the decision
  - Must be provided no later than the close of business day of the QIO's notification.

When to Provide SNF ABN or ABN

- **SNF Advanced Beneficiary Notice – CMS 10055-SNF ABN**
  - Used for a traditional Medicare Part A stay. **Never** used for Medicare Advantage plans.
  - Intended to inform the beneficiary that SNF has determined Medicare will not pay for stay and what their cost will be should they decided to remain in the facility.
  - Must be issued to beneficiary prior to terminating Part A services.
  - Can be used in situations such as benefit exhaust where no notice is required but recommended.
    - Referred to as a "voluntary" SNF ABN
- **Advanced Beneficiary Notice – CMS-R-131 - ABN**
  - Used for Part B services only.
  - Intended to inform the beneficiary that Medicare will not pay for Part B services.
  - Must be issued to beneficiary prior to initiating, reducing, or terminating services.
  - CMS updated form on 04/04/23, and to be used effective June 30, 2023.

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Medicare Beneficiary Notices

- Downloadable Expedited Determination Notices, Detailed Notice of Non-coverage, SNF ABN, and ABN can be found at this link:
  - https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices.html
- Large print and Spanish versions are also available.

Best Practices for Medicare Notices

- Designate a staff member who has a good understanding of Medicare Beneficiary Notices
- Know when a notice is required, and which form to use
- Ensure form is completed and delivered properly
- Make certain you are using the most up to date version of the form

The Challenges of Medicare as Secondary Payer

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Identifying MSP Situations

- Providers may gather MSP data using the HETS 270/271 (Medicare Verification)
- Data should then be reviewed with patient upon admission, but must be completed prior to submitting a claim to Medicare
- If using the HETS 270/271 transaction, the admission staff must ask the beneficiary if any insurance information found on the Common Working File has changed in lieu of asking all of the MSP questions
- If the beneficiary answers that there are no changes then there is no need to ask all of the questions
- A provider must still ask the MSP questions if there is any uncertainty regarding any information in the conversation
- A provider must make a notation for auditing purposes that all the questions were not asked upon admission , or during the telephone screening, based on the beneficiary's statement that their insurance information has not changed or does not require updating
- MACs shall request this notation and confirmation during reviews
- Note: Providers are still held liable to obtain the correct MSP information, so claims are billed to the correct primary payer accordingly per the CMS regulations 42 CFR 489.20
- CMS recommends that providers retain MSP information for 10 years.

Where to Find the MSP Model Questions

- Model Questions for MSP can be obtained from the Medicare Secondary Payer Manual, Chapter 3, 20.2.1.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf

Billing Medicare as Secondary

- Provider must first submit claim to the primary payer before submitting claim to Medicare
- Submit any MSP information on your Medicare claim using proper payment information, value codes, condition and occurrence codes, etc.
- Primary payer is required to process and make primary payment on the claim in accordance with the coverage provisions of the contract.
- If after the primary payer processes the claim, services are not paid in full, Medicare secondary benefits may pay for the services.

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MSP Claims

- MSP claims must adhere to all Medicare rules.
- Must have a qualifying 3-day hospital stay in order to bill Medicare as secondary.
- MDS should follow the Medicare assessment schedule, however MDSs for MSP claims are not submitted to iQIES (Internet Quality Improvement and Evaluation System).
- Normal timely filing requirements apply for Medicare-covered services.

Conditional Billing

- Allows provider to receive payment from Medicare if there is a delay with primary payer payment of more than 120 days.
- Does not apply to dual entitlements; Working Aged claims, ESRD claims, or Disability claims.
- If the primary payment is received after Medicare pays, Medicare must be refunded within 60-days of the overpayment.
- If payment is for an accident, liability monies can not be accepted if Medicare was billed conditionally.

Medicare Credit Balance Reports

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What is a Credit Balance Report?

- Providers use the quarterly CMS-838 (Credit Balance Report) to disclose Medicare credit balances.
- The CMS-838 is specifically used to monitor identification and recovery of "credit balances" owed to Medicare.
- A credit balance is an improper or excess payment made to a provider as the result of patient billing or claims processing errors.

Credit Balance Report Forms

- There are two forms associated with the Credit Balance Report. Links to both forms can be found at the bottom of this page
- The Certification Page that must be completed by all providers (CMS 838 form)
- The Detail Page which is required only if there are credit balances to report

https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms838.pdf

When is the Credit Balance Report Due?

- A completed CMS-838 must be submitted within 30 calendar days after the close of each calendar quarter.

Quarter	Quarter End	Credit Balance Report Due
1st	March 31	On or Before April 30
2nd	June 30	On or Before July 30
3rd	September 30	On or Before October 30
4th	December 31	On or Before January 30

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Penalty for Not Submitting Credit Balance Report Timely

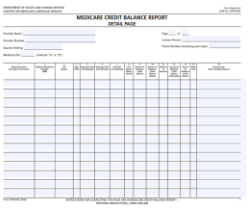
- If a complete and acceptable credit balance report is not received by the 15th calendar day after the credit balance report is due, a Suspension Warning Letter will be issued
- If a complete and acceptable credit balance report is not received within 15 calendar days from the date of the Suspension Warning Letter, all payments to the provider will be suspended until a complete and acceptable report is received and processed.

Submission of Credit Balance Report

- Can be faxed or mailed to Medicare Administrative Contractor
- Most MACs allow Credit Balance Report to be uploaded in the MAC Portal – (Preferred method)

CMS - 838


MEDICARE CREDIT BALANCE REPORT
CERTIFICATION PAGE


MEDICARE CREDIT BALANCE REPORT
DETAIL PAGE

Medicare Informational Claims Are you Compliant?

Medicare Informational Claims

- These bills have been required in three situations:
  - When the beneficiary has exhausted his/her 100 covered days under the Medicare SNF benefit.
  - When the beneficiary no longer needs a Medicare covered level of care.
  - When a beneficiary enrolled in a Medicare Advantage plan uses skilled days.
- Guidelines can be found in the Medicare Claims Processing Manual, Chapter 6.
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf

Informational Claims and Compliance

CMS requires informational claims to be submitted to track a beneficiary's Benefit Period even if no payment is expected from Medicare.	No-Pay and Benefit Exhaust claims required as of October 1, 2006.	Informational claims for Medicare Advantage plans required as of January 1, 2008.
A SNF is required to submit a claim for a beneficiary that has started a spell of illness under the SNF Part A benefit for every month of the related stay.	Unless the provider submits a correct no pay claim, CMS has no way of knowing if 60 days of non-covered skilled care has passed.	If the spell of illness is not broken, the patient will NOT be entitled to a new benefit period, even with a new illness or injury.

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Benefit Periods and Benefit Exhaust Claims

- Level of care is NOT determined by the payer source; it is determined by the services being provided.
  - It's important for nurses to be educated on the difference between benefit exhaust and level of care changes.
  - Medicaid and private pay residents can and do at times remain at a skilled level of care beyond his/her 100-day Medicare benefit period.
  - Skilled patients should continue to be followed in the UR meeting until they are no longer receiving a skilled service.
  - Exercise an efficient process for reporting level of care changes to the business office and biller.

What is a Medicare Benefit Period?

- Way to measure services
- 100 Skilled Nursing Days paid by Medicare per benefit period
- Begins with first admission to hospital after Medicare entitlement
- Ends when the person has not been an inpatient of a hospital or received skilled care in a nursing home for 60 consecutive days
- Not based on calendar year or specific diagnosis
  - A new diagnosis will not provide a new benefit period
- As long as skilled care continues, the benefit period remains open, even if the benefits have exhausted

Benefits Exhaust Claim

- A SNF must submit a benefit exhaust claim monthly to Medicare for a beneficiary who continues to receive skilled services until there is a change in the level of care
- This is regardless of who the payer is beyond the Medicare 100-day benefit period
- Part B claims (22X) bill types must be submitted after the benefit exhaust claim has processed

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Types of Benefit Exhaust Claims

- **There are two types of benefit exhaust claims**
  - **Partial Benefit Exhaust Claims** – Only one or some benefit days in the beneficiary's applicable benefit period remain for the submitted statement covers from/thru date of the claim.
  - **Full Benefit Exhaust Claims** – No benefit days remain in the beneficiary's applicable benefit for the submitted statement covers from/thru date of the claim.

Coding of the Benefit Exhaust Claim

- Appropriate covered type of bill (210 is not appropriate)
- HIPPS ZZZZZ
- Occurrence Span Code 70 with the dates of the qualifying stay
- All days and charges submitted as covered
- Value Code 09 with $1.00
- Appropriate Patient Status Code

Medicare No-Pay Claims

- In addition to the Benefit Exhaust claim, SNF providers are required to submit No-Pay claims if the patient continues to reside in a SNF bed.
- No-Pay claims reset the benefit period when the care level has changed.
- The No-Pay claim may span multiple months but must be as often as necessary to meet timely filing guidelines.
- ECS/HW&Co. recommends to submit at the end of the Medicare fiscal year (September 30th) but can span both the provider and Medicare fiscal year end dates.
- Required up until a resident is discharged from a SNF bed.

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Coding of the Medicare No-Pay Claim

- Claims are submitted as 210 bill types
- Submit with value code 81 indicating days as non-covered
- Submit with appropriate status code
- HIPPS code ZZZZZ
- Show as non-covered days and charges
- Condition Code 21 is used indicating non-disputed liability
- Part B claims should be submitted prior to the No-Pay claim being submitted
- Claims must be followed up on to ensure they have processed correctly with Reason Code 31992 or 39934

Medicare Advantage No-Pay Claims

- Providers are required to submit an informational claim to Medicare when a beneficiary is enrolled in a Medicare Advantage Plan
- The days reported will be subtracted from the patient's benefit period
- Informational claims keep the Common Working File correct for beneficiaries by tracking the 100-days in the benefit period
- Required until the 100-days are used and level of care changes

Coding of the MCR Advantage No-Pay Claim

- Duplicate the Medicare Managed Care Claim
- Change payee to Medicare
- Change Policy Number to Medicare Beneficiary Number (MBI)
- Remove authorization number
- Bill as covered care with condition code 04
- When a resident is cut from skilled care by a MA plan, discharge with status code 04.
- No additional bills are required
- Claims will process but not pay. Processed claim will show as "R" with Reason Code 37191 in DDE

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Tips on Information Claims

- Create a tracking log to monitor Level of Care changes
- Track patients who remain at a skilled level of care through your UR meeting. When level of care drops from skilled, notify billing office.
- Review census each month for discharges including discharges to hospice
- Monitor claims for correct processing
  - Note: MACs may use different reason in codes to indicate correctly processed claims

5 Claim Targeted Probe & Educate Audit

CMS Targeted Probe & Educate

- CMS Mandated Medicare Administrative Contractors perform a 5-claim probe and educate audit on every SNF provider
- In June of 2023 providers began seeing additional development requests related to this program
- MACs complete 1 round of probe and educate for each provider instead of the normal 3 rounds
- Education will be offered based on finding

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What We Are Seeing

- Claims that go to a "T" status in DDE and are corrected in DDE appear to be most often targeted for this review, especially claims that continued to be billed using the DR condition code.
- Many providers are not faring well
- Focus on physician certifications and re-certifications
- Also looking at diagnosis codes on the claim that not substantiated on MDS or documentation therefore claims are being down coded

Recovery Audits are on the Rise

- Recovery Audits appear to be on the ***rise***
- They are also focusing on Physician Certifications and Re-Certifications

Recovery Audit Contractors

- RAC will send additional development requests (ADR)
- These audits are typically post pay
- Follow the instructions in the request on how to return the necessary documentation
- Pay close attention to timeframes
- Put documentation in the order that it is requested in the ADR
- Make certain to include the physician certification and re-certification if appropriate
- If decision is unfavorable provider has 30 days to file a redetermination with the MAC

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Managed Care Updates

New Rules for Advantages Plans

- Reenforces the requirement that MA plans must cover basic Medicare benefits like traditional Medicare and lists additional Medicare coverage resources to guide those decisions. They are not permitted to impose more restrictive criteria.
- The rule also includes restrictions regarding the use of artificial intelligence (AI) and technology that can be used in making decisions regarding ending coverage.
- Provides limits for when prior authorizations can be used. Under the new rule, plans have 3 days to send prior authorization decisions for expedited requests and 7 days for standard requests.
- The rules require that plans make coverage decisions based on individual needs and circumstances. They cannot use blanket rules for the duration of a course of treatment.

New Rules for Advantages Plans

- Requires physician recommendations be considered when making medical necessity determinations, i.e., when a physician orders SNF services instead of home health services unless the plan can prove the services are not medically necessary or appropriate.
- Prohibits plans from retroactively denying an approved, medically necessary service unless there is good cause. It provides clarification of what "good cause" is or the plan must provide "reliable evidence of fraud."
- Plans are required to provide a minimum 90-day transition period from one plan to another for beneficiaries in the middle of an active course of treatment without prior authorization.
- When a plan denies coverage, the denial is required to be reviewed by a provider that has expertise in the area of the service that is being denied.
- Plans must also disclose the internal criteria they used to make a decision to deny services and must provide a specific reason for that prior authorization denial.
- Established several additional marketing prohibitions to protect beneficiaries from deceptive practices.

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Cleaning Up Bad Habits Post Pandemic

Tips & Tricks to Clean Up Bad Habits

- Review and Update Billing Processes
  - Identify any inefficiencies or errors and streamline processes where possible to reduce the likelihood of mistakes.
  - Locate & review your Managed Care contracts!
- Stay Updated on Regulatory Changes
  - Regulations constantly change!
  - Stay informed about any updates or changes to billing requirements to ensure compliance and accuracy in your billing practices.
- Invest in Training
  - Provide comprehensive training to your billing staff to ensure they understand current regulations and best practices.
  - Regular training sessions can help reinforce good habits and correct any misunderstandings.

Tips & Tricks to Clean Up Bad Habits

- Implement Quality Assurance Measures
  - Establish quality assurance measures to review billing documentation and claims before submission
  - Does your facility participate in a Medicare Triple Check meeting?
- Utilize Technology
  - Is your billing software/clearing house user friendly?
  - Invest in billing software or electronic health record systems that can help streamline billing processes and reduce the likelihood of errors.
  - Remember – No billing software program is 100% accurate!
- Maintain Accurate Documentation
  - Ensure that all patient records are complete, detailed, and up-to-date to support the services billed.
    - Post Pay Audits – Never really went away but back with a vengeance!
    - Physician Certs – Are these completed & signed appropriately?
    - NOMNC's & ABN's – Are these completed accurately & delivered timely?

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Tips & Tricks to Clean Up Bad Habits

- Monitor Accounts Receivable (AR) Aging
  - Keep a close eye on your accounts receivable aging to identify any outstanding claims, delayed payments, rate issues, etc. to prevent cash flow issues and excessive write offs.
  - Do you notice any Days in Sales Outstanding (DSO) trends?
- Communicate with Payers
  - Establish open lines of communication to address billing concerns or disputes promptly.
  - Building positive relationships with payers can help resolve issues more efficiently.
- Seek Professional Assistance if Needed
  - Don't be afraid to reach out to billing consultants or other professionals who specialize in SNF billing if you are struggling to clean up bad billing habits.

Consolidated Billing – Don't Pay What you Don't Owe

Review Your Invoices!

- Make it a point to review your invoices from Hospitals, Clinics, and other Ancillary Service providers.
- Too often a SNF pays bills from any other ancillary provider of service without checking to ensure is it ***really*** the SNF's responsibility to pay.

It is important to know and understand Consolidated Billing and the guidelines under Part A for SNF responsibility

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What is Consolidated Billing?

- Consolidated billing began as a result of the BBA of 1997 and the onset of the PPS reimbursement system for Part A
- The consolidated billing provision requires that, effective for services and items furnished on or after July 1, 1998, payment is made directly to the SNF
- Patient service costs bundled back to SNF – Except for specific services deemed to be excluded, most services provided to the Medicare Part A SNF patient are paid for by SNF & listed on the facility's Part A claim
- The SNF is reimbursed by an all-inclusive HIPPS rate determined by and based on the patient's level of care and other requirements.

Two Types of Consolidated Billing

- **Consolidated billing for Part A**
  - ALL services except those deemed as EXCLUDED
- **Consolidated billing for Part B**
  - Therapy Services – PT, OT, ST, SLP
  - SNF must bill for all therapy for patients who reside in a Medicare certified bed

Know Your Components of Consolidated Billing

- **Professional Component**
  - Direct services of physician or medical professional. His or her time, expertise, or service.
  - "The reading, examination or interpretation of specimen or procedure."
- **Professional component is always *EXCLUDED***.

Know Your Components of Consolidated Billing

- **Technical Component**
  - Actual test or procedure
  - "The physical part of attaining the specimen, performing procedure, or taking the x-ray"
- The technical component is normally included in consolidated billing and the responsibility of the SNF.

Included or Excluded?

- **Use CMS Exclusion list on CMS website**
  - https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/Downloads/2019-General-Explanation.pdf
- **General Explanation of Major Categories** shows how to read exclusion file & detailed information on exclusions.

Major Category I Items are Location Driven

- **Ensure all Major Category I procedures are performed in a hospital**
  - A. CT Scans (Computerized Axial Tomography)
  - B. Catheterization
  - C. MRIs (Magnetic Resonance Imaging)
  - D. Radiation Therapy
  - E. Angiography, Lymphatic, Venous, and Related Procedures
  - F. Certain Outpatient Surgery and Related Procedures
  - G. Emergency Services
  - H. Medically Necessary Ambulance Trips (For Excluded Major Categories)
  - I. Additional Surgery HCPCS - EXCLUSIONS

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Emergency Room Visit

- G. Emergency Services: These services are identified on claims submitted to Part A MACs by a hospital or CAH using revenue code 045x (Emergency Room—"x" represents a varying third digit). Related services with the same line item date of service (LIDOS) are also excluded. Note that in order to get a match on the LIDOS there must be a LIDOS and HCPCS in revenue code 045x.
- Note: In order to bypass services related to the ER encounter, which are performed on subsequent service dates, hospitals must identify those services by appending a modifier ET (Emergency Services) to those line items. Please review Change Request 5389 for further information.

Emergency Room Example

0307	LAB/UROLOGY	81003	071016	1	53 99
0324	DX X-RAY/CHEST	71010	071016	1	531 00
0402	ULTRASOUND	76770	071116	1	1374 00
0410	RESPIRATORY SVC	94640	071016	1	195 00
0410	RESPIRATORY SVC	94640 76	071016	1	166 00
0420	PHYSICAL THERP	G8978 GPCL	071116	1	0 01
0420	PHYSICAL THERP	G8979 GPCK	071116	1	0 01
0424	PHYS THERP/EVAL	97001 GP	071116	1	580 00
0430	OCCUPATION THER	G8987 GOCL	071116	1	0 01
0430	OCCUPATION THER	G8988 GOCK	071116	1	0 01
0434	OCCUP THERP/EVAL	97003 GO	071116	1	580 00
0440	SPEECH PATHOL	G8996 GNCJ	071116	1	0 01
0440	SPEECH PATHOL	G8997 GNCI	071116	1	0 01
0444	SPEECH PATH/EVAL	92510 GN	071116	1	754 00
0450	EMERG ROOM	96361	071016	1	222 00
0450	EMERG ROOM	99285 25	071016	1	2372 00
0636	DRUGS/DETAIL CODE	J1650	071116	3	11 03
0636	DRUGS/DETAIL CODE	J3490	071116	10	25 00
0730	EKG/ECG	93005	071016	1	480 00
0730	EKG/ECG	93005	071116	1	480 00
0761	TREATMENT RM	96365	071116	1	486 00
0761	TREATMENT RM	96365	071116	1	222 00

Chemo Therapy Example

0300	LABORATORY OR LAB	36415	012419	1	15 00
0301	LAB/CHEMISTRY	80053	012419	1	50 00
0301	LAB/CHEMISTRY	84443	012419	1	98 00
0305	LAB/HEMATOLOGY	85025	012419	1	28 00
0335	CHEMOTHERP-IV	96413	012419	1	323 00
0335	CHEMOTHERP-IV	96417	012419	2	580 00
0335	CHEMOTHERP-IV	96413	012819	1	323 00
0343	NUC MED/DX RADIOPHARM	A9552	012319	1	278 00
0404	PET SCAN	78815	012319	1	3435 00
0636	DRUGS/DETAIL CODE	J2405 TB	012419	12	11 22
0636	DRUGS/DETAIL CODE	J7059	012419	4	88 08
0636	DRUGS/DETAIL CODE	J1453 TB	012419	150	971 78
0636	DRUGS/DETAIL CODE	J9022 TB	012419	126	25407 97
0636	DRUGS/DETAIL CODE	J9045 TB	012419	16	553 72
0636	DRUGS/DETAIL CODE	J9181 TB	012419	17	87 75
0636	DRUGS/DETAIL CODE	J7040 TB	012419	1	28 07
0636	DRUGS/DETAIL CODE	J7059	012519	1	22 02
0636	DRUGS/DETAIL CODE	J2405 TB	012519	12	11 22
0636	DRUGS/DETAIL CODE	J9181 TB	012519	17	87 75
0636	DRUGS/DETAIL CODE	J7040 TB	012519	1	28 07
0636	DRUGS/DETAIL CODE	J2405 TB	012819	12	11 22
0636	DRUGS/DETAIL CODE	J7059	012819	1	22 02
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	MEDICARE		Y Y	9925 91	
	MEDICAID		Y Y	3898 80	

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What Transportation is Excluded?

- Initial trip from hospital to SNF
- Trip to hospital for an inpatient hospital admission
- Trip to emergency room
- Trip to beneficiary's home to receive services from Medicare Certified HHA
- Trip to receive Major Category I excluded services
- Trip to receive dialysis at ESRD Clinic
- Formal discharge from the SNF not followed by a re-admission to the same or another SNF by midnight of the same day

Medically Necessary

- For ambulance trips to be excluded, they must be deemed and proved to be medically necessary.
- Non-ambulance transportation can be charged to private pay residents even if in a Part A stay.

Transportation

- Medicare does not provide coverage under Part A or Part B for any non-ambulance forms of transportation such as wheelchair van or ambulette transportation
- The beneficiary is financially liable to pay when they can be transported safely by other means.
- If the beneficiary has Medicaid, Medicaid may pay

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Ambulance Transfers Between Two SNFs

- Medically necessary ambulance transportation between SNFs is included in consolidated billing and the discharging facility is responsible for payment of the transportation when the transportation required is because the needed care is unavailable at the originating SNF
- A SNF-to SNF transfer prompted by non-medical considerations is not considered reasonable and necessary and would not be the responsibility of the SNF
  - https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c06.pdf

Best Practices to Prevent Losses

- **Designate a staff member to be knowledgeable in consolidated billing**
  - Understand what items are Included and excluded
  - Ambulance Invoices – Common expense paid in error by SNF
  - Review all vendor bills to make sure you are only paying what is INCLUDED in consolidated billing
- **Explain to patients how the process works and why** they must receive their radiation therapy and other Major Category I services from the hospital as opposed to a freestanding clinic
- **Know who and what services will be provided to your patient prior to them leaving your facility**

Best Practices to Prevent Losses

- **Send a letter with the patient** to give to the outside provider to ensure the provider understands the patient is in a Part A stay at your SNF.
- **Look up the Medicare Fee Screen prior to paying any charges** your facility is responsible for.
- **Have contracts in place with Providers/Vendors to only pay the Medicare Fee Screen or less.**
- **Contact the hospital or vendor when billed for anything** that is not your responsibility
  - Provide copies of guidelines when necessary

Know what you are responsible for prior to paying any invoice!

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Vaccine Billing

Part B Vaccine Billing

- SNFs can still roster bill for the flu, pneumonia and COVID-19 vaccine and administration to traditional Medicare
- If the individual is enrolled in a Medicare Advantage plan, you must submit the claim to the plan
- Make certain you are billing with the correct CPT code as each drug and dose have a separate CPT code
- Can be billed to Part B even when the client is in a Part A stay
- Can be roster billed in DDE

Vaccine Coding

- Type of Bill – 22X or 23X
- Revenue codes:
  - 0636 - Vaccine
  - 0771 – Vaccine Administration
- Diagnosis Code
  - Z23
- Condition Code
  - A6

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Vaccine Coding

- CPT Codes
- https://www.cms.gov/medicare/payment/all-fee-service-providers/medicare-part-b-drug-average-sales-price/vaccine-pricingt

RSV Vaccine

- Only covered under Part D so it is not billable by the SNF
- If SNF administers vaccine, should negotiate with pharmacy for reimbursement of administration fee
  - Billing Medicare for Respiratory Vaccines (ahcancal.org)

Let's Talk

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