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BROAD RIVER REHAB

Consolidated Billing: What you need to know!

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Agenda

Consolidated Billing

Agenda

- A History of Consolidated billing
- General Consolidated Billing Principles
- Excluded vs. Not Excluded
- General Exclusion Categories
- Annual Update
- Management Strategy

CB Resources

- **CMS 100-4 Chapter 6:** https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf
- **Background:** https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/ConsolidatedBilling
- **General Explanation of Major Categories:** https://www.cms.gov/files/document/general-explanation-major-categories-snf-cb.pdf-1
- **Historical Q&A:** https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/historyQA.pdf
- **Annual Updates:** https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling
- **Best Practice Guidelines:** https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/BestPractices

CB History

- In the Balanced Budget Act of 1997, Congress mandated that payment for the majority of services provided to beneficiaries in a Medicare covered SNF stay be included in a bundled prospective payment made through the Part A Medicare Administrative Contractor (MAC) to the SNF.
- These bundled services had to be billed by the SNF to the Part A MAC in a consolidated bill.
- No longer would entities that provided these services to beneficiaries in a SNF stay be able to bill separately for those services.
- Medicare beneficiaries can either be in a Part A covered SNF stay which includes medical services as well as room and board, or they can be in a Part B non-covered SNF stay in which certain medical services are still covered though room and board is not.
- The consolidated billing requirement confers on the SNF the billing responsibility for the entire package of care that residents receive during a covered Part A SNF stay and physical, occupational, and speech therapy services received during a non-covered stay.
- **Exception:** There are a limited number of services specifically excluded from consolidated billing, and therefore, separately payable.

CB History

- In effect, SNFs can no longer “unbundle” services that are subject to CB to an outside supplier that can then submit a separate bill directly to the Part B carrier.
- Instead, the SNF itself must furnish the services, either directly, or under an “arrangement” with an outside supplier in which the SNF itself (rather than the supplier) bills Medicare. The outside supplier must look to the SNF (rather than to Medicare Part B) for payment.
- In addition, CB:
  - Provides an essential foundation for the SNF PPS, by bundling into a single facility package all of the services that the PPS payment is intended to capture;
  - Spares beneficiaries who are in covered Part A stays from incurring out-of-pocket financial liability for Part B deductibles and coinsurance;
  - Eliminates potential for duplicative billings for the same service to the Part A fiscal intermediary (FI) by the SNF and to the Part B carrier by an outside supplier; and
  - Enhances the SNF's capacity to meet its existing responsibility to oversee and coordinate each resident's overall package of care.

CB Principles

- Under the SNF PPS all Medicare covered Part A services that are considered within the scope or capability of SNFs are considered paid in the PPS rate.
- In some cases, this means that the SNF must obtain some services that it does not provide directly. Neither the SNF nor another provider or practitioner may bill the program for the services under Part B, except for services specifically excluded from PPS payment and associated consolidated billing requirements.
- Under the CB requirement, the SNF must submit ALL Medicare claims for ALL the services that its residents receive under Part A, except for certain excluded services and for all physical, occupational and speech-language pathology services received by residents under Part B
- CB principles apply for beneficiaries who have been admitted to the SNF and are considered ‘SNF residents”. When that status ends, i.e., when the resident is admitted as an inpatient to a hospital or is out of the facility at midnight, SNF CB rules no longer apply.

CB Principles

- SNFs are no longer able to “unbundle” services to an outside supplier that can then submit a separate bill directly to an A/B MAC (B) or DME MAC for residents in a Part A stay, or for SNF residents receiving physical therapy, occupational therapy, and/or speech-language pathology services paid under Part B.
- Instead, the SNF must furnish the services either directly or under an arrangement with an outside supplier or provider of services in which the SNF (rather than the supplier or provider of services) bills Medicare.
- Medicare does not pay amounts that are due a provider to any other person under assignment, or power of attorney, or any other direct payment arrangement. As a result, the outside supplier must look to the SNF (rather than the A/B MAC (A), or (B), or DME MAC or the beneficiary) for payment. The SNF may collect any applicable deductible or coinsurance from the beneficiary.
- Enforcement of CB is done through editing in Medicare claims processing systems using lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the CB provision of SNF PPS. In order to assure proper payment in all settings, Medicare systems must edit for services, provided to SNF beneficiaries, both included and excluded from CB.

CB Principles

- The list of HCPCS codes enforcing CB may be updated each quarter. For the notice on CB for the quarter beginning January, separate instructions are published for A/B MACs (A) and A/B MACs (B)/DME MACs. Since this is usually the only quarter in which new permanent HCPCS codes are produced, **this recurring update is referred to as an annual update.** Other updates for the remaining quarters of the year will occur as needed prior to the next annual update.
- Effective July 1, 1998, CB became effective for those services and items that were not specifically excluded by law from the SNF prospective payment system (PPS) when they were furnished to residents of a SNF in a covered Part A stay and also includes physical therapy, occupational therapy, and/or speech-language pathology services in a noncovered stay. SNFs became subject to CB once they transitioned to PPS.
- Consolidated billing does not apply to a nursing home that is not Medicare-certified, such as:
  - A nursing home that does not participate at all in either the Medicare or Medicaid programs;
  - A non-certified part of a nursing home that also includes a participating distinct part SNF unit; and
  - A nursing home that exclusively participates in the Medicaid program as an NF.

CB Principles

- **Services Provided Under Arrangement**
  - 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) under an “arrangement,”.
  - Under such an arrangement, the SNF must reimburse the outside entity for those Medicare-covered services that are 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.
  - Several problematic situations have been identified where the SNF resident receives services that are subject to consolidated billing from an outside entity, such as a supplier. such situations most commonly arise in one of the following two scenarios:
  - 1) A SNF does not accurately identify services as being subject to consolidated billing when ordering such services from a supplier or practitioner; or
  - 2) A supplier fails to ascertain a beneficiary’s status as a 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.

CB Principles

- **Services Provided Under Arrangement (cont.)**
  - The absence of a valid arrangement in these situations creates confusion and friction between SNFs and their suppliers. Suppliers need to understand which services are subject to consolidated billing to avoid situations where they might improperly attempt to bill the A/B MAC (B) (or other payers such as Medicaid and beneficiaries) directly for the services.
  - In addition, both parties need to reach a common understanding on the terms of payment; e.g., how to submit an invoice, how payment rates will be determined, and the turn-around time between billing and payment. Without this understanding, it may become difficult to maintain the strong relationships between SNFs and their suppliers that are necessary to ensure proper coordination of care to the Medicare beneficiaries.
  - It is important to note that the absence of a valid arrangement does NOT invalidate the SNF's responsibility to reimburse suppliers for services included in the SNF "bundle" of services represented by the SNF PPS global per diem rate.
  - **This obligation applies even in cases where the SNF did not specifically order the service**; e.g., during a scheduled physician's visit, the physician performs additional diagnostic tests that had not been ordered by the SNF; a family member arranges a physician visit without the knowledge of SNF staff and the physician bills the SNF for "incident to" services.

CB Principles

- **Services Provided Under Arrangement (cont.)**
  - If a SNF elects to utilize an outside supplier to furnish medically appropriate services that are subject to consolidated billing, but then refuses to reimburse that supplier for the services, then there is no valid arrangement
  - **Not only would this potentially result in Medicare's noncoverage of the particular services at issue, but a SNF demonstrating a pattern of nonpayment would also risk being found in violation of the terms of its provider agreement.**
  - Problems involving the absence of a valid arrangement between an SNF and its suppliers typically tend to arise in one of the following two situations.
    - **Problem Scenario 1**: 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.
    - **Problem Scenario 2**: A resident 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.
  - The arrangement must also comply with the fraud and abuse laws (see Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, chapter 1, section 20.3, and Pub. 100-04, Medicare Claims Processing Manual, chapter 6, section 80.5) as well as anti-kickback provisions in section 1128B(b) of the Social Security Act.

Excluded Services

- **Physician Services**
  - Physician's professional services and services of certain nonphysician providers are excluded from Part A PPS payment and the requirement for consolidated billing, and must be billed separately by the practitioner to the A/B MAC (B).
    - Physician assistants, working under a physician's supervision;
    - Nurse practitioners and clinical nurse specialists working in collaboration with a physician;
    - Certified nurse-midwives;
    - Qualified psychologists; and
    - Certified registered nurse anesthetists.
    - See list of provider specialty codes on pages 17-18 of CMS 100-4 Ch. 6
  - For this purpose "physician service" means the professional services of the physician as defined under the Medicare physician Fee Schedule. For services that contain both a technical component and a professional component, the technical component, if any, must be billed by the SNF for its Part A inpatients.
  - The A/B MAC (B) will pay only the professional component to the physician. For example, the technical component of a diagnostic radiology test (representing the performance of the procedure itself) is subject to SNF CB, whereas the professional component (representing the physician's interpretation of the test results) is excluded and, thus, remains separately billable under Part B.

Excluded Services

- **Physician Services (cont.)**
  - This exclusion applies specifically to those professional services that ordinarily require performance by the practitioner personally (see the regulations at 42 CFR 411.15(p)(2)(i) and 415.102(a)(3)).
  - This means, for example, that an otherwise bundled task (such as a routine blood draw) cannot be converted into an excluded physician service merely by having a physician perform it personally, as such a task does not ordinarily require performance by the physician.
  - This exclusion also **does not encompass services that are performed by someone else as an *incident to* the practitioner's professional service.** Such *"incident to"* services remain subject to SNF CB and, accordingly, must be billed to Medicare by the SNF itself. (See MLN Matters SE0441).
    - To qualify as "incident to," services must be part of your patient's normal course of treatment, during which a physician personally performed an initial service and remains actively involved in the course of treatment.
    - Examples of qualifying "incident to" services include cardiac rehabilitation, providing non-self-administrable drugs and other biologicals, and supplies usually furnished by the physician in the course of performing his/her services (for example, gauze, ointments, bandages, and oxygen).

Excluded Services

- **Physician Services (cont.)**
  - **RHC/FQHC Instructions:** Effective January 1, 2005, section 410 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) amended the SNF consolidated billing law to specify that when a SNF's Part A resident receives the services of a physician (or another type of practitioner that the law identifies as being excluded from SNF consolidated billing) from a RHC or a FQHC, those services are not subject to CB merely by virtue of being furnished under the auspices of the RHC or FQHC. Accordingly, under section 410 of the MMA, services otherwise included within the scope of RHC and FQHC services that are also described in clause (ii) of section 1888(e)(2)(A) are excluded from consolidated billing, effective with services furnished on or after January 1, 2005. Only this subset of RHC/FQHC services may be covered and paid separately when furnished to SNF residents during a covered Part A stay (see the regulations at 42 CFR 411.15(p)(2)(xvii) and 405.2411(b)(2)).
  - When a beneficiary receives clinic services from a hospital-based physician, the physician in this situation would bill his or her own professional services directly to the A/B MAC (B) and would be reimbursed at the facility rate of the Medicare physician fee schedule - which does not include overhead expenses. The hospital historically has submitted a separate Part B "facility charge" for the associated overhead expenses to its A/B MAC (A). The hospital's facility charge does not involve a separate service (such as a diagnostic test) furnished in addition to the physician's professional service; rather, it represents solely the overhead expenses associated with furnishing the professional service itself. Accordingly, hospitals bill for "facility charges" under the physician evaluation and management (E&M) codes in the range of 99201-99245 and G0463 (for hospitals paid under the Outpatient Prospective Payment System). E&M codes, representing the hospital's "facility charge" for the overhead expenses associated with furnishing the professional service itself, are excluded from SNF CB.

Excluded Services

- **Major Category I - Exclusion of Services Beyond the Scope of a SNF**
  - **These services must be provided on an outpatient basis at a hospital, including a critical access hospital (CAH) only**, not by a SNF, and are excluded from SNF PPS and CB for beneficiaries in a Part A stay. Services directly related to these services, defined as services billed for the same place of service and with the same line item date of service as the services listed below, are excluded from SNF CB

A. Computerized Axial Tomography (CT) Scans

B. Cardiac Catheterization

C. Magnetic Resonance Imaging (MRIs)

D. Radiation Therapy

E. Angiography, Lymphatic, Venous and Related Procedure s

F. Outpatient Surgery and Related Procedure s– INCLUSION (see note below)

Note : Inclusions, rather than exclusions, are given in this one case, because of the great number of surgery procedures that are excluded and can only be safely performed in a hospital operating room setting. It is easier to automate edits around the much shorter list of inclusions under this category, representing minor procedures that can be performed in the SNF itself.

Excluded Services

- **Major Category I - Exclusion of Services Beyond the Scope of a SNF (cont.)**

  G. Emergency Service

  H. Ambulance Trips (See Sample Notification #2 handout)

  - In order for the Part A SNF benefit to cover transportation via ambulance, the regulations at 42 CFR 409.27(c) specify that the ambulance transportation must be medically necessary, that is, the patient's condition is such that transportation by any means other than ambulance would be medically contraindicated.

  - This means that in a situation where it is medically feasible to transport an SNF resident by some means other than an ambulance, for example, via wheelchair van, an ambulance would not be covered (because the use of an ambulance in such a situation would not be medically necessary). Medicare simply does not provide any coverage at all under Part A or Part B for any non-ambulance forms of transportation, such as ambulette, wheelchair van, or litter van.

Ambulance Trips

Under the consolidated billing provisions, the ambulance service should bill Medicare directly for the following services because they are excluded from consolidated billing under SNF PPS:

__ The initial trip to the SNF before the patient is a SNF resident

__ The trip that conveys the beneficiary at the end of the stay as per 42 CFR 411.15(p)(3)(i)-(iv) and ends the patient's status as a SNF resident:

__A trip for inpatient admission to a Medicare-participating hospital or critical access hospital (CAH)

__A trip to the beneficiary's home to receive services from a Medicare-participating home health agency under a plan of care

__A trip to a Medicare-participating hospital or CAH for the specific purpose of receiving emergency services or certain other intensive outpatient services that are not included in the SNF's comprehensive care plan

____Emergency room; ____Cardiac catheterization; ____Computerized axial tomography (CT) scans; ____ Magnetic resonance imaging (MRIs); ____ Ambulatory surgery involving the use of an operating room (including PEG tube removal, replacement, and insertion); ____Radiation therapy; ____Angiography; and ____ Lymphatic and venous procedures.

__A formal discharge (or other departure) from the SNF that is not followed by readmission to that or another SNF by midnight of that same day

__A trip necessary to transport a SNF resident offsite to receive Part B dialysis service

Excluded Services

- **Major Category II - Additional Services Excluded when Rendered to Specific Beneficiaries**
  - These services must be provided to specific beneficiaries, either: (A) End Stage Renal Disease (ESRD) beneficiaries, or (B) beneficiaries who have elected hospice, by specific licensed Medicare providers, and are excluded from SNF PPS and consolidated billing. SNFs will not be paid for Category II.A. Services (dialysis, etc.) when the SNF is the place of service, as to receive Medicare payment, these services must be provided in a renal dialysis facility. Hospices must also be the only type of provider billing hospice services.

A. Dialysis, EPO, Aranesp, and Other Dialysis Related Services for ESRD Beneficiaries

- Beneficiaries with ESRD may receive dialysis and dialysis related services from a hospital-based or free-standing RDF or may receive home dialysis supplies and equipment from a supplier. Home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies (other than those that are furnished or arranged for by the SNF itself) are not included in the Part A PPS payment. They may be billed separately to the A/B MAC (A) by the hospital or ESRD facility as appropriate. Note that SNFs may not be paid for home dialysis supplies.

- **NOTE:** When epoetin alfa (EPO) or darbepoetin alfa (Aranesp) are given by the dialysis facility in conjunction with dialysis, these drugs are excluded and must be billed by the RDF. These drugs for non- ESRD use are always bundled to the SNF for beneficiaries in a covered Part A stay.

Excluded Services

- **Major Category II - Additional Services Excluded when Rendered to Specific Beneficiaries**

  - Services that fall outside the scope of the Part B dialysis benefit do not qualify for the dialysis exclusion from SNF CB.

  - Similarly, the SNF CB exclusion described above for Erythropoiesis Stimulating Agents does not encompass situations involving their use for a non-dialysis purpose (such as ameliorating the side effects of chemotherapy treatments). The Part B dialysis benefit generally does not cover dialysis for those beneficiaries who do not have ESRD.

  - However, an exception involves “acute” dialysis (HCPCS code G0491), for patients who do not have ESRD but require dialysis temporarily following an acute kidney injury (AKI) from a severe medical trauma (such as a drug overdose or a traffic accident). In contrast to maintenance dialysis for ESRD patients (who, in the absence of a kidney transplant, would remain on periodic dialysis indefinitely), there is an expectation with acute dialysis that the patient’s own kidneys will eventually recover and resume their normal function.

B. Hospice Care for a Beneficiary’s Terminal Illness

- Hospice care related to a beneficiary’s terminal condition is excluded from SNF PPS and consolidated billing. Services unrelated to the beneficiary’s terminal condition are included in SNF PPS and consolidated billing.

Excluded Services

- **Major Category III - Additional Excluded Services Rendered by Certified Providers**
  - These services may be provided by any Medicare provider licensed to provide them, except a SNF, and are excluded from SNF PPS and consolidated billing.

A. Chemotherapy

- The excluded chemotherapy codes serve to identify those high-intensity chemotherapy drugs that are not typically administered in a SNF, are exceptionally expensive, or require special staff expertise to administer.

- By contrast, chemotherapy drugs that are relatively inexpensive and are administered routinely in SNFs do not qualify for this exclusion and, thus, remain subject to SNF CB.

- Further, this exclusion would not encompass any related items that, while commonly furnished in conjunction with chemotherapy, are not themselves inherently chemotherapeutic in nature (that is, they specifically address the side effects of the chemotherapy rather than actively fighting the cancer itself). Examples of such chemotherapy-related drugs would include anti-emetics (anti-nausea drugs), as well as drugs that function as an adjunct to an anti-emetic, such as an anti-anxiety drug that helps to relieve anticipatory nausea. These related drugs would remain subject to SNF CB.

- Similarly, if a drug designated by one of the excluded chemotherapy codes is prescribed for a use that is not actually associated with fighting cancer, it would no longer be considered an excluded “chemotherapy” drug in such an instance, because it is not being used for a chemotherapeutic purpose within the meaning of this exclusion.

Excluded Services

- **Major Category III - Additional Excluded Services Rendered by Certified Providers**

  A. Chemotherapy Administration

  - Note : Chemotherapy Administration codes listed with an asterisk (*) in the file are included in SNF PPS payment for beneficiaries in a Part A stay when performed alone or with other surgery, but are excluded if they occur with the same line item date of service as an excluded chemotherapy agent.

  - Codes listed w/o an asterisk (*) are treated the same as those with an (*) for all providers except hospitals, including CAHs. Codes w/o an (*) are excluded surgery codes and may be billed w/o a chemotherapy agent in hospital settings only

  C. Radioisotope s and their Administration

  D. Customized Prosthetic Devices

  E. Certain blood clotting factors indicated for the treatment of hemophilia and other bleeding disorders, and items and services related to the furnishing of such factors.

Excluded Services

- **Major Category IV - Additional Excluded Preventive and Screening Services**
  - The Part A SNF benefit is limited to services that are reasonable and necessary to “diagnose or treat” a condition that has already manifested itself. Accordingly, this benefit does not encompass screening services or preventive services.
  - Coverage of screening and preventive services is a separate Part B inpatient benefit when rendered to beneficiaries in a covered Part A stay and is paid outside of the Part A payment rate.
  - For this reason, screening and preventive services must not be included on the global Part A bill. However, screening and preventive services remain subject to consolidated billing and, thus, must be billed separately by the SNF under Part B.
  - Principle of preventative vs. therapeutic: There are certain limited circumstances in which a vaccine would no longer be considered preventive in nature, and this can affect how the vaccine is covered. For example, while a booster shot of tetanus vaccine would be considered preventive if administered routinely in accordance with a recommended schedule, it would not be considered preventive when administered in response to an actual exposure to the disease. In the latter situation, such a vaccine furnished to an SNF’s Part A resident would be considered therapeutic rather than preventive in nature, as its use is reasonable and necessary for treating an existing condition would be included on the SNF’s global Part A bill for the resident’s covered stay.

Excluded Services

- **Major Category IV - Additional Excluded Preventive and Screening Services (cont.)**
  - If the resident receives a type of vaccine that is preventive in nature but for which no Part B benefit category exists (e.g., diphtheria), then the vaccine would not be covered under either Parts A or B and, as a consequence, would become coverable under the Part D drug benefit.

A. Mammography

B. Vaccine s (Pneumococcal, Flu, Hepatitis B, or Covid-19)

C. Vaccine Administration

D. Screening Pap Smear and Pelvic Exams

E. Colorectal Screening Services

F. Prostate Cancer Screening

G. Glaucoma Screening

H. Diabetic Screening

I. Cardiovascular Screening

J. Initial Preventative Physical Exam

K. Abdominal Aortic Aneurysms (AAA) Screening

Excluded Services

- **Major Category V - Part B Services Included in SNF Consolidated Billing**

  A. Therapy services

  -Therapy services are considered as inclusions, rather than exclusions, to consolidated billing.

  - Physical therapy, speech-language pathology services, and occupational therapy are bundled into the SNF's global per diem payment for a resident's covered Part A stay.

  -They are also subject to the SNF "Part B" consolidated billing requirement (for services furnished to SNF residents during noncovered stays) and must be billed by the SNF alone for its Part B residents

  - While most services either clearly fall within the category of therapy or clearly fall outside of it, there are a few services (such as certain debridement codes) which, based on the specific type of practitioner involved, are sometimes considered "therapy" services and other times not. However, because the consolidated billing provision focuses on the nature of the therapy service itself (rather than the type of practitioner who happens to be performing it), these "sometimes therapy" codes are always considered therapy services in the specific context of SNF consolidated billing. This means that a practitioner who furnishes such a service to an SNF resident must always look to the SNF itself (rather than to Part B) for payment.

Annual Update

- **SNF CB Annual Update Process for A/B MACs (A)**
  - Barring any delay in the Medicare Physician Fee Schedule, CMS will provide the new Annual Update code file to CWF by November 1.
  - Should this date change, CWF will be notified through the appropriate mechanism. All future updates will be submitted via a Recurring Update Notification form.
  - These Recurring Update Notifications also describe how the changes will be implemented.
  - The CWF contractor shall compare the new code list for Major Categories I through V to the codes in the current edits. Codes that appear on the new list, but not in the current edit, shall be added to the edit.
  - CMS will make a determination as to which codes should be deleted from which edits. This mechanism will allow for any changes in professional component/technical component designations to be correctly coded for edits and for deleted codes and codes no longer valid for Medicare purposes as of the end of the calendar year, to continue to pay correctly for prior dates of service.
  - Coding changes throughout the year may also be made as necessary through a quarterly update process.
  - As soon as the new code file is posted to the CMS Web site, through their Web sites and list serves, A/B MACs (A) shall notify providers of the availability of the new file.

Management Strategy

1. Don’t Assume everything is ok!
2. Be sure that your team understands CB guidelines.
3. Have solid Arrangements with your outside suppliers.
4. Negotiate terms of payment.
5. Have proper notifications and use them regularly.
6. Review the CB Annual update. Keep the annual excluded list handy.
7. Understand the excluded categories.
8. Know how to access and use the Physician Fee Schedule. User’s Guide.
8. Always review invoices from suppliers of outside services for every Part A resident. Pay only what you are required to pay. limit payment to what the fee schedule allows when there is no arrangement in place. Negotiate miscommunications.

QUESTIONS?

Find Out More

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