Overview
This guide includes an overview of Medicare reimbursement methodologies and potential coding options for the use of select Medtronic technologies and services and related CY 2016 Medicare payment rates. Similarly, reimbursement opportunities may exist under individual state Medicaid programs and commercial payer policies. Providers should consult with their appropriate payer contacts to ensure alignment on coverage, coding and payment expectations for the utilization of these technologies and/or the associated services.

Skilled Nursing Facilities
Skilled Nursing Facilities (SNFs) are acute care facilities that provide skilled nursing care or rehabilitation services for injured, disabled or sick patients. Typically, a patient who has received inpatient hospital services, but requires extended services and ongoing daily care, may be admitted under physician orders into a SNF or swing bed facility.

In rural areas where there are no dedicated SNFs, acute care level hospitals with fewer than 100 beds can use these beds either as acute care or SNF-level care as needed. These beds are considered “swing beds”.

Patient Benefits
SNFs are considered acute care hospitals and as such are covered under a patient’s Medicare benefits for hospital insurance (Part A). In order to qualify for ongoing skilled nursing care in a SNF-level facility, a patient is required to have received acute care in an inpatient hospital for at least three consecutive calendar days. The patient must also be transferred to the SNF within 30 days after discharge from the inpatient hospital (not counting the day of discharge).

Medicare requires patient assessments at the start of a SNF admission, and at periodic intervals throughout the stay. The initial assessment, known as the 5-day assessment, must be completed within 8 days of admission. The goal is for the care team to evaluate the patient’s condition, and decide on a care plan and goals.

Coverage
Medical Necessity: As in all cases with services and products provided to Medicare patients, all necessary supplies and equipment that are ordinarily furnished by the hospital for the care and treatment of a patient during the SNF stay are considered covered services, even if the supplies or equipment leaves with the patient when discharged.

Further, care in a SNF is covered by Medicare if all of the following four factors are met:

- The patient requires skilled nursing services or skilled rehabilitation services, i.e. services that must be performed by or under the supervision of professional or technical personnel; are ordered by a physician and the services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services
- The patient requires these skilled services on a daily basis
- As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF
- The services delivered are reasonable and necessary for the treatment of a patient’s illness or injury, i.e. are consistent with
the nature and severity of the individual’s illness or injury, the individual’s particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

Because individual patient circumstances can affect SNF coverage and payment eligibility, it is advisable that providers seek further information from their carriers or on the CMS website.

Coding
Coding for SNFs under Part A are reported under the ICD-10-CM, ICD-10-PCS and revenue code systems. Payment is then made on a per diem basis (see below) under consolidated billing, and is intended to cover all costs related to Part A services furnished in the SNF. For any portion of the stay that is eligible for Part B services, SNFs should report these separately using the appropriate HCPCS or CPT® codes. Providers are advised to first check the following CMS website to determine whether a code is included or excluded from consolidated billing and whether it is eligible to be billed to Part B: www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/Index.html

Providers may also request coding assistance through the Medtronic Reimbursement Support Line at 877-278-7482.

Payment
Payment for SNFs is made under the Medicare program on a per diem basis using the Skilled Nursing Facility Prospective Payment System (SNF PPS). The SNF PPS annual cycle begins on October 1 and runs through September 30 the following year. The SNF PPS payment rates are based on an adjusted federal rate, and are intended to cover all routine, ancillary and capital-related costs of the Part A stay. Adjustments are made for the individual facility’s case mix using a classification system which accounts for resource utilization by patient type. Refer to the Patient Case-Mix Classification System below.

SNFs bill the Medicare Administrative Contractors (MACs) for all routine, ancillary and capital-related services that a patient receives during their covered Part A stay in that facility under consolidated billing, with a few exceptions (see below). Consolidated billing means that a facility cannot “unbundle” any services that a patient receives through an outside supplier that could potentially be billed directly to the MAC under Part B. Instead, the SNF must make separate contractual arrangements with suppliers so that the SNF itself submits a single “consolidated bill” for each patient. Under federal statute, this includes physical, occupational and speech-language therapy services.

Additional SNF Billing and Payment Under Part B

All routine, ancillary and capital-related costs provided to a SNF patient are included in the Part A payment to that facility and not separately billable. When no Part A payment is possible (e.g., if benefits are exhausted), some or all medically necessary services may be covered under Part B. These must be billed by the SNF in order to be eligible for payment unless the patient is not entitled to Part B benefits. This includes:

- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians
- Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations
- Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices
- Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient’s physical condition
- Outpatient physical therapy, outpatient speech-language pathology services, and outpatient occupational therapy
- Screening mammography services
- Screening pap smears and pelvic exams
- Influenza, pneumococcal pneumonia, and hepatitis B vaccines
- Some colorectal screening
- Prostate screening
- Ambulance services
- Hemophilia clotting factors
- EP for ESRD patients when given in conjunction with dialysis

Any durable medical equipment (DME) and supplies used during a SNF covered stay are included in the payment to that facility and not separately billable. Subsequently, any DME and supplies furnished to a patient for use outside the facility (home) should be billed under the patient’s Part B benefits. If a SNF wishes to become a DME supplier, they must enroll with the National Supplier Clearinghouse and be given a separate supplier number for billing DME to the DME MAC. For our products, this may include ventilator accessories, enteral nutrition supplies, and remote monitoring devices.

SNFs should bill the A/B MAC for prosthetic/orthotic devices under revenue code 274 and surgical dressings under revenue code 263. If the patient is not eligible for Part A benefits and is thus considered a SNF outpatient, supplies may be billed under revenue code 270. In all cases, the appropriate HCPCS code must be linked with the revenue code.

Of note: parenteral nutritional (PEN) therapies, along with the equipment, supplies and nutrients are by definition considered under the prosthetic device benefit for Medicare.

Separately Billable Services Excluded from SNF Consolidated Billing

There are a number of services that are excluded from Consolidated Billing (CB) that may be separately billable to Part B for patients being treated in a SNF. Claims are filed by the individual provider. This includes services provided by physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified nurse midwives, qualified psychologists, certified registered nurse anesthetists, hospice care related to a patient’s terminal condition, and any ambulance trips bringing the patient to the SNF initial admission or from the SNF following discharge. This does not include physician “incident to” services which are still subject to CB.

Additional equipment and supplies described that are deemed excluded from CB include home dialysis supplies and equipment, self-care home dialysis support services, institutional dialysis services and supplies, and Epoetin Alfa (EPO).

Other services that CMS has deemed to be exceptionally intensive, costly or emergent that typically fall outside of SNF patient care plans are able to be billed to the Part B MAC separately and include: cardiac catheterization, CT scans, MRIs, emergency services, radiation therapy services, angiography, ambulatory surgery that involves the use of an OR, certain lymphatic and venous procedures, chemotherapy items/administration, radioisotope services and customized prosthetics.

Patient Case-Mix Classification System

Upon admission to a SNF, Medicare patients must undergo an initial 5-day assessment using the Resident Assessment Instrument (RAI) which must be completed within 8 days of admission. The goal is for the care team to evaluate the patient’s condition, and decide on a care plan and goals. The RAI uses a Minimum Data Set (MDS) of more than 300 items to describe a patient’s physical and psychosocial needs.

Upon completion of the 5-day assessment, the patient is then assigned to a Resource Utilization Group (RUG) based on the level of care they require. The RUG Version 4 (RUG-IV) Classification System includes nine groups (see below) which are further divided into 66 total groups by the activities of daily living (ADL) needs of the patient. This helps to define the resource utilization needed for each care level:

- Rehabilitation plus Extensive Services
- Ultra High Rehabilitation
- Very High Rehabilitation
- Medium Rehabilitation
- Low Rehabilitation
- Extensive Services
- Special Care High
- Special Care Low
- Clinically Complex

The SNF PPS payment rates are based on an adjusted federal rate with adjustments made for the individual facility’s case mix using the case-mix classification system which accounts for resource utilization by patient type.
Quality Reporting

A required Quality Reporting Program (QRP) was added for SNFs under the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act). The proposed measures and specifications are to be announced through the Notice of Proposed Rulemaking (NPRM) process and be implemented by FY 2019. This includes a SNF 30-Day All-Cause Readmission Measure being proposed for implementation. To date, CMS has adopted measures meeting three quality domains for payment determinations beginning FY 2018: functional status, skin integrity and incidence of major falls.

Therapy Specific Coding and Reimbursement Information

All supplies and equipment which are ordinarily furnished by the hospital for the care and treatment of a Medicare patient during a SNF stay are considered covered services under Part A, even if the supplies or equipment leaves with the patient when discharged. This includes the following Medtronic products:

- Enteral feeding, access and GI product
- Compression systems and sleeves
- Electrodes for monitoring and diagnostics
- Incontinence products
- Oximetry products
- Sharps safety products
- Tracheostomy supplies
- Urology catheters
- Ventilators
- Wound care dressings

In certain circumstances when Part A payment is not possible (e.g., if benefits are exhausted), some or all medically necessary services may be covered under Part B. In these cases, the SNF may bill the following Medtronic products under the patient’s Part B benefits unless the patient is not entitled to Part B benefits:

- Wound care dressings if used for the reduction of fractures and dislocations
- Prosthetic and orthotic devices; this includes parenteral nutritional (PEN) therapies along with the equipment, supplies and nutrients

Any of the above durable medical equipment (DME) and supplies used during a SNF covered stay are included in the payment to that facility and not separately billable. Subsequently, any DME and supplies furnished to a patient for use outside the facility should be billed under the patient’s Part B benefits. Please refer to the Medtronic Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Reimbursement Reference Guide.
REFERENCES:
5. Social Security Act: Sections 1861(s)(2)(E) and 1861(s)(2)(O). www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/ConsolidatedBilling.html

DISCLAIMER:
The information contained in this guide is for educational purposes only and is not intended to serve as reimbursement advice. The information herein is taken from the materials published by the Centers for Medicare and Medicaid Services and the American Medical Association and may be helpful to providers in staying up to date on coding and billing of services. This information is subject to change, cannot guarantee coverage or reimbursement. Medtronic makes no other representations as to selecting codes for procedures or compliance with any other billing protocols or prerequisites. As with all claims, providers are responsible for exercising their independent clinical judgment in selecting the codes that most accurately reflect the patient’s condition and procedures performed for a patient and to consult with each patient’s health plan for appropriate reporting of each procedure. Providers should refer to current, complete, and authoritative publications such as AMA HCPCS Level II, CPT, ICD-10, Revenue Code publications, or insurer policies for selecting codes based on the care rendered to an individual patient, and may wish to contact individual carriers, fiscal intermediaries, or other third-party payers as needed.

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