	<b>Regulatory Compliance Policy</b>	<b>No. COMP-RCC 4.28</b>
	<b>Title:</b> <b>HOSPITALS PROVIDING OUTPATIENT SERVICES TO MEDICARE SKILLED NURSING FACILITY/UNIT RESIDENTS</b>	<b>Page: 1 of 6</b>
		<b>Revised Date:</b>
		<b>Original Date: 03-23-05</b>

**Hospitals Providing Services to Medicare Skilled Nursing Facility/Unit Residents**

**I. SCOPE:**


This policy applies to Tenet Healthcare Corporation, its consolidated subsidiaries and all hospitals and other healthcare operations owned or operated by Tenet’s consolidated subsidiaries (Tenet) that provide outpatient services to Medicare fee-for-services beneficiaries residing in a Medicare certified skilled nursing facility including hospital-based skilled nursing units (SNF).

**II. PURPOSE:**

To ensure that services provided by Tenet entities to Medicare fee-for-services beneficiaries who are residing in Medicare certified SNFs are appropriately billed to Medicare or to the SNF under the SNF consolidated billing (CB) requirements. (See RCC policy 4.08 Skilled Nursing Facilities Consolidated Billing Requirements).

**III. POLICY:**

- A. Under no circumstances shall hospital outpatient services furnished to a Medicare resident of a SNF be scheduled, provided, arranged for, or coded for the purposes of circumventing the CB requirements. Further, no patient shall be admitted as an inpatient to a Tenet facility for the purpose of circumventing the Medicare SNF CB requirements.
- B. In compliance with CB requirements, every Tenet facility shall have processes and procedures in place to identify Medicare beneficiaries that are residing in a Medicare-certified SNF and to identify services provided by the Tenet facility which are subject to the SNF CB requirements. Such processes and procedures must include effective means to prevent inappropriate submission of claims to Medicare for payment.
- C. Tenet facilities shall enter into written agreements with SNFs for the provision of services subject to SNF CB requirements. Such a written agreement is required in order to ensure appropriate payment to the Tenet facility from the SNF. The arrangement shall be formally processed through Tenet’s eCATS system and receive prior approval from the facility’s Regional Counsel.
- D. Any outpatient physical, occupational, or speech-language therapy services to be provided by a Tenet entity to a Medicare SNF resident, regardless of whether the resident is in a Part A covered stay, must be furnished under arrangements.

	<b>Regulatory Compliance Policy</b>	<b>No. COMP-RCC 4.28</b>
	<b>Title:</b> <b>HOSPITALS PROVIDING OUTPATIENT SERVICES TO MEDICARE SKILLED NURSING FACILITY/UNIT RESIDENTS</b>	<b>Page: 2 of 6</b>
		<b>Revised Date:</b>
		<b>Original Date: 03-23-05</b>

**IV. PROCEDURE:**

**A. Definition of a SNF Resident for Consolidated Billing Purposes.**

A SNF resident is defined as any beneficiary who is admitted to a Medicare-participating SNF or the participating, Medicare-certified distinct part unit (DPU) of a larger institution. A beneficiary's status as a SNF resident for consolidated billing purposes ends when one of the following events occurs:

1. The beneficiary is admitted as an inpatient to a Medicare-participating hospital or critical access hospital or as a resident to another SNF;
2. The beneficiary dies; or
3. The beneficiary is formally discharged or otherwise departs from the SNF, unless the beneficiary is readmitted (or returns) to that or another SNF **before midnight of the same day.**


**B. Services not subject to SNF Consolidated Billing.**

The services not subject to the CB requirements and most likely to be furnished by a Tenet entity are:

1. Outpatient hospital services<sup>1</sup> that are considered to fall outside the scope of a typical SNF comprehensive plan of care<sup>2</sup>. Specifically:
  - a) emergency services;
  - b) cardiac catheterization;
  - c) computerized axial tomography (CT) scans;
  - d) magnetic resonance imaging (MRIs);
  - e) ambulatory surgery involving the use of a hospital operating room<sup>3</sup>;

<sup>1</sup> Outpatient hospital services for purposes of this policy and the SNF CB requirements does not include outpatient services furnished in non-hospital settings, such as ambulatory surgical centers (ASC). Such services ARE subject to the SNF CB requirements and the non-hospital entity shall not bill Medicare for the services.

<sup>2</sup> This exclusion is not invoked merely because a particular outpatient hospital service does not appear in the individual SNF care plan of the SNF resident. Instead, the exclusion applies only to those specified categories of services that, by definition, generally lie well beyond the scope of a SNF care plan.

	<b>Regulatory Compliance Policy</b>	<b>No. COMP-RCC 4.28</b>
	<b>Title:</b> <b>HOSPITALS PROVIDING OUTPATIENT SERVICES TO MEDICARE SKILLED NURSING FACILITY/UNIT RESIDENTS</b>	<b>Page:</b> 3 of 6
		<b>Revised Date:</b>
		<b>Original Date:</b> 03-23-05

- f) radiation therapy;
- g) angiography;
- h) lymphatic and venous procedures; and
- i) ambulance trips that transport a beneficiary from the SNF to receive any of the above mentioned excluded outpatient services.

Hospitals may only bill for those services and supplies provided to a SNF patient covered by Part A that are directly related and required to complete the outpatient procedure or treat the emergency condition for which the beneficiary came to the hospital (e.g., anesthesia when used during ambulatory surgery involving the use of a hospital operating room). All other services and supplies must be bundled back to the SNF, and the hospital must look to the SNF for payment.

- 2. An ambulance trip that transports a beneficiary to the SNF for the initial admission or from the SNF following a final discharge; and
- 3. A subset of HCPCS codes in the following categories:
  - a) chemotherapy;
  - b) chemotherapy administration services;
  - c) radioisotope services; and
  - d) customized prosthetic devices.


For a complete list of services not subject to the CB requirements, please refer to Tenet’s RCC policy 4.08 “Skilled Nursing Facilities Consolidated Billing Requirements.”

**C. Services Provided Under Arrangement.**

As stated in Section B above, not all services are subject to SNF CB requirements. However, for services that are subject to SNF CB requirements each of the following apply:

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<sup>3</sup> Services provided by an ambulatory surgery center (ASC) are not automatically excluded from the SNF CB requirements. Rather, such services might fall under the standard plan of care and therefore are not billable to Medicare by the ASC.

	<b>Regulatory Compliance Policy</b>	<b>No. COMP-RCC 4.28</b>
	<b>Title:</b> <b>HOSPITALS PROVIDING OUTPATIENT SERVICES TO MEDICARE SKILLED NURSING FACILITY/UNIT RESIDENTS</b>	<b>Page: 4 of 6</b>
		<b>Revised Date:</b>
		<b>Original Date: 03-23-05</b>

1. Every Tenet entity that provides services to SNF residents that are subject to SNF CB billing requirements **must have a written agreement** in place, which specifies how the Tenet entity will be paid for its services. Tenet policies governing contracting must be followed and Regional Counsel should be contacted for guidance. For services subject to SNF CB, the services must be provided under an arrangement, and Medicare’s payment to the SNF represents payment in full for the arranged-for service. The Tenet entity that provided the services must look to the SNF for payment.
2. The written agreement must specify that the SNF assumes responsibility for the quality and timeliness of the arranged-for services (See 42 CFR 483.75(h)(2)). The SNF cannot function as a mere billing conduit, but must actually exercise professional responsibility and control over the arranged-for service. The lack of a written agreement could potentially result in Medicare’s noncoverage of the particular services, and the SNF could be found in violation of the terms of its Medicare provider agreement and at risk for civil monetary penalties.
3. For all services provided under arrangement, the SNF must provide the Tenet entity furnishing the services with a copy of the medical order. The SNF must maintain the **original** medical orders on file for billing purposes.

**D. Consolidated Billing Examples.**

**1. Therapy Services**

*Scenario:*

A Tenet hospital is asked to provide physical therapy services to a SNF resident who is a Medicare beneficiary and is not in a covered Part A.


*Analysis:*

Therapy services are subject to CB, regardless of whether the beneficiary is in a covered Part A stay. The Tenet hospital and the SNF must have a written agreement and the hospital must look to the SNF for payment and the SNF must bill the services to Medicare under Part B. The Tenet hospital may not bill Medicare for the therapy services.

**2. Surgical Procedures**

*Scenario:*

A SNF resident who is Medicare beneficiary in a Part A covered stay requires a cataract procedure. The patient is transported to a Tenet hospital for the procedure.

	<b>Regulatory Compliance Policy</b>	<b>No. COMP-RCC 4.28</b>
	<b>Title:</b> <b>HOSPITALS PROVIDING OUTPATIENT SERVICES TO MEDICARE SKILLED NURSING FACILITY/UNIT RESIDENTS</b>	<b>Page: 5 of 6</b>
		<b>Revised Date:</b>
		<b>Original Date: 03-23-05</b>

The outpatient surgical procedure is performed in the hospital operating room. The patient returns to the SNF before midnight of the same day.

*Analysis:*

The procedure qualifies as an exception to CB since it was performed in a hospital outpatient department and required the use of a hospital operating room. Therefore, the hospital must bill Medicare for the procedure.

If the same procedure had been performed in a freestanding ambulatory surgical center (ASC), the procedure would be subject to the SNF CB requirements, and the ASC would turn to the SNF for payment of all non-physician services. The SNF must include charges and codes pertaining to the ASC procedure on the SNF's claim to Medicare.

A Tenet ASC is required to have a written arrangement with the SNF to ensure payment from the SNF.

### **3. Hospital Observation Services**

*Scenario:*

A SNF resident covered under a Part A stay is taken to a hospital and is held in an observation bed past midnight but less than forty-eight hours.

*Analysis:*

CB would not apply because the patient was away from the SNF past midnight. Thus, the hospital would bill the Medicare program for the services provided.


*Scenario:*

A SNF resident covered under a Part A stay is taken to a hospital and is held in an observation bed but returns to the SNF prior to midnight.

*Analysis:*

The resident's status as an SNF resident for CB purposes would continue during the stay in the hospital, regardless of whether the SNF had formally discharged the patient.

The SNF would have to bill Medicare for the services provided at the hospital (except for those services specifically excluded from SNF CB, such as emergency room treatments that are beyond a SNF's typical plan of care).

	<b>Regulatory Compliance Policy</b>	<b>No. COMP-RCC 4.28</b>
	<b>Title:</b> <b>HOSPITALS PROVIDING OUTPATIENT SERVICES TO MEDICARE SKILLED NURSING FACILITY/UNIT RESIDENTS</b>	<b>Page: 6 of 6</b>
		<b>Revised Date:</b>
		<b>Original Date: 03-23-05</b>

## V. REFERENCES

1. 63 Federal Register 26252 (5/12/98)
2. 65 Federal Register 46790 (07-31-00)
3. 42 C.F.R. § 411.15(p)(2)
4. 42 CFR § 424.101
5. 42 CFR § 483.75(h)(2)
6. 42 CFR § 489.20(s)
7. 42 CFR § 483.10 (b)(6)
8. CMS Program Memorandum A-01-45 (3/30/01)
9. CMS Pub. 100-04, Transmittal 183 (5/21/04)
10. Consolidated Billing for Skilled Nursing Facilities – 2004 Annual Updates  
<http://www.cms.hhs.gov/medlearn/2004snfannualupdate.asp>
11. CMS' General Information on Consolidated Billing  
<http://www.cms.hhs.gov/medlearn/snfcode.asp>
12. Medicare Claims Processing Manual Chapter 6