

Medicare: Part Two

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Introduction

- Prospective Payment for Skilled Nursing Facilities (SNF)
- Physician Certification Statement (PCS) requirements
- Advance Beneficiary Notices (ABN)
- Beneficiary signatures
- How to research rules and documents

SNF Prospective Payments

- Only Applies to Patients on Part A
 - First 100 days
- Not to be Confused with Consolidated Part B Payments
- OIG Warnings on Discounts
 - Cannot be tied
 - Must be realistic
 - Could be used to determine your Medicare rate

Prospective SNF Payments

- 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

Separately Payable Services

- dialysis-related services, including covered ambulance transportation to obtain the dialysis services;
- certain ambulance services, including services that transport the beneficiary to the SNF initially, services that transport the beneficiary from the SNF at the end of the stay (other than in situations involving transfer to another SNF), and roundtrip services furnished during the stay that transport the beneficiary offsite temporarily in order to receive dialysis, or to receive certain types of intensive or emergency outpatient hospital services;

Intensive Services

- Emergency services;
- Cardiac catheterizations;
- Computerized Axial Tomography (CT) scans;
- Magnetic Resonance Imaging (MRI) services;
- Ambulatory surgery;
- Radiation therapy;
- Angiography; and
- Lymphatic and venous procedures.

Physician Certification Statement

- Required
 - Non-emergency
 - Under direct care of physician
 - Transport origin
 - Skilled nursing facility
 - Hospital
 - Time of transport or after—demonstrate effort
 - Repetitive trips—prior to transport (60 days)

Who Can Sign

- Physician
- Physician Assistant (PA)
- Nurse Practitioner (NP),
- Clinical Nurse Specialist (CNS),
- Registered nurse (RN), or discharge planner,

Criteria

- Must have personal knowledge of the beneficiary's condition at the time the ambulance transport, and
- Must be employed by the beneficiary's attending physician or by the hospital or facility where the beneficiary is being treated and from which the beneficiary is transported

Cannot Obtain PCS?

- After 21 days of repeated attempts
 - Document attempts
 - Certified mail of proof of postage
 - Submit claims
 - Provider is always responsible for determining coverage and medical necessity

Important for PCS

- Consistency with documentation
- Signature of appropriate person and date
- Specific description of why patient must be transported by ambulance
- Physician must sign for repetitive transports
- PCS does not eliminate or reduce provider liability for coverage and medical necessity determination

Beneficiary Signatures

- Previously required prior to submitting to Medicare for Reimbursement
 - Exceptions to beneficiary signing
 - Expired
 - Physically or mentally disabled—then authorized signer
 - Authorized signers
 - Legal guardian
 - Relative or other person who receives governmental benefits on beneficiary's behalf
 - Relative or other person who arranges treatment or exercises other responsibilities for their affairs
 - Representative from agency or institution that did not furnish the services for which reimbursement is claimed

Patient Signatures

- Required prior to submitting to Medicare for Reimbursement
 - Exception—For **Emergency and NON-Emergency** ambulance transport services IF...
 - The beneficiary was physically or mentally incapable of signing;
 - No authorized signer was available or willing to sign at time of service;
 - The provider or supplier maintains three types of documentation in its files for 4 years

Patient Signatures

- Three types of documentation required for use of provider/supplier signatures and only on emergency calls...
 - Contemporaneous statement from employee of service that patient was physically or mentally incapable of signing and not authorized signers were available or willing, AND...
 - Documentation of date, time and name of destination facility
 - Contemporaneous signed statement from representative of facility with name, date, and time OR secondary request form of verification acquired from the facility at a later date

Advance Beneficiary Notice (ABN)

- Must use CMS form when rendering a service that is “not reasonable and necessary”
- Failure to use form means you cannot bill patient
- Not necessary for lack of medical necessity

Advance Beneficiary Notice (ABN)

- Examples of when form is needed:
 - Take patient to hospital for simple procedure that could have been done at the nursing home
 - Dressing change, simple catheter replacement, routine exam, blood draw, etc.
 - Downgrade from ALS to BLS
 - Downgrade from air to ground

Advance Beneficiary Notice (ABN)

- May use same form for voluntary notification of noncoverage
 - Excess mileage
 - Lack of medical necessity
 - Transports to doctor’s offices or other non-covered destinations
 - Transports for patient or family convenience
 - Wheelchair van services
- Replaces the “Notice of Exclusion from Medicare Benefits” form (NEMB)
- Different rules on who can sign

Where To Go For Help

- Carrier
 - Ambulance Services Manual
 - Carrier updates
 - Phone
 - Websites

Where To Go For Help

- CMS
 - Manuals (Part A and Part B)
 - Public use files
 - Program transmittals
 - Federal register
 - Ambulance Open Door Forum
 - Email notifications

Conclusion

- Medicare rules continually change and expand
- Providers (Suppliers) are accountable
- Multiple sources for relevant information