REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1 - A-04
(June 2004)

Subject: Medicare Payment for Services to Skilled Nursing Facility Residents in Physicians' Offices

Presented by: Ardis D. Hoven, MD, Chair

Referred to: Reference Committee A
(Joan E. Cummings, MD, Chair)

At the 2003 Annual Meeting, the House of Delegates adopted, as amended, Resolution 112. The resolution calls for the AMA to "study the problems associated with a change in the Medicare skilled nursing facility (SNF) consolidated billing policy to allow physicians to bill the Medicare program directly for the technical component of services provided to SNF residents in a physician's office." The Board of Trustees referred the requested study to the Council on Medical Service for a report back to the House at the 2004 Annual Meeting.

This report describes how the consolidated billing protocol works in situations in which Medicare patients are treated in the offices of physicians during the terms of their SNF stays. Specifically, it addresses the issue of payment for the technical component of services rendered to those patients by physicians. It also summarizes the logic behind the law and its related regulations according to information received from staff at the Centers for Medicare and Medicaid Services (CMS). In addition, the report reviews the impact of the billing protocol on patient care and medical practice from the perspective of practicing physicians.

MEDICARE SNF CONSOLIDATED BILLING PROTOCOL

As part of the Balanced Budget Act of 1997 (P.L. 105-33), 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 a fiscal intermediary to the SNF. These bundled services had to be billed by the SNF to the fiscal intermediary in a consolidated bill. Congress created the Medicare SNF consolidated billing protocol to address three perceived problems: payment by Medicare Part B to physicians for services already paid to SNFs under Part A; extra out-of-pocket liability for beneficiaries in meeting Part B coinsurance and deductible requirements; and suboptimal accountability on the part of SNFs for the coordination and oversight of the total package of care provided to residents.

The consolidated billing protocol requirement confers on the SNF responsibility for billing for the entire array of services provided to SNF residents during the terms of their stays, except for a limited number of services specifically excluded from the consolidated billing protocol by federal statute. Among those services specifically excluded are the professional services of physicians, which are separately billable to Medicare Part B. However, because diagnostic services do not appear on the list of those which are excluded from the consolidated billing protocol by statute, payment for the technical component of these services is included in the consolidated payment to the SNF. Therefore, in strict accordance with the law, the professional component of physician services to SNF residents is billable to Part B by the physician, but payment for the technical

component of services provided by a physician can only be recovered by the physician from the SNF.

Medicare's normal payment rules apply once a patient is no longer deemed by Medicare to be in a Part A-covered SNF stay. The SNF stay is considered to be ended when any of the following has occurred:

- The beneficiary is admitted as an inpatient to a Medicare-participating hospital or critical access hospital, or as a resident to another SNF.

- The beneficiary has been discharged from the SNF and receives services from a Medicare-participating home health agency under a plan of care.

- The beneficiary receives emergency or other excluded outpatient hospital services.

- The beneficiary is formally discharged or otherwise departs from the SNF. However, if the beneficiary is readmitted or returns to that or another SNF before midnight of the same day, the beneficiary will still be considered to be in a SNF stay.

IMPACT ON CARE OF PATIENTS AND MEDICAL PRACTICE

The Council received input from several practicing physicians as to the impact of the consolidated billing protocol. In general, three types of concerns were raised:

- Excessive costs borne by the patient and family, including the burden of needless delays in care and unnecessary transportation costs. These may occur in some cases when physicians rely on SNFs to provide diagnostic services.

- Excessive costs to taxpayers, generated by the absence of alignment between the incentives of the consolidated billing protocol and the requirements of effective and efficient medical practice. These take the form of unnecessary office visits or higher-intensity office visits than would otherwise be necessary, in some cases in which physicians rely on SNFs to provide diagnostic services.

- Excessive costs borne by the physician, including uncompensated care and its unintended consequences, which may include inappropriate financial incentive to withhold care and inefficient curtailment of patients' access to those services. These may occur in some cases in which physicians themselves supply diagnostic services to SNF residents.

Many of the deficiencies of the consolidated billing protocol, as it currently stands, are well illustrated by the following example provided to the Council by a practicing orthopedic surgeon:

> The gist of the matter is that, as an orthopedic surgeon, I cannot get the x-rays that I need when a SNF resident is transported to my office. If I do take the films in my office, I either must eat the costs or seek reimbursement from the SNF. The SNF is supposed to take films in the facility and send them with the patient. I have personally never been consulted beforehand by any SNF as to what x-ray views I might need. In reality, either the x-rays are not taken, or incorrect x-rays are taken, or the x-rays are taken, but not sent with the

> patient. This tends to result in longer and more frequent office visits, which generate higher costs to both Medicare and to the patient's family (e.g., unnecessary transportation costs; time lost from work while accompanying the patient). It can also result in the delay of proper care, as well as the clinical risks that arise from those unnecessary delays. As a consequence, I have many times taken the images the patient required without receiving payment.
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> Similarly, there is no effective and efficient process consistent with the consolidated billing protocol for obtaining x-rays for a broken wrist after I have reduced the fracture in my office. The "system" is preying upon my sense of medical commitment to "do the right thing" and take x-rays at my expense, rather than send the patient back to the SNF. In such cases, more than a week can elapse between the time when a fracture is reduced in my office and the time an incorrect reduction is detected using the follow-up x-ray that the SNF sends me, assuming that the SNF ever does send me the x-ray. The unnecessarily lengthy and high number of visits that stem from compliance with the consolidated billing protocol generate needless additional expense to Medicare and reduce the amount of time that I can spend giving care to other patients. As the number of doctors who treat Medicare patients decreases, those of us who are still in the trenches need to operate efficiently.

In fact, physicians may face two basic choices, either of which may have adverse implications for patients, physicians, and for Medicare. The physician may choose to provide the appropriate standard of care to the SNF patient at his or her own expense, which is inequitable to the physician, causes health care resources to be used inefficiently, and creates unintended incentives to withhold appropriate care. Alternatively, SNFs may provide the services themselves. But not all SNFs have the resources and administrative systems in place to do so as efficiently or effectively as physicians can in their own offices. In some cases, this may generate lower quality for the patient or higher costs to both the patient and to Medicare.

PROBLEMS WITH CHANGES TO THE SNF CONSOLIDATED BILLING PROTOCOL

In reviewing these issues with staff from the CMS Division of Medicare Operations, the Council obtained important information bearing on the matter of changes to the consolidated billing protocol. The most important of these is that it is not within the authority of CMS to revise the statute, so advocacy to promote revision of the statute must be directed toward the U.S. Congress.

In advocating revision to the statute, the issue of double-payment must be addressed. The consolidated per diem payments to SNFs are adjusted according to the Resource Utilization Group assignment of the patient. These assignments are used to vary the consolidated payment amount in consideration of the expected intensity of resource utilization of each resident. So, in principle, the additional resources used by patients who require outside services are reflected in payments already made to the SNF. Payment to physicians by Part B for the technical component of services provided to these patients would, according to Medicare, constitute double-payment for the service.

In addition, appropriate care would need to be taken to ensure that appropriate funding resources follow any shift in the mechanism by which physicians are to be paid for the technical component of their services to SNF residents. Specifically, any revision to the statute which would result in the exemption of payment of the technical component of physicians' services from the SNF

consolidated billing protocol must also ensure that the funds allocated to the consolidated bundle of services to SNF residents be reallocated from Part A to Part B.

RELEVANT POLICY

Policies H-390.866 and H-390.970 (AMA Policy Database) are generally consistent with the intent of Resolution 112 (A-03) in that they oppose CMS implementation of a payment methodology that consolidates facility and physician components in a single prospective payment.

DISCUSSION

Although the SNF consolidated billing protocol was created by Congress to address three perceived problems, a strong case can be made that the consolidated billing protocol is not an appropriate or effective means of addressing those problems, and that in some cases, it may create more problems than it attempts to resolve. The problem of payment to physicians under Part B for services already paid to SNFs under Part A is no longer an issue for Medicare, since Part A and Part B billing systems are now linked together and automatically reject the duplicative Part B claims. As to the argument that beneficiaries are exposed to increased liability for Part B coinsurance and deductibles, it is difficult to identify many scenarios in which large dollar values would attach to these added liabilities. For example, it is likely that many Medicare SNF residents exhaust their annual Part B deductibles, whether or not payment for the technical component of medical services provided by physicians were billed to Part B.

While the beneficiaries' coinsurance liability for those services would be greater absent the consolidated billing protocol, the increment would be very small in most cases. The patient's extra copayment liability would be calculated as 20% of the Medicare allowed amount for only the technical component of the service. For example, average incremental coinsurance payments for the technical components of ankle (CPT code 73610), wrist (CPT code 73110), and hip x-rays (CPT code 73510) would amount to only $4.05, $4.05, and $4.41, respectively. The Council is sensitive to the fact that every incremental financial liability to beneficiaries, no matter how small, is of some significance. However, the Council also recognizes that these small increments are more than offset by the benefits that accrue to beneficiaries and their families when their health care services are delivered in the appropriate setting, at the time they are needed, by appropriately qualified medical staff.

The consolidated billing protocol also was intended by Congress to create a financial incentive for SNFs to meet their responsibility to oversee, coordinate, and account for the total package of care provided to its residents. The Council finds that this objective, though laudable, is not effectively or efficiently achieved, either in principle or in practice, through the implementation of the consolidated billing protocol. The theoretical limitation is obvious. Medicare SNF residents would not look to their physicians for acute or follow-up services if they could obtain the same services without having to leave the SNF. It makes just as little sense for their treating physicians to look to the SNF for partial payment of those services, when those services have nothing to do with the SNF. It appears that the presumption that SNFs are, or should be, capable of and responsible for providing or overseeing the complete packages of their residents' care, is not always consistent with the actual clinical, financial, and administrative capabilities of some SNFs or the medical needs of some of their residents. Furthermore, although CMS believes that revision of the consolidated billing protocol statute may lead to the problem of double-payment for services to

SNF residents, the potential for double-payment would be eliminated by the reallocation of the funds that pay for those services from Part A to Part B.

Based on its review of the experiences of several practicing physicians, the Council also believes that the consolidated billing protocol potentially results in adverse implications for the care of patients, medical practices, and conservation of precious health care resources. Specifically, the consolidated billing protocol may contribute to delayed or forgone patient care, inequitable reimbursement to physicians, and/or excessive costs to patients, their families, and taxpayers. Therefore, the Council believes that the AMA should undertake several actions to rectify the problems of nonpayment for the technical component of the services physicians provide to SNF residents. First, the AMA should communicate with CMS about the problem and propose a collaborative approach to remedial action. Second, CMS should be encouraged to improve its oversight and enforcement of SNFs' compliance with their Medicare Provider Agreements, specifically as they relate to payment to physicians for their services to SNF residents. Finally, due to the unintended consequences of the statute cited above and the lack of authority on the part of CMS to revise the statute, the Council believes the AMA should seek Congressional revision of the statute to exempt the technical component of medical services provided to SNF Part A residents in physicians' offices from the consolidated billing protocol.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of this report be filed:

1. That the American Medical Association (AMA) inform the Centers for Medicare and Medicaid Services of the problems physicians and their patients experience as a result of the inclusion of the technical component of physicians' office-based services in the consolidated billing protocol for Medicare Skilled Nursing Facility residents. (Directive to Take Action)

2. That the AMA urge the Centers for Medicare and Medicaid Services to provide greater oversight of Medicare Skilled Nursing Facilities (SNFs) in meeting their obligations to pay physicians for the technical component of services those physicians provide in their offices to Medicare SNF residents. (Directive to Take Action)

3. That the AMA advocate to Congress that it exclude from Medicare's Skilled Nursing Facility (SNF) consolidated billing protocol the technical component of medical services provided in physicians' offices to Medicare SNF residents, because of concern with the negative impact on care that could potentially occur. (Directive to Take Action)

4. That the AMA urge the Centers for Medicare and Medicaid Services to require Medicare Skilled Nursing Facilities (SNF) to clearly identify those patients who fall under the Medicare SNF consolidated billing program, as opposed to non-skilled extended care facility patients, prior to sending patients to physicians' offices for care. (Directive to Take Action)

1 5. That the AMA communicate to physicians that in order to assure payment whenever a
2 Medicare Skilled Nursing Facility (SNF) resident receives a service that is subject to SNF
3 consolidated billing, the SNF and the physician are required to enter into an arrangement
4 prior to providing services and the physician must look to the SNF for payment. (Directive
5 to Take Action)

Fiscal Note: Advocate to the Center for Medicare and Medicaid Services and to members of Congress at an estimated total staff cost of $1,859.