CMS Referral for Own Motion Review by DAB/MAC

<table>
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<tr>
<th>Appellant at ALJ Level</th>
<th>ALJ Appeal Number</th>
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<tr>
<td><strong>Comprehensive Decubitus Therapy</strong></td>
<td>1-994717993 + 8 others</td>
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<td>Beneficiary (if not the Appellant)</td>
<td>List attached</td>
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<td>ALJ Decision Date</td>
<td>December 4, 2012</td>
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<tr>
<td>Health Insurance Claim Number (HICN)*</td>
<td>Specific Item(s) OR Service(s)</td>
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<td>Provider, Practitioner OR Supplier</td>
<td>Surgical dressings</td>
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**Basis for referral**

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<th>Any Case</th>
<th>CMS as a Participant</th>
<th>Pre-BAIPA</th>
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<tr>
<td>[x] Error of law material to the outcome of the claim</td>
<td>[x] Decision not supported by the preponderance of evidence</td>
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<td>[ ] Broad policy or procedural issue of public interest</td>
<td>[ ] Abuse of discretion</td>
<td>[ ] Decision not supported by substantial evidence</td>
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<td>[ ] Abuse of discretion</td>
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**Rationale for Referral:**

Comprehensive Decubitus Therapy (Appellant), a durable medical equipment, prosthetics, orthotics and supplies supplier, billed for surgical dressings it furnished to nine Medicare beneficiaries who were residents of skilled nursing facilities (SNF). Durable medical equipment Medicare administrative contractors (DME MACs) paid the claims initially but later recouped the overpayments because the patients were in covered Part A stays on the dates of service. On appeal, the Appellant argued that it is entitled to waiver under section 1870 (b) of the Act because it reviewed information available on Medicare’s Common Working File (CWF) on the dates of service that did not reflect Part A coverage, and therefore it could not have known the nursing home residents were in covered Part A stays. The denials and recoupment were upheld at the first two levels of appeal.

On further appeal, the administrative law judge (ALJ) affirmed that the “surgical dressings provided to the Beneficiary here are not separately payable to the Appellant due to Consolidated Billing provisions.” However, he waived recoupment pursuant to Section 1870(b) of the Act, finding the Appellant to be “without fault with respect to this overpayment, based on its efforts to verify the Beneficiary’s coverage status prior to supplying the items.” ALJ decision at 7. Specifically, the ALJ cited the Appellant’s review

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1 The DME MACs in the nine cases are Noridian Administrative Services, CIGNA Government Services, and National Government Services.
of “commercial screening tools to verify that the Beneficiary was not currently in a Part A SNF stay.” Id. at 6.

The ALJ erred as a matter of law in waiving recoupment under § 1870 of the Social Security Act (the Act). The services were denied pursuant to § 1862(a)(18) of the Act, which provides that no payment may be made to an entity other than the SNF for any items of services which are covered SNF services. See also Medicare Claims Processing Manual (MCPM) (CMS Pub 100-4), Chapter 6, § 10 (“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”). It is undisputed that the services in this case are subject to the SNF prospective payment system (PPS). To limit problems arising from duplicate billing, CMS requires suppliers and SNFs to share the responsibility of billing for SNF services correctly. MCPM, Chapter 6, §§ 10 – 10.4.2. This includes requiring suppliers to establish arrangements with SNFs before furnishing SNF PPS services. Id. Even if no valid arrangement exists, the supplier must coordinate with the SNF before furnishing such services. Id. Accordingly, a supplier’s reliance on contemporaneous information in the CWF on the date of service does not constitute reasonable care in billing for, and accepting, payment, as it is contrary to CMS instructions and does not provide a reasonable basis for assuming that the payment was correct.

Furthermore, a supplier’s remedy if it is overpaid in these situations is to obtain payment from the SNF. A SNF is required by law to bill for and furnish, either directly or under arrangement, all services subject to consolidated billing. Section 1862(a)(18) of the Act; § 1861(w) of the Act; 42 C.F.R. § 411.15(p); 42 C.F.R. § 489.20(s); 42 C.F.R. § 483.75(h); MCPM, Chapter 6, §§ 10 – 10.4.2. Since a SNF has been paid in full for all services subject to consolidated billing, the SNF is responsible for reimbursing any entity that furnishes those services. Id. Waiver of recoupment under § 1870 is contrary to law and longstanding policy because waiving recoupment would result in Medicare paying twice for the same service instead of the supplier seeking payment from the responsible entity.

Background:

This request for review involves nine claims for surgical dressings the Appellant billed to DME MACs with dates of service March 7, 2011, August 1, 2011, October 3, 2011, October 5, 2011, October 21, 2011, November 9, 2011, November 16, 2011 and November 21, 2011. The Appellant reported the services with the following Healthcare Common Procedure Coding System (HCPCS) codes:

- A6212 – Foam dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing
- A6402 – Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing
The DME MACs paid the claims initially but later recouped payment after learning the beneficiaries were in Part A covered skilled nursing facility (SNF) stays on the dates of service. Exh 14 at P 049. The Appellant does not dispute that the patients were in covered SNF stays. The Appellant’s sole argument on appeal has been that it is entitled to waiver under section 1870 (b) of the Act because “Due diligence was taken prior to or on the date of service to ensure patient was not receiving home health, hospice, skilled nursing facility/Medicare A or acute inpatient care at the time of our service.” See request for redetermination, Exh 12 at P 075; request for reconsideration, id. at P 067.

The DME MACs affirmed the denials explaining, “records indicate the beneficiary was in a skilled nursing facility during the date of service in question. Medicare does not allow payment for items or services when the beneficiary is in a skilled nursing facility. We do not find due diligence was taken in this case and the print out submitted does not show the date inpatient was checked.” Exh 13 at P 055. The Appellant was held liable for the denied services. Id.

The QIC also upheld the denials on the basis that the patient was in a covered Part A stay. The QIC explained further, “If you have supplied an item or service to a beneficiary who is a resident in a covered Part A stay, you must look to the SNF, rather than to the beneficiary or to the DME MAC for payment.” Exh 13 at P 055.

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2 Procedural documents in individual beneficiary records are substantially similar; we cite the administrative record for appeals 1-994717993, unless otherwise noted. The files are not paginated, so we cite the last three digits of the imprint stamp located in the lower left of the page.
The Appellant requested a hearing from an ALJ and asked the ALJ to aggregate the claims. Exh 14 at p 031-035. The ALJ conducted a telephone hearing on November 14, 2012 that addressed multiple appeals, including the nine at issue here. A representative of the QIC and the DME MAC attended parts of the hearing and provided testimony regarding six of the nine appeals subject to this referral.

On December 4, 2012, the ALJ issued nine partially favorable decisions, concluding the “surgical dressings provided to the Beneficiary here are not separately payable to the Appellant due to Consolidated Billing provisions,” but “the Appellant is without fault with respect to this overpayment, based on its efforts to verify the Beneficiary’s coverage status prior to supplying the items. Therefore, the recovery of the overpayment is waived, pursuant to Section 1870(b) of the Act.” ALJ decision at 7. The ALJ reasoned:

The Appellant submitted a CMN Order that indicated that the patient was not being seen by home health. The CMN was signed by the patient (or authorized representative). In addition, the record contains printouts showing that the Appellant utilized commercial screening tools available to access the Medicare Common Working File, to verify that the Beneficiary was eligible to receive supplies under Part B for the date of service. Nothing in the record indicated that the patient was in a Part A SNF stay. The record shows that supplies were delivered to Beneficiary for the disputed date of service. Exh. 14. The Appellant noted that surgical dressings may be delivered to a nursing facility as long as the patient is not accessing a Part A stay.

The Medicare Contractor submitted an inpatient hospital/SNF claim history, which stated that the patient was an inpatient from October 1, 2011 to October 14, 2011. However, the record shows that the history was printed on September 24, 2012, well after the date of service. The Appellant noted that there was no way of knowing on the date of service that the patient was in the SNF. Exh. 14.

Based on the facts of this case, I find that the Appellant exercised reasonable care in billing for the items at issue. In addition, based on the information available at the time, the Appellant had a reasonable basis for assuming the payment was correct. The Appellant contacted the Beneficiary and utilized commercial screening tools to verify that the Beneficiary was not currently in a Part A SNF stay. Based on these assurances, the Appellant’s determination that the Beneficiary was not in a Part A SNF stay when it supplied and billed for the items at issue, was reasonable. Therefore, the Appellant was without fault in this overpayment, and the recovery of the overpayment is waived, pursuant to Section 1870(b) of the Act.

Id. at 6.

Applicable Law, Regulation, and Medicare Policy:

The Balanced Budget Act of 1997 amended § 1862(a) and § 1861(w) of the Act. Section 1862(a)(18) excludes from Medicare payment:
covered skilled nursing facility services described in section 1888(e)(2)(A)(i) and which are furnished to an individual who is a resident of a skilled nursing facility during a period in which the resident is provided covered post-hospital extended care services (or, for services described in section 1861(s)(2)(D), which are furnished to such an individual without regard to such period), by an entity other than the skilled nursing facility, unless the services are furnished under arrangements (as defined in section 1861(w)(1)) with the entity made by the skilled nursing facility.

Section 1861(w)(1) provides:

The term “arrangements” is limited to arrangements under which receipt of payment by the hospital, critical access hospital, skilled nursing facility, home health agency, or hospice program (whether in its own right or as agent), with respect to services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.

An overview of SNF consolidated billing on the CMS website explains:

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 fiscal intermediary (FI)/A/B Medicare Administrative Contractor (MAC) to the SNF. These bundled services had to be billed by the SNF to the FI/A/B 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 the Part A benefits are exhausted, but 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 [except for certain enumerated services.]

CMS sets forth the following pertinent instructions in Chapter 6 of the MCPM:

10 – Skilled Nursing Facility (SNF) Prospective Payment System (PPS) and Consolidated Billing Overview

All SNF Part A inpatient services are paid under a prospective payment system (PPS).

…

Also under 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.
10.4 - Furnishing Services that are Subject to SNF Consolidated Billing Under an “Arrangement” With an Outside Entity

Further, 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,” as described in §1861(w) of the Act and in §80.5. 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.

Since the inception of the SNF PPS, 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. ... As discussed in greater detail below, such situations most commonly arise in one of the following two scenarios: 1) An 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 an 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.

The absence of a valid arrangement in the situations described above 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 Part B (or other payers such as Medicaid and beneficiaries) directly for the services. In addition, when ordering or furnishing services “under arrangements,” 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. Whenever possible, SNFs should document arrangements with suppliers in writing, particularly with suppliers furnishing services on an ongoing basis, such as laboratories, x-ray suppliers, and pharmacies. This also enables the SNF to obtain the supplier’s assurance that the arranged-for services will meet accepted standards of quality (under the regulations at 42 CFR 483.75(h)(2), SNFs must ensure that services obtained under an arrangement with an outside source meet professional standards and principles that apply to professionals providing such services).

However, 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. As the SNF has already been paid for the services, the SNF must be considered the responsible party when medically necessary supplier services are furnished to beneficiaries in Medicare Part A stays. 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.

Finally, while establishing a valid arrangement prior to ordering services from a supplier
minimizes the likelihood of a payment dispute between the parties, it is not unreasonable to
expect occasional disagreements between the parties that may result in non-payment of a
supplier claim. However, it is important to note that there are potentially adverse
consequences to SNFs when patterns of such denials are identified. Specifically, all
participating SNFs agree to comply with program regulations when entering into a Medicare
provider agreement which, as explained below, requires an SNF to have a valid
arrangement in place whenever a resident receives services that are subject to consolidated
billing from any entity other than the SNF itself. Moreover, in receiving a bundled per diem
payment under the SNF PPS that includes such services, the SNF is accepting Medicare
payment--and financial responsibility--for the service.

Accordingly, these instructions reiterate and clarify the applicable consolidated billing
requirements that pertain to SNFs and to the outside suppliers that serve SNF residents.

10.4.1 - “Under Arrangements” Relationships

Under an arrangement as defined in §1861(w) of the Act, Medicare’s payment to the SNF
represents payment in full for the arranged-for service, and the supplier must look to the
SNF (rather than to Part B) for its payment. Further, in entering into such an arrangement,
the SNF cannot function as a mere billing conduit, but must actually exercise professional
responsibility and control over the arranged-for service (see the Medicare General
Information, Eligibility, and Entitlement Manual, Chapter 5, “Definitions,” §10.3, for additional
information on services furnished under arrangements).

Medicare does not prescribe the actual terms of the SNF’s relationship with its suppliers
(such as the specific amount or timing of payment by the SNF), which are to be arrived at
through direct negotiation between the parties to the agreement. However, in order for a
valid “arrangement” to exist, the SNF must reach a mutual understanding with its supplier as
to how the supplier is to be paid for its services. Documenting the terms of the arrangement
confers the added benefit of providing both parties with a ready means of resolution in the
event that a dispute arises over a particular service. This type of arrangement has proven to
be effective in situations where suppliers regularly provide services to facility residents on an
ongoing basis; e.g., laboratory and x-ray suppliers, DME supplies, etc.

If an 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 as contemplated under §1862(a)(18) of the Act.
Not only would this potentially result in Medicare’s noncoverage of the particular services at
issue, but an SNF demonstrating a pattern of nonpayment would also risk being found in
violation of the terms of its provider agreement. Under §1866(a)(1)(H)(ii) of the Act (and 42
CFR 489.20(s)), the SNF’s provider agreement includes a specific commitment to comply
with the requirements of the consolidated billing provision. Further, §1866(g) of the Act imposes a civil money penalty on any person who knowingly and willfully presents (or causes to be presented) a bill or request for payment inconsistent with an arrangement or in violation of the requirement for such an arrangement.

10.4.2 – SNF and Supplier Responsibilities

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.

Based on the inaccurate impression that the resident’s SNF stay is noncovered, the supplier inappropriately submits a separate Part B claim for the service, and may also improperly bill other insurers and the resident. Then, the supplier only learns of the actual status of the resident’s Medicare-covered SNF stay when that Part B claim is denied. In this scenario, even though the supplier made reasonable efforts to ascertain from the SNF both the beneficiary’s status as an SNF resident and the specific nature of the beneficiary’s SNF stay, the information from the SNF (on which the supplier relied) proved to be inaccurate.

While we recognize that inadvertent errors may occasionally occur in the course of furnishing such information, an SNF should not only make a good faith effort to furnish accurate information to its supplier, but must reimburse the supplier once such an error is called to its attention. If, in the scenario at issue, the SNF refuses to pay the supplier for the service even after being apprised of the inaccuracy of its initial information, the SNF would not be in compliance with consolidated billing requirements. As discussed previously, having supporting documentation in place for the disputed service would not only help to ensure compliance with the consolidated billing requirements, but should also provide a vehicle for resolving the dispute itself.

Of course, the SNF can often prevent such disputes from arising to begin with, simply by ensuring that the supplier receives accurate and timely information about the status of a resident’s Medicare-covered SNF stay. The SNF’s responsibility to communicate accurate and timely resident information to its suppliers is especially important in those instances where a particular portion of an otherwise bundled service remains separately billable to Part B (for example, the professional component that represents a physician’s interpretation of an otherwise bundled diagnostic test).

…

Moreover, while the SNF itself should take reasonable steps to prevent such problems from arising, the supplier in this scenario is also responsible for being aware of and complying with the consolidated billing requirements. This means that prior to furnishing services to a
Medicare beneficiary, the supplier should routinely ascertain whether the beneficiary is currently receiving any comprehensive Medicare benefits (such as SNF or home health benefits) for which Medicare makes a bundled payment that could potentially include the supplier’s services. If the supplier ascertains that a particular beneficiary is, in fact, a resident of an SNF with which the supplier does not have a valid arrangement in place, then the supplier should contact the SNF before actually furnishing any services to that beneficiary that are subject to the consolidated billing provision. Further, under the regulations at 42 CFR 489.21(h), the beneficiary cannot be charged for the bundled services.

The above instructions were first issued on December 23, 2004 in Transmittal R412CP (CR 3592), available online at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R412CP.pdf. See also Historical Questions & Answers on SNF Consolidated Billing, online at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/historyQA.pdf

The Medicare Financial Management Manual (MFMM) (CMS Pub 100-6) sets forth criteria for determining whether a provider may be considered without fault in causing an overpayment. Chapter 3, § 90 states, “A provider is liable for overpayments it received unless it is found to be without fault.” Generally, a provider is without fault if it “exercised reasonable care in billing for, and accepting, the payment.” “Reasonable care” means the provider “made full disclosure of all material facts” and “on the basis of the information available to it, including, but not limited to, the Medicare instructions and regulations, it had a reasonable basis for assuming that the payment was correct, or, if it had reason to question the payment; it promptly brought the question to the FI or carrier’s attention.”

Discussion:

The Appellant does not dispute that the beneficiaries in these cases were in covered Part A SNF stays on the dates of service but asserts it had no way of knowing on the dates of service the patient was in a covered Part A stay because it relied on a commercial application to access CWF information and verify the beneficiaries were not identified as receiving SNF services. See id. at P 067 - at P 070; see also ALJ decision at 6. The Appellant testified in some cases that it contacted the DME MAC’s interactive voice response (IVR) system to confirm that the patients were not in a covered SNF stay. Hearing CD at 14:01:45. Generally, the Appellant is aware the patient resides in a SNF and, in some cases, acknowledges receiving and order for the supplies from the SNF. E.g., hearing CD at 14:33.

The Appellant’s sole argument on appeal is that recoupment should be waived under § 1870 of the Act because it performed due diligence “prior to or on the date of service to ensure patient was not receiving home health, hospice, skilled nursing facility/Medicare A or acute inpatient care at the time of our service.” See, e.g., Exh 12 at P 075. At the
hearing, the Appellant cited Chapter 15, § 250.A – C of the MBPM, which allows payment under Part B when, for instance, a beneficiary has exhausted her or his Part A benefits.

Noting that the Appellant had accessed information available on the CWF to verify that the Beneficiary was eligible to receive supplies under Part B, the ALJ agreed that the Appellant had “no way of knowing on the date of service that the patient was in the SNF” and therefore “that the Appellant exercised reasonable care in billing for the items at issue [and] had a reasonable basis for assuming the payment was correct.” ALJ decision at 6.

The services in this case were denied pursuant to § 1862(a)(18) of the Act, which provides that no payment may be made to an entity other than the SNF for any items of services which are covered SNF services. See also MCPM, Chapter 6, § 10 (“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”). Thus, 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. See http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html.

In comments to the interim final rule for “Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities” CMS (then HCFA) discussed vulnerabilities arising from duplicate billing prior to implementation of the SNF PPS:

> Historically, an SNF could choose to furnish services to its residents either directly with its own resources, or under an “arrangement” with an outside source; in either instance, the SNF itself was responsible for submitting the bill for the service to its Medicare fiscal intermediary (FI). However, the SNF has also had the additional option of “unbundling” a service altogether; that is, permitting an outside supplier to furnish the service directly to an SNF resident and to submit a bill independently to the carrier under Part B, in lieu of any actual involvement by the SNF itself. The ability on the part of suppliers to submit separate bills directly to the carrier for these unbundled services has been extremely problematic in several ways.

> First, it has created a potential for duplicate billing. For example, an SNF might include a particular service in its bill to the FI under Part A at the same time that an outside supplier is improperly submitting a Part B claim to the carrier for the identical service. Unless the Medicare contractors detect this inappropriate duplication in billing, the program ultimately pays twice for the same service.

> …

> For years, HCFA pursued legislative proposals to prohibit the practice of unbundling in SNFs, but without success. As with inpatient hospital services, the event that finally brought about a comprehensive billing requirement for SNF services was the creation of a PPS for SNFs. In order to have a prospective payment that includes all of the medically necessary
services that an SNF resident receives, it is essential to tie all of those services into a single facility package, by prohibiting unbundling. Otherwise, the Medicare program would once again be faced with potentially paying twice for the same service—once to the SNF under the Part A prospective payment, and again to an outside supplier under Part B.

63 FR 26252, 26295, May 12, 1998 (emphasis added). Accordingly, “Under the SNF Consolidated Billing requirement established by section 4432(b) of the BBA 1997, the SNF itself has the Medicare billing responsibility for virtually all of the Medicare-covered services that its residents receive.” Id. See also Historical Questions & Answers on SNF Consolidated Billing, online at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/historyQA.pdf (“Prior to the introduction of the SNF prospective payment system (PPS), significant problems arose from the unrestricted ability of outside entities to bill Part B directly for services furnished to SNF residents during a covered Part A stay: Duplicate billing when the SNF billed Part A and the outside entity billed Part B for the same service.”)

In 2002, CMS established billing edits that detect and deny Part B services subject to consolidated billing by checking SNF claims in the CWF. However, the prepayment edits are not effective if suppliers bill for Part B services before the SNF submits its claims. In a 2004 Audit Report, the OIG remarked that this circumstance “will result in Part B payments that have to be recouped through offset or collection activities. In order to minimize costly postpayment recovery activities, it is essential that SNFs and suppliers strengthen billing controls to ensure that suppliers bill SNFs, not Medicare, for services subject to the consolidated billing provision.” OIG Audit Reports – Review of Improper Payments Made by Medicare Part B for Services Covered Under the Part A Skilled Nursing Facility Prospective Payment System in Calendar Years 1999 and 2000, A-01-02-00513 (May 28, 2004) at ii (emphasis added). Available online at https://oig.hhs.gov/oas/reports/region1/10200513.pdf. The OIG noted further that “The logic behind the consolidated billing edits makes it clear that it is incumbent upon the suppliers to recognize their obligation to bill correctly—if a Part B supplier submits a Medicare claim for services that are subject to the consolidated billing provision because they were provided during a resident’s Part A PPS stay, the Part B claim is rejected or adjusted.” Id. at 7.


Since the inception of the SNF PPS, 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) An 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 an 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.

See also MCPM, Chapter 6, § 10.4. CMS explained that, pursuant to § 1862(a)(18) and § 1861(w) of the Act, “Medicare’s payment to the SNF represents payment in full for the arranged-for service, and the supplier or practitioner must look to the SNF (rather than to Part B) for its payment.” Id. and MCPM, Chapter 6, § 10.4.1. While not prescribing the terms of a SNF’s relationship with its supplier, CMS emphasized that the SNF must furnish the services either directly or under arrangement, and it must reimburse the supplier or practitioner for those Medicare-covered services that are subject to consolidated billing. Id. and MCPM, Chapter 6, § 10.4. CMS stressed the importance of the two entities establishing a valid arrangement to avoid “confusion ad friction between SNFs and their suppliers,” and cautioned that “suppliers need to understand which services are subject to consolidated billing to avoid situations where they might improperly attempt to bill Part B (or other payers such as Medicaid and beneficiaries) directly for the services.” Id. Absence of a valid arrangement, however, “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. As the SNF has already been paid for the services, the SNF must be considered the responsible party when medically necessary supplier services are furnished to beneficiaries in Medicare Part A stays.” Id. Emphasis added. CMS admonished that the SNF’s “obligation applies even in cases where the SNF did not specifically order the service.” Id.

While SNFs are responsible for furnishing, and billing for, consolidated services, suppliers also bear responsibility for ensuring SNF PPS services are billed correctly:

While the SNF itself should take reasonable steps to prevent such problems from arising, the supplier in this scenario is also responsible for being aware of and complying with the consolidated billing requirements. This means that prior to furnishing services to a Medicare beneficiary, the supplier should routinely ascertain whether the beneficiary is currently receiving any comprehensive Medicare benefits (such as SNF or home health benefits) for which Medicare makes a bundled payment that could potentially include the supplier’s services. If the supplier ascertains that a particular beneficiary is, in fact, a resident of an SNF with which the supplier does not have a valid arrangement in place, then the supplier should contact the SNF before actually furnishing any services to that beneficiary that are subject to the consolidated billing provision. Further, under the regulations at 42 CFR 489.21(h), the beneficiary cannot be charged for the bundled services.

Id. Emphasis added. See also MCPM, Chapter 6, § 10.4.2.

Instructions provided in associated Medlearn Matters Article MM3592 include, inter alia:
• SNFs must include almost all of the services a resident receives during a covered stay on its Part A claim submitted to its Medicare intermediary.

• SNFs must provide any Part A or Part B service that is subject to SNF consolidated billing either directly with its own resources, or through an outside entity (e.g., a supplier) under an “arrangement,” as set forth in Section 1861(w) of the Act.

• If an outside entity provides a service that is subject to SNF consolidated billing to a SNF resident during a covered stay, the outside entity must look to the SNF for payment (rather than billing under Part B).

• Medicare’s payment to the SNF represents payment in full for the arranged-for service, and the SNF in turn is responsible for making payment to an outside entity that furnishes a service which is included in the SNF’s prospective payment system (PPS) per diem payment.

• Absence of an agreement with its supplier (written or not) does not relieve the SNF of its responsibility to pay suppliers for services “bundled” in the SNF PPS payment from Medicare.

• The SNF must be considered the responsible party (even in cases where it did not specifically order the service) when beneficiaries in Medicare Part A stays receive medically necessary supplier services, because the SNF has already been paid under the SNF PPS.

• All SNFs, under the terms of their Medicare provider agreement, must comply with program regulations.

• These regulations require a valid arrangement to be in place between the SNF and any outside entity providing resident services subject to consolidated billing.


In a 2007 Audit Report revisiting the subject of improper payments made to suppliers on behalf of beneficiaries in covered SNF stays, the OIG noted:

When SNFs submit their claims before DMEPOS suppliers submit theirs, prepayment edits are designed to identify and deny payments for inappropriately billed Part B services before CMS reimburses the suppliers. When suppliers submit their claims before SNFs submit theirs, postpayment edits are designed to identify Part B overpayments after CMS has reimbursed the suppliers. Overpayments identified on a postpayment basis must be recovered through offset or collection activities.

to the report, CMS acknowledged that it uses both prepayment edits and postpayment edits to identify improper billing of Part B services and to prevent or recoup improper payment for those services. *Id.* at APPENDIX G. The government thus recognizes that prepayment edits will not catch situations in which the DME supplier bills before the SNF does, and in such cases postpayment edits will result in an overpayment to be recouped from the supplier.

A review of the history of the SNF PPS and CMS’ ongoing struggles with duplicate payment evinces two clear principles. First, the supplier, along with the SNF, bears responsibility for ensuring services subject to consolidated billing are billed correctly. To this end, the law requires SNFs and suppliers to enter into arrangements to furnish services subject to consolidated billing. However, “If the supplier ascertains that a particular beneficiary is, in fact, a resident of an SNF with which the supplier does not have a valid arrangement in place, then the supplier should contact the SNF before actually furnishing any services to that beneficiary that are subject to the consolidated billing provision.” MCPM, Chapter 6, § 10.4.2.

CMS recognizes that information in the CWF will trigger prepayment edits only if a SNF has already submitted a claim before the supplier does. Consequently, CMS applies postpayment edits in addition to prepayment edits to identify and then recoup any overpayments resulting from what it considers improper and duplicate billing. It is insufficient, therefore, that the Appellant checked the DME MAC’s IVR and the CWF on the date of service, as these resources will *never* identify a Part A SNF stay if the supplier checks before the SNF submits its claim.

A provider or supplier is without fault if it “exercised reasonable care in billing for, and accepting, the payment.” “Reasonable care” means “on the basis of the information available to [the provider], including, but not limited to, the Medicare instructions and regulations, it had a reasonable basis for assuming that the payment was correct, or, if it had reason to question the payment; it promptly brought the question to the FI or carrier’s attention.” MFMM, Chapter 3, § 90. CMS expressly places the burden on both suppliers and SNFs to bill for SNF services correctly. This includes requiring suppliers to establish arrangements with SNFs before furnishing SNF PPS services. If no valid arrangement exists, the supplier must still coordinate with the SNF before furnishing such services. As a matter of law and longstanding policy, a supplier’s reliance on contemporaneous information in the CWF on the date of service does not constitute reasonable care in billing for, and accepting, payment, as it is contrary to CMS instructions and does not provide a reasonable basis for assuming that the payment was correct.3 Accordingly, the ALJ erred in finding the Appellant to be without fault with

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3 The Appellant also cites Chapter 15, § 250.A – C of the MBPM as authority allowing DME suppliers to bill Part B for surgical dressings furnished to SNF residents if Part A payment is unavailable. However, the Appellant’s reliance on § 250 is misplaced, as parallel guidelines in Chapter 7, § 10.1 of the MCPM state that such services are to be “billed by the SNF or the rendering provider or supplier under arrangement with the SNF.” Moreover, it is undisputed that the beneficiaries here were in covered Part A stays and the surgical dressings were subject to consolidated billing requirements. The fact that certain
regard to the overpayment on the basis that it “utilized commercial screening tools to verify that the Beneficiary was not currently in a Part A SNF stay.” ALJ decision at 6.

Second, the supplier’s remedy if it is overpaid is to obtain payment from the SNF. As a matter of law, the SNF is solely responsible for:

- **billing** for all services subject to the SNF prospective payment system in a single consolidated bill and “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.” MCPM, Chapter 6, § 10; Section 1862(a)(18) of the Act; 42 C.F.R. § 411.15(p).
- **furnishing**, either directly or under arrangement, all services subject to consolidated billing. Section 1861(w) of the Act; 42 C.F.R. § 489.20(s); 42 C.F.R. § 483.75(h); MCPM, Chapter 6, § 10.4.
- **reimbursing** an outside entity for those Medicare-covered services that are subject to consolidated billing. Id.

CMS has stated, “As the SNF has already been paid for the services, the SNF must be considered the responsible party when medically necessary supplier services are furnished to beneficiaries in Medicare Part A stays.” MCPM, Chapter 6, § 10.4; Medlearn Matters Article MM3592; Transmittal R412CP. CMS recognizes that problems may arise in the absence of a valid arrangement between a SNF and its suppliers, particularly when the SNF “fails to inform the supplier that the resident receiving the service is in a covered Part A stay [thereby causing] the supplier to conclude mistakenly that the service it furnishes to that resident is not subject to consolidated billing.” MCPM, Chapter 6, § 10.4.2. When such “inadvertent errors” occur, CMS states a “SNF should not only make a good faith effort to furnish accurate information to its supplier, but must reimburse the supplier once such an error is called to its attention.” Id. Emphasis added.

Thus, regardless of whether the supplier in fact had an agreement with the SNF, and regardless of whether the SNF adequately informed the supplier that the patient is in a Part A stay, the SNF has been paid and the supplier must look to the SNF for payment. MCPM, Chapter 6, § 10.4.1. A supplier’s billing Part B for services subject to the SNF PPS in these circumstances is *prima facie* improper billing. Accordingly, the ALJ erred in allowing recoupment of the overpayment to be waived under § 1870 because by law the SNF is responsible for reimbursing the supplier, and waiver under § 1870 would result in Medicare paying twice for the same service. *See also* MFMM, Chapter 3, § 90.1.B (finding a provider is not without fault if it “receives duplicate payments”).