



Billing Alert

for Long-Term Care

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Communication: Are we talking? Are we listening?

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Communication is known to be the Achilles' heel of the SNF. Many errors in the business office can be traced back to poor communication. Merriam-Webster includes in its definition of communication a message that is given to someone: a letter, telephone call, etc. Is that message being received, and is it acted upon promptly and properly?

In the long-term care industry, communication is the key to resident care, payment, compliance, and much more. Problems occur when there is limited communication between departments, limited sharing of information, and a lack of understanding of what is being shared. By breaking down the top communication needs among nursing, therapy, and billing, cleaner Medicare claims can be submitted, correct vendor invoices can be paid, the admission process will become more compliant with regulatory requirements, and other everyday operational issues can run more smoothly.

There are common elements across the various Medi-

care payer types (Part A, Part B, and Medicare Advantage), but each presents unique issues from a billing perspective—we go into a few of them below. In addition to addressing Medicare and private pay communication issues, it is important to also review the facility's Medicaid process, which varies greatly from state to state. This article will only focus on Medicare communication, but facilities are encouraged to review all processes.

- 1. Medicare covered inpatient stays (Part A).** Regulations require quite a few conditions to be met prior to submitting a UB-04. If there is no written process, or if the process is not being followed, the biller will not know whether:
 - The Medicare MDS was completed and accepted by the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system
 - A new assessment for payment was completed or is in the process of being completed
 - The physician certification/recertification is complete, signed, and properly dated

- The therapy plans of treatment are signed and dated
- The resident has had an appointment with an outside provider for which an invoice from the provider is expected, and the consolidated billing implications have been investigated
- The ICD-10 coding has been completed and indicates the reason for Medicare coverage
- The medication invoice included over-the-counter medications, which should not be shown on the UB-04
- Any equipment and supplies used that require a cost for ancillary charges are documented
- There is a payment ban that prevents the facility from billing new admissions and vice versa: Nursing and admissions must be informed of any payment ban to ensure that if a resident is admitted, he or she is given the proper information regarding financial responsibility
- Therapy has reported all treatment information in a timely manner
- There are days in the benefit period
- Medicare level of skilled coverage has ceased

From a consolidated billing point of view, it is important that both nursing and the business office are fluent in the categories of exclusions, some of which are based on the location of the service. The scheduler must know where to schedule the appointment to avoid rendering the facility responsible for payment. The business office needs to know what portion of an invoice the facility is responsible to pay, since some items may be excluded, while others are not. Additionally, there is the need to look up Medicare allowable amounts or contractually agreed-to amounts to ensure that the facility is not overpaying. This leads to another potential communication issue: Does the facility have a contract with the outside providers to pay the Medicare allowable amount? If not, the facility must pay whatever the provider bills.

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2. Medicare Part B. Though not as cumbersome, this part of the Medicare program has several areas where miscommunication can be costly:

- Therapy units, logs, and G coding must be submitted timely and accurately.
- Support must exist for the use of the -KX and -59 modifiers.
- HCPCS codes must be provided on a line item date of service basis.
- ICD-10 codes must be provided.
- Therapy caps and thresholds must be tracked.
- Accurate occurrence dates are being provided to billing, including:
 - Onset date
 - Date the plan of treatment was established or last reviewed (for each modality)
 - Date the treatment started (for each modality)
- Plans of treatments must be signed and dated prior to submission of the bill.
- ABNs, when appropriate, were signed for particular services.
- It's not only therapy: Specific nursing supplies and/or services billable to the program must be communicated to the billing person.

3. Medicare Advantage (Part C). With so many policies available, it is essential that the facility staff know all the details of the coverage prior to billing. Nursing staff need to know the details from the side of providing care, while the billing staff need to know what will be paid for by the plan. In fact, the bulk of this information should be obtained prior to admission. The items listed below generally apply to all private insurance as well as Medicare Advantage policies:

- Is the facility in-network? If not, can a contract be arranged or does the resident need to be transferred to another facility?
- Is a three-day hospital stay required for this plan, and was the requirement met?
- Payment is based on a level of care or RUG.
- If payment is based on MDS assessments, have they been completed (these assessments cannot be transmitted)?
- If prior authorization is required, was it obtained?
- Frequency of reporting to the company for an ex-

ension of the coverage has been obtained, as needed.

- Are therapy plans of treatment signed and dated?
- Does nursing or therapy documentation support the need for continued coverage?
- Does the policy have the same consolidated billing requirements as Medicare fee-for-service?
- Have Medicare as secondary payer issues been resolved?
- Is there a supplemental policy that will pay coinsurance or extended SNF coverage after Medicare exhausts?
- Have the requirements for an informational claim to be submitted to Medicare for an insurance denial or to update the Common Working File (CWF)?

Facilities have various pay structures for their private pay population. Some choose to charge based on level of care and/or services. It is vital for both nursing and billing to understand that unless the latter knows about the resident's condition and services rendered, reimbursement is lost. Make sure the following questions are answered:

- Have contracts been signed?
- Have there been changes in level of care based on charge structure?
- Have there been chargeable services rendered? If so, in what quantity? Here are just a few that may be charged:
 - Restorative programs
 - Accu-Chek®
 - Dressing changes
 - Syringes
 - Under-pads or diapers

Following are a few tips to enhance communication. Facilities should look at their processes and see where changes in current operations may make their communication better.

- **Communicate in writing.**
 - Keep copies of all communication.
 - Whether emailed, texted, or hand-written, the communication must be clear and understandable to the recipient.
 - Develop a list of medical supplies to be completed throughout the month. Some facilities may have

a bar code system, but most keep track as an item is used. Follow up, cross off, and update items as necessary.

- **Conduct monthly triple-check meetings.**
 - Meetings must be attended by therapy, nursing, and billing, as well as others deemed necessary by the team, such as specialty services and the MDS coordinator.
 - The meetings do not need to be lengthy if everyone is prepared and there is ongoing monitoring throughout the month.
- **Have a checklist for admissions.**
 - Make sure the checklist indicates insurance requirements (if Medicare Advantage); level of care and services required; and accurate hospital days as well as confirmation of inpatient rather than observation status.
 - Print out the HETS or CWF to ensure benefits. Review and reprint prior to billing (in some facilities, this may be the responsibility of the billing office).

- **Conduct ongoing QA or QAPI activities.**

- Therapy (initial orders for evaluation, signed and dated plan of treatment, progress notes indicating progress and need to continue Medicare coverage for skilled therapy)
- MDS (accurate completion; validation)
- Physician certifications and recertifications
- Updated ICD-10 coding
- Appointments and ancillary services
- Beneficiary notices
- Contracts

In this day and age, much of the needed information can be obtained by viewing it electronically or printing. However, using a communication form still has merit, since it reminds both nursing and billing of some of the essentials that are typically not easily located in a computer. Every SNF can improve the flow of communication between departments. By taking the time to review the current processes, costly mistakes can be avoided. See the sample communication form on the following page. 