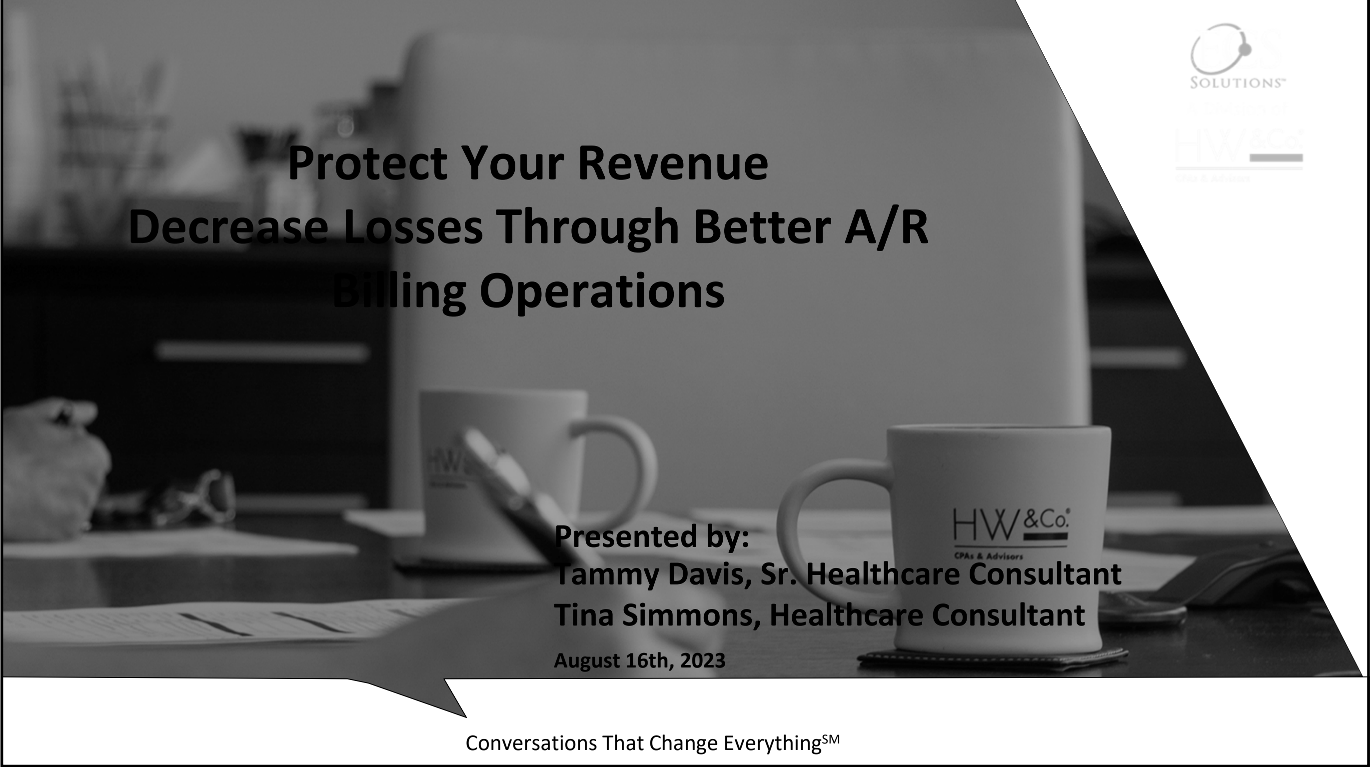

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Your Presenters

Tammy Davis
Sr Healthcare
Consultant

Tina Simmons
Healthcare
Consultant

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Conversations That Change Everything SM

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Our Objectives for You Today

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- ▶ To provide you with important information on:
  - How to prevent losses
  - How to prevent money from "flying out the door"
  - Get and retain all money due & paid
  - Save on costs
    - ECS/HW&Co are here to support you!

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Outline

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- ▶ How to retain your money and be compliant at the same time
  - Ensure Your Physician Certification & Recertification are Compliant
  - Be sure to capture the MOST out of your Diagnosis Coding – to get higher & appropriate reimbursement
  - Watch for and resolve Therapy Line-item therapy denials (Use of modifiers)
  - Only pay bills that are Your responsibility - Consolidated Billing
  - Be sure to do Medicare ABNS, NOMNC -Notices of Non-Coverage
  - Make certain to claim all bad debt you are entitled to
  - Be sure to do Medicare No-Pay and Benefits Exhaust claims

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Outline

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- Additional ways to protect revenue & save on costs
  - Understanding audits and submitting complete and timely information
  - Know your managed care plans
  - Contracting - Should you, or shouldn't you?
  - Payment posting
  - Solid self pay collections policy

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Compliance
Physician Certifications

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Physician Certification

- Physician certifications are THE #1 REASON for Medicare recoupments
- To prevent losses and to be compliant make certain that the physician certification and re-certifications are signed and dated appropriately and that the required information is included in the cert/re-cert

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Elements of Physician Certification

- Initial signature must be obtained at the time of admission. If not upon admission, no later than the 3rd day following admission
- Physician signature and date should be in the same handwriting
- Specific guidelines regarding physician certs can be found on the CMS.gov website, in the Medicare Benefits Policy Manual, Chapter 8
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08pdf.pdf

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Elements Required on Physician Certifications

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- Make certain the initial certification indicates the following notations:
  - Post hospital extended care services are required because of the individual's need for skilled care on a continuing basis
  - This care must be provided directly by skilled nursing personnel, or it must require the supervision of skilled nursing personnel, or skilled rehabilitation personnel
  - These services can only be provided in a SNF on an inpatient basis
  - The care is required for a condition that was treated during the hospital stay
    - **Make it a best practice to review the Physician Certifications during your triple check meeting!**

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Elements of Re-certifications

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- Recertification must include:
  - Reason for re-certification (detail for reason for skilled care to continue)
  - Estimated time services will be needed
  - Note discharge plans, if applicable
  - Timely Signature and date by physician

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Elements Required on a Physician Re-Certification

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▶Timing of Recertification

- The first recertification must be made no later than the 14th day of inpatient extended care services
- Subsequent recertifications are required every 30 days thereafter from the physician signature date

Delayed Certifications

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- Delayed certifications may be honored where, for example, there has been an isolated oversight or lapse.
- Content requirements must be met
- Explanation for the delay and any medical or other evidence which the SNF considers relevant for purposes of explaining the delay.
- Facility determines the format of delayed certification and recertification statements and method by which they are obtained.
- A delayed certification and recertification may appear in one statement.

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Are Faxed Signatures Acceptable?

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- **Medicare General Information, Eligibility, and Entitlement Chapter 4, Section 40**
  - The skilled nursing facility determines the method by which the certification and recertification statements are to be obtained. There is no requirement that a specific procedure or specific forms be used, as long as the approach adopted by the facility permits a verification to be made that the certification and recertification requirements are in fact met. Certification and recertification statements may be entered on or included in forms, NOTEs, or other records that would normally be signed in caring for a patient, or a separate form may be used. Except as otherwise specified, each certification and recertification statement is to be separately signed. See Pub. 100-08, Medicare Program Integrity Manual, chapter 6, section 6.3 regarding medical review of certification and recertification in SNFs.

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Compliance
Medicare Beneficiary
Notices

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The Importance of Medicare Beneficiary Notices

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- In order to shift liability to the beneficiary, Medicare says that a provider MUST notify a beneficiary in advance when the provider believes that items or services will likely be denied because they no longer meet coverage criteria under Medicare guidelines.
- If PROPER notice is not given, providers may not shift financial liability for the services to the beneficiary which can result in significant financial penalty to the facility.

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How to Prevent Provider Liable Days

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- A provider will likely have financial liability for items or services provided if:
  - he or she knew, or should have known, that Medicare would not pay and fails to issue an ABN when required.
  - Issues a defective form
    - Missing Signature
    - Signed but not dated
    - No box checked
    - Incomplete sections
    - Use of Medicare number vs medical record number
    - Alterations to the form

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Know What Forms to Use and When to Use Them!

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- **Generic Notice/Expedited Review – CMS 10123-NOMNC**
  - For Traditional Medicare Part A, Part B and Medicare Managed Care Plans
  - Should be issued at least 2 days prior to the cut
  - Not used in benefit exhaust situations
- **Detailed Notice/Expedited Review – CMS 10124 - DENC**
  - Used if beneficiary chooses to appeal the decision
  - Must be provided no later than the close of business of the day of the QIO's notification.

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Know What Forms to Use and When to Use Them!

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- **SNF Advanced Beneficiary Notice – CMS 10055- SNF ABN**
  - Used for Part A stay and NOT for Medicare Advantage plans.
  - Intended to inform the beneficiary that SNF has determined Medicare will not pay for stay.
  - Must be issued to beneficiary prior to initiating, reducing, or terminating services.
  - Can be used in situations such as benefit exhaust where no notice is required but recommended.
    - Referred to as a "voluntary" SNF ABN
- **Advanced Beneficiary Notice – CMS-R-131 - ABN**
  - Used for Part B services only.
  - Intended to inform the beneficiary that Medicare will not pay for Part B services.
  - Must be issued to beneficiary prior to initiating, reducing, or terminating services.

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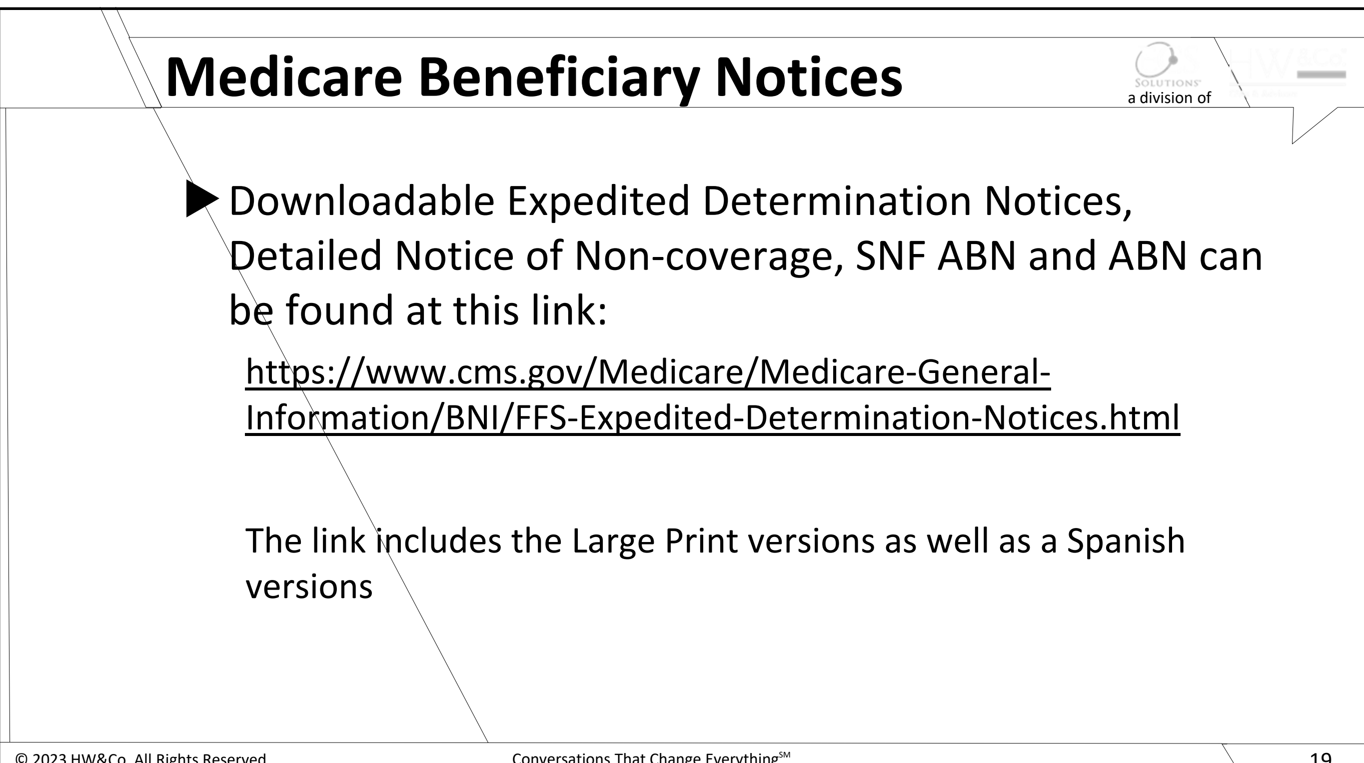

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Best Practices When It Comes to Issuing Medicare Beneficiary Notices

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01
Designate a staff member who has a good understanding of Medicare Beneficiary Notices.

02
Know which form to use and when to use it.

03
Ensure the form is completed properly.

04
Make sure to use the most updated form provided by Medicare.

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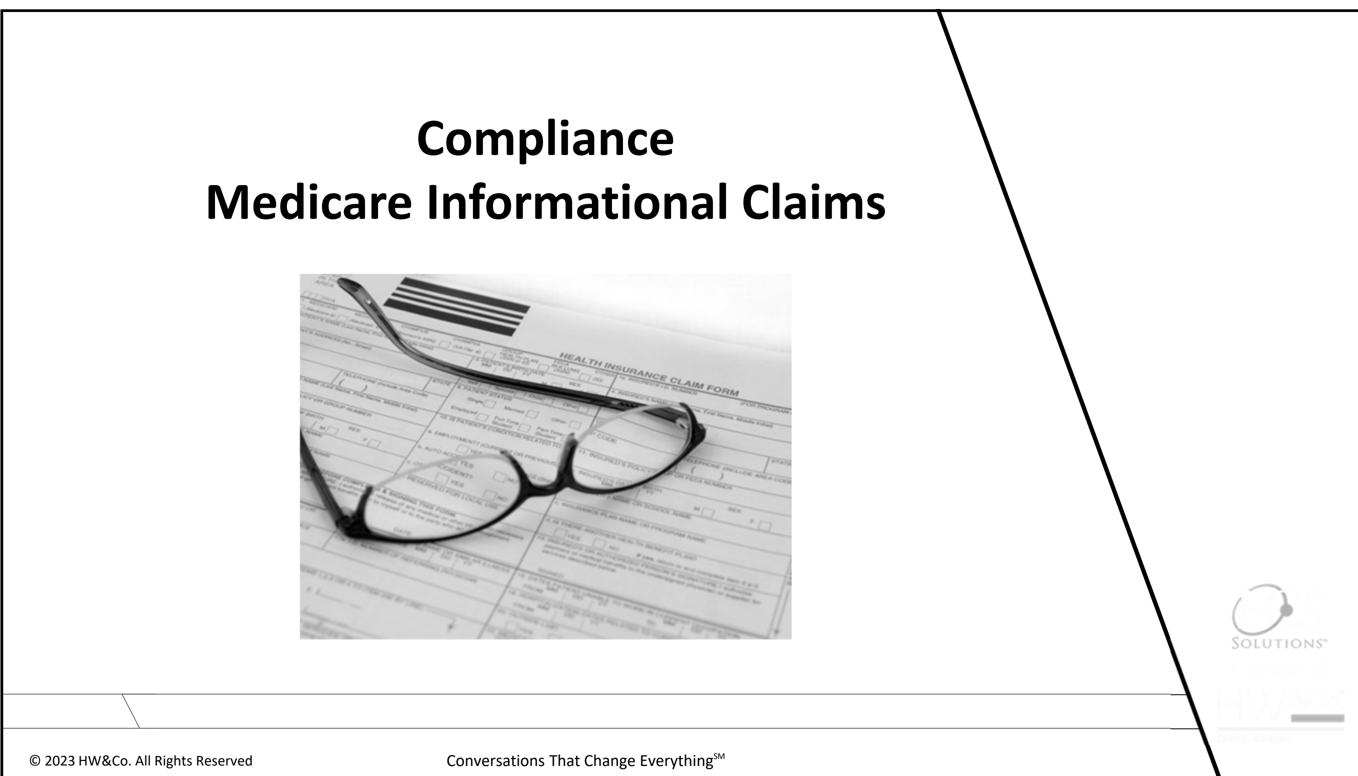

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Informational Claims – Financial Losses and Compliance

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- CMS requires informational claims to be submitted to track a resident's Benefit Period even if no payment is expected from Medicare.
- Unless the provider submits the correct no pay claim, CMS has no way of knowing whether 60-days of non-covered skilled care has passed
- If the spell of illness is not broken, the patient will NOT be entitled to a new benefit period, even with a new illness or injury
- A SNF is required to submit a claim for a beneficiary that has started a spell of illness under the SNF Part A benefit for every month of the related stay.

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Benefits Exhaust Claims

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- A SNF must submit a benefit exhaust claim monthly to Medicare for a beneficiary who continues to receive skilled services until there is a change in the level of care.
- This is regardless of who the payer is beyond their Medicare 100-day benefit period
- Medicare and private pay can remain at a skilled level of care beyond the 100-day Medicare benefit period.

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No-Pay Claims

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- In addition to the Benefit Exhaust claim, SNF providers are required to submit No-Pay claims as long as the patient continues to reside in a Medicare certified bed.
- The No-Pay claim may span multiple months but must meet timely filing guidelines
- ECS recommends to submit at the end of the Medicare fiscal year which is September 30th but can span both the provider and the Medicare fiscal year end dates

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Medicare Advantage No-Pay Claims

- Providers are required to submit an informational claim to Medicare when a beneficiary is enrolled in a Medicare Advantage Plan
- The days reported will be subtracted from the patient's benefit period
- Informational claims keep the Common Working File correct for beneficiaries by tracking the 100-days in the benefit period
- Required until the 100-days are used and level of care changes.

A Few Best Practices

- Create a tracking log to monitor Level of Care changes
- Review census each month for discharges including discharges to hospice
- Monitor claims for correct processing
  - Note: MACs may use different reason codes to indicate correctly processed claims

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Consolidated Billing is Still Misunderstood

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What is Consolidated Billing?

- Consolidated billing began as a result of the BBA of 1997 and the onset of the PPS reimbursement system for Part A
- The consolidated billing provision requires that, effective for services and items furnished on or after July 1, 1998, payment is made directly to the SNF
- Patient service costs bundled back to SNF – Except for specific services deemed to be excluded, most services provided to the Medicare Part A SNF patient are paid for by SNF & listed on the facility's Part A claim
- The SNF is reimbursed by an all-inclusive HIPPS rate determined by and based on the patient's level of care and other requirements.

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Invoices from Outside Providers

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- Too often a SNF pays bills from other ancillary providers of service without checking to ensure is it **really** the SNF's responsibility to pay.
- It is important to know and understand Consolidated Billing and the guidelines under Part A for the SNF's responsibility

Two Types of Consolidated Billing

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- Consolidated billing for Part A
  - All services except those deemed as excluded
- Consolidated billing for Part B
  - Therapy Services – PT, OT, & ST
  - Any therapy received by a Medicare beneficiary occupying a Medicare certified bed must be billed by the SNF to Medicare

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Know the Components of Consolidated Billing

- **Professional component**
  - Direct services of physician or medical professional. His or her time, expertise, or service
  - The reading, examination or interpretation of a specimen or procedure.
- **Professional component is always excluded**

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Know the Components of Consolidated Billing

- **Technical Component**
  - Actual test or procedure
  - The physical part of obtaining the specimen, performing procedure, or taking the x-ray
- **The technical component is normally included in consolidated billing and the responsibility of the SNF**

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A Note About Consolidated Billing

- When a beneficiary selects a particular SNF, the beneficiary has effectively exercised his right of free choice with respect to the entire package of services for which the SNF is responsible for under the consolidated billing requirement.
  - In essence, the beneficiary agrees to the use of any outside suppliers from which the SNF chooses to obtain such services.
- A designated staff member at the SNF must communicate these requirements to the beneficiary and family members upon admission.

How to Identify if Procedures are Included or Excluded

- Use CMS Exclusion list on CMS website
  - https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/Downloads/2019-General-Explanation.pdf
- General Explanation of Major Categories shows how to read exclusion file & detailed information on exclusions.

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Best Practices on Ways to Prevent Losses

- Ensure all Major Category I procedures are performed in a hospital.
  - A. CT Scans (Computerized Axial Tomography)
  - B. Catheterization
  - C. MRIs (Magnetic Resonance Imaging)
  - D. Radiation Therapy
  - E. Angiography, Lymphatic, Venous, and Related Procedures
  - F. Certain Outpatient Surgery and Related Procedures
  - G. Emergency Services
  - H. Medically Necessary Ambulance Trips (For Excluded Major Categories)
  - I. Additional Surgery HCPCS - EXCLUSIONS

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Additional Ways to Prevent Losses

- Designate a staff member to become knowledgeable in consolidated billing.
  - Understand what items are Included and Excluded
  - Ambulance Invoices – Common expense paid in error by SNF
  - Review all vendor bills to make sure you are only paying what is INCLUDED in consolidated billing.
- Explain to patients how the process works and why they must receive their radiation therapy and other Major Category I services from the hospital as opposed to a freestanding clinic.
- Know who and what services will be provided to your patient prior to leaving your facility.

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Additional Ways to Prevent Losses

- Send a letter with the patient to give to the outside provider to ensure the provider understands the patient is in a Part A stay at your SNF.
- Look up the Medicare Fee Screen prior to paying any charges your facility is responsible for.
- Have contracts in place with Providers/Vendors to only pay the Medicare Fee Screen or less.
- Contact the hospital or vendor when billed for anything that is not your responsibility
  - Provide copies of guidelines when necessary

Know what you are responsible for prior to paying any invoice!

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Diagnosis Coding

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Diagnosis Coding

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- Diagnosis coding can impact payments positively or negatively
  - Get the most out of your reimbursement by proper tracking and use of diagnosis coding
  - Accuracy and understanding of diagnosis coding on admission is imperative
  - Incorrect ICD-10 coding under PDPM can result in improper payments
  - SNF will need to know how a surgical procedure during the qualifying hospital stay will impact the clinical category a patient will fall into under PDPM

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PDPM Clinical Categories

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- SNF patients are first classified into one of 10 clinical category based on the primary diagnosis for the SNF stay
- ICD 10 codes on the MDS are mapped to a PDPM category
- They may be adjusted if a surgical procedure occurred during the prior inpatient stay, again coded on the MDS

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Ten Primary Diagnosis Clinical Categories

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- Acute Infections
- Acute Neurologic
- Cancer
- Cardiovascular and Coagulations
- Medical Management
- Non-Orthopedic Surgery
- Non-Surgical Orthopedic/Musculoskeletal
- Major Joint Replacement or Spinal Surgery
- Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)
- Pulmonary

Accounting for AIDS Related Costs Under PDPM

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- PDPM includes specific provisions to ensure that it accounts accurately for the increased costs associated with caring for SNF patients with HIV/AIDS.
- Research shows SNF residents with AIDS, NTA costs per day were 151 percent higher, and wage-weighted nursing staff time was 18 percent greater, than for other residents.
- Residents with AIDS
  - Are assigned the highest point value (8 points) under the PDPM's NTA component
  - Receive a special 18% add-on to the nursing component.
  - Are Identified by using ICD-10-CM code B20 on claim.

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Selection & Sequencing of HIV Codes

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- Code only confirmed case of HIV infections
  - Confirmation does not require documentation of positive serology or culture for HIV
  - A statement from the physician stating that the patient is HIV positive or has an HIV related illness is sufficient

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HIV Patient Admitted for Unrelated Condition

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- Code for the unrelated condition should be listed as primary diagnosis
- Following diagnoses would be B20 (Human Immunodeficiency Virus) followed by additional diagnosis codes for all reported HIV-Related conditions

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Patient Admitted for an HIV-Related Condition

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- Use B20 (HIV) as primary diagnosis code
- Following diagnosis codes should include all reported HIV-related conditions.

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Use of Unspecified Diagnosis Codes

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- In an inpatient setting, unspecified codes should seldomly be used.
- Medicare returns claims to providers when an unspecified diagnosis code is:
  - A Complication or Comorbidity (CC), or Major Complication or Comorbidity (MCC) or;
  - Includes other codes in that subcategory that further specifies the anatomic site

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Knowledge & Tools for Your Team

- A current ICD-10 Code book or software equivalent will be a must have for the individual determining codes on Part A Stay
- A good understanding of how to navigate through the ICD-10 book.
- Need to have a working knowledge of official coding guidelines.

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Therapy Line-Item Denials and the Use of Modifiers

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What is National Correct Coding Initiative for Therapy?

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- Correct Coding Initiative (CCI) Edits were developed by CMS to encourage consistent and correct coding as well as prevent improper payment
- CCI Edits are based on policies developed by The American Medical Association's (AMA's) Current Procedural Terminology (CPT) manual
- All therapy services are subject to CCI Edits.

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What are Modifiers and What Do They Do?

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- Modifiers consist of two alphanumeric characters following the HCPCS/CPT codes to provide additional information regarding the services performed
- Modifiers answer the questions of "which one, how many, what kind, and when?"
- Clinical circumstances must justify the use of the modifier (different limb, different time of day, etc.)
- In some cases, the use of modifiers may affect reimbursement
- Eliminates Duplicative types of services

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Correct Use of Modifiers

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- Modifier Information should come from the therapy department
  - Documentation must support the use of the modifier
  - Modifier must appear on the correct code
    - https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd

Line-Item Denials

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- Determining why a line denied determines your course of action
  - Was an authorization required?
  - Did the patient go over the therapy threshold?
    - If so, did you use the KX modifier correctly?
  - Were there duplicative type services billed without a modifier?
    - If so, did you use the 59 modifier correctly?
  - Were speech services denied because there was no speech diagnosis code on the claim?

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Therapy Best Practices For Optimal Financial Results!

- Verify eligibility and therapy caps prior to providing therapy services
- Understand and know how to read a remittance advice
  - Do not assume an unpaid balance is a contractual adjustment and write off the balance
- Take the time to review each line-item to identify denied lines
- Know your appeal options
  - Provide supporting documentation as requested timely to avoid denials on reconsiderations and appeals.

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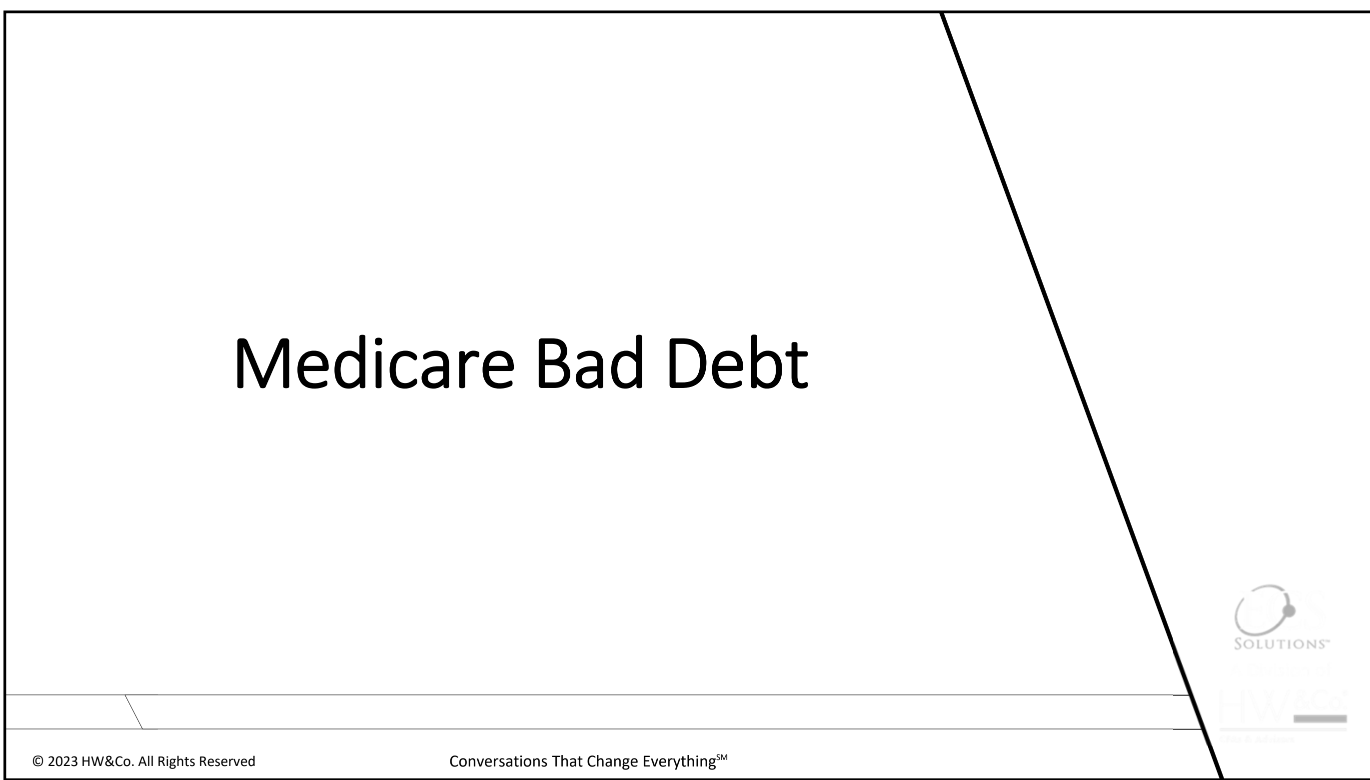

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Medicare Defines Bad Debt

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- 302.1 - Bad Debts.--Bad debts are amounts considered to be uncollectible from accounts and notes receivable which are created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from rendering services and are collectible in money in the relatively near future.
- Medicare bad debt guidelines can be found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929

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Medicare Defines Allowable Bad Debt

Allowable Medicare bad debts are bad debts of the provider resulting from uncollectible deductibles and coinsurance amounts as well as meeting the criteria set forth in HIM 15-1 Chapter 3, Section 308.

For SNF’s, allowable bad debts must relate to coinsurance amounts resulting from traditional Medicare Part A claims.

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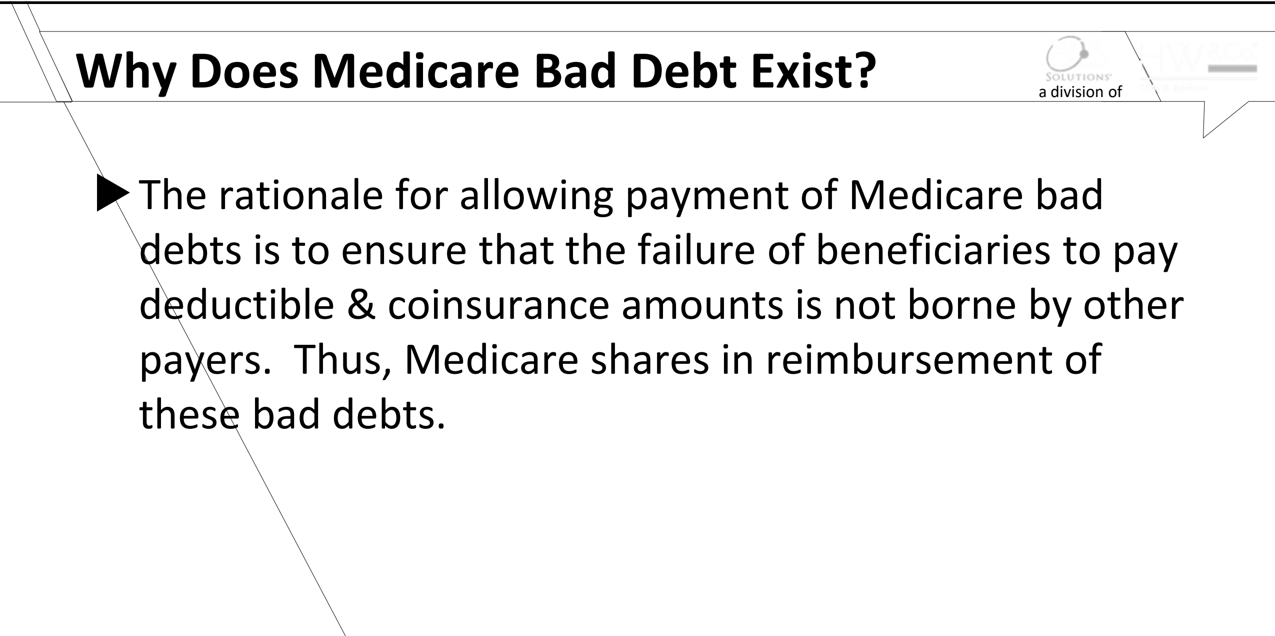

Medicare Allowable Bad Debt Criteria

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- $ The debt must be related to covered services and derived from deductible and coinsurance amounts for Traditional Part A services.
- The provider must be able to establish that reasonable collection efforts were made.
- The debt was uncollectible when claimed as worthless.
- Sound business judgment established that there was no likelihood of recovery at any time in the future.

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Important Reminders for Medicare Bad Debt

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- For SNFs applicable to traditional Medicare Part A only.
- Does not apply to Medicare HMOs – cannot claim unpaid Medicare Advantage Plan co-insurance as bad debt
- Does not apply to any fee for service claims – i.e., Medicare Part B claims are not eligible
- They must be written off in the same year as claimed
- Claims reported as bad debt CANNOT be claimed again (even when declined or if there is a provider error)
  - Example – You listed it on the cost report but did not write it off. If discovered, Medicare would disallow the bad debt, and you cannot claim it on subsequent cost reports.

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Important Reminders Continued…

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- Bad debt reimbursement for all providers was reduced to and remains at 65% as of 10/01/12.
- Bad debts cannot be written off to a contractual allowance account. They Must be written off to a bad debt / uncollectible receivables account that shows as a reduction in revenue
  - **Clarified & Applied after 10/1/20**

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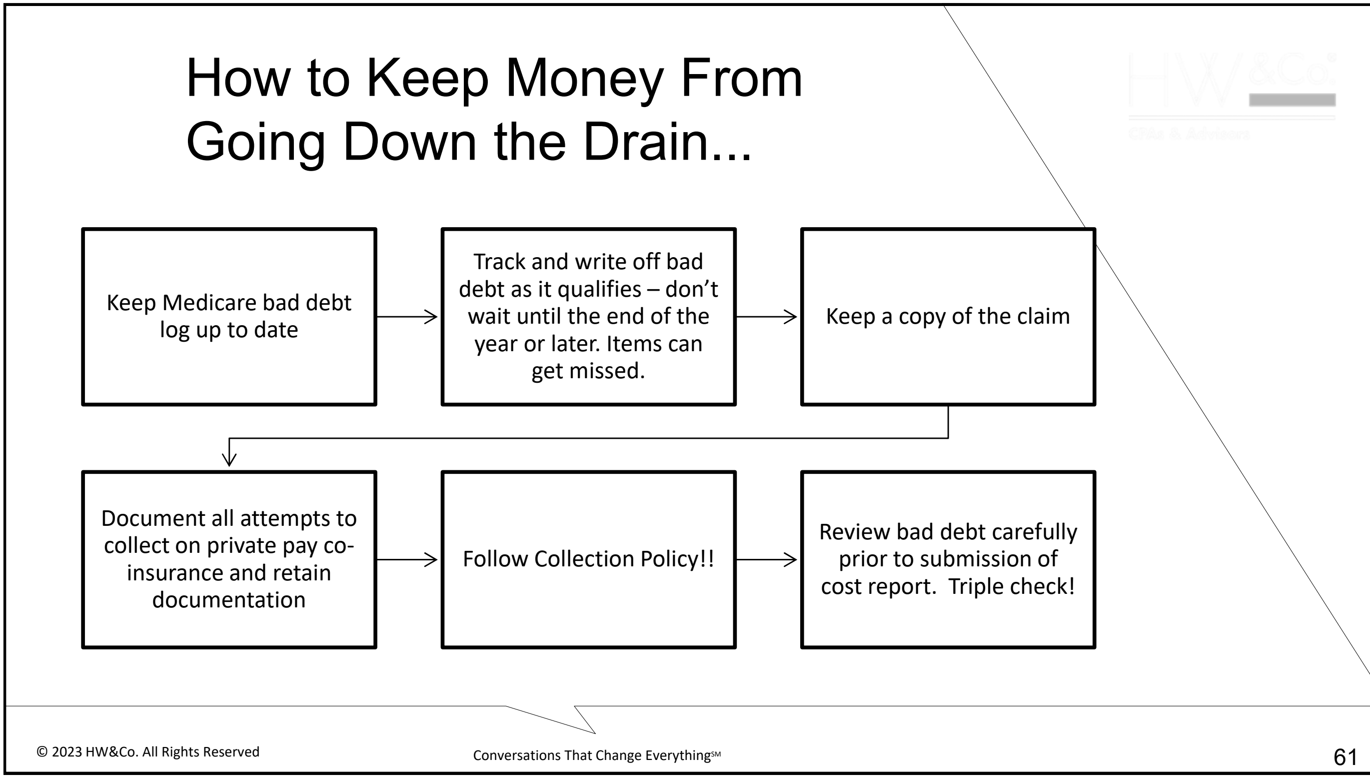

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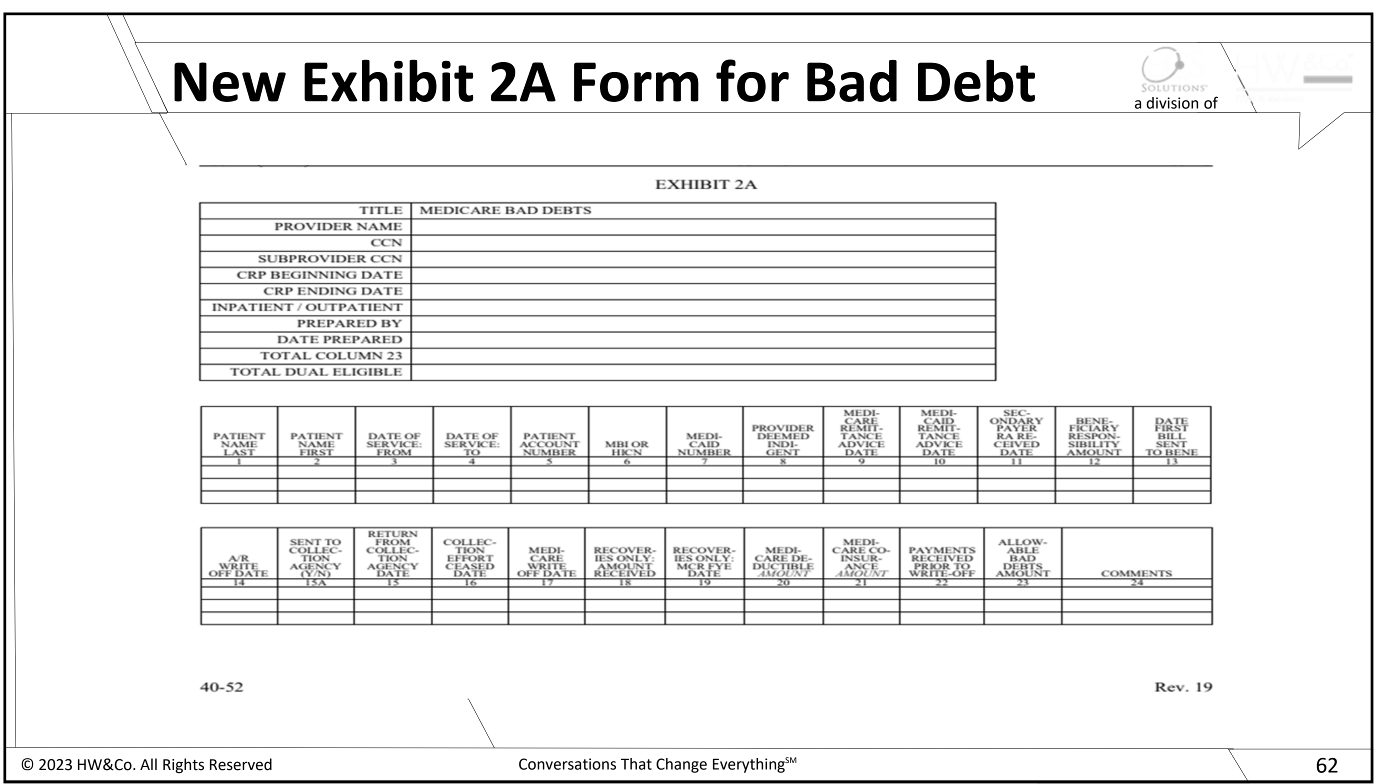

EXHIBIT 2A

TITLE	MEDICARE BAD DEBTS
PROVIDER NAME	
CCN	
SUBPROVIDER CCN	
CRP BEGINNING DATE	
CRP ENDING DATE	
INPATIENT / OUTPATIENT	
PREPARED BY	
DATE PREPARED	
TOTAL COLUMN 23	
TOTAL DUAL ELIGIBLE	

PATIENT NAME LAST	PATIENT NAME FIRST	DATE OF SERVICE: FROM	DATE OF SERVICE: TO	PATIENT ACCOUNT NUMBER	MBI OR HICN	MEDI-CAID NUMBER	PROVIDER DEEMED INDI-GENT	MEDI-CARE REMIT-TANCE ADVICE DATE	MEDI-CAID REMIT-TANCE ADVICE DATE	SEC-ONDARY PAYER RA RE-CEIVED DATE	BENE-FICIARY RESPON-SIBILITY AMOUNT	DATE FIRST BILL SENT TO BENE
1	2	3	4	5	6	7	8	9	10	11	12	13

A/R WRITE OFF DATE	SENT TO COLLEC-TION AGENCY (Y/N)	RETURN FROM COLLEC-TION AGENCY DATE	COLLEC-TION EFFORT CEASED DATE	MEDI-CARE WRITE OFF DATE	RECOVER-IES ONLY: AMOUNT RECEIVED	RECOVER-IES ONLY: MCR FYE DATE	MEDI-CARE DE-DUCTIBLE *AMOUNT*	MEDI-CARE CO-INSUR-ANCE *AMOUNT*	PAYMENTS RECEIVED PRIOR TO WRITE-OFF	ALLOW-ABLE BAD DEBTS AMOUNT	COMMENTS
14	15A	15	16	17	18	19	20	21	22	23	24

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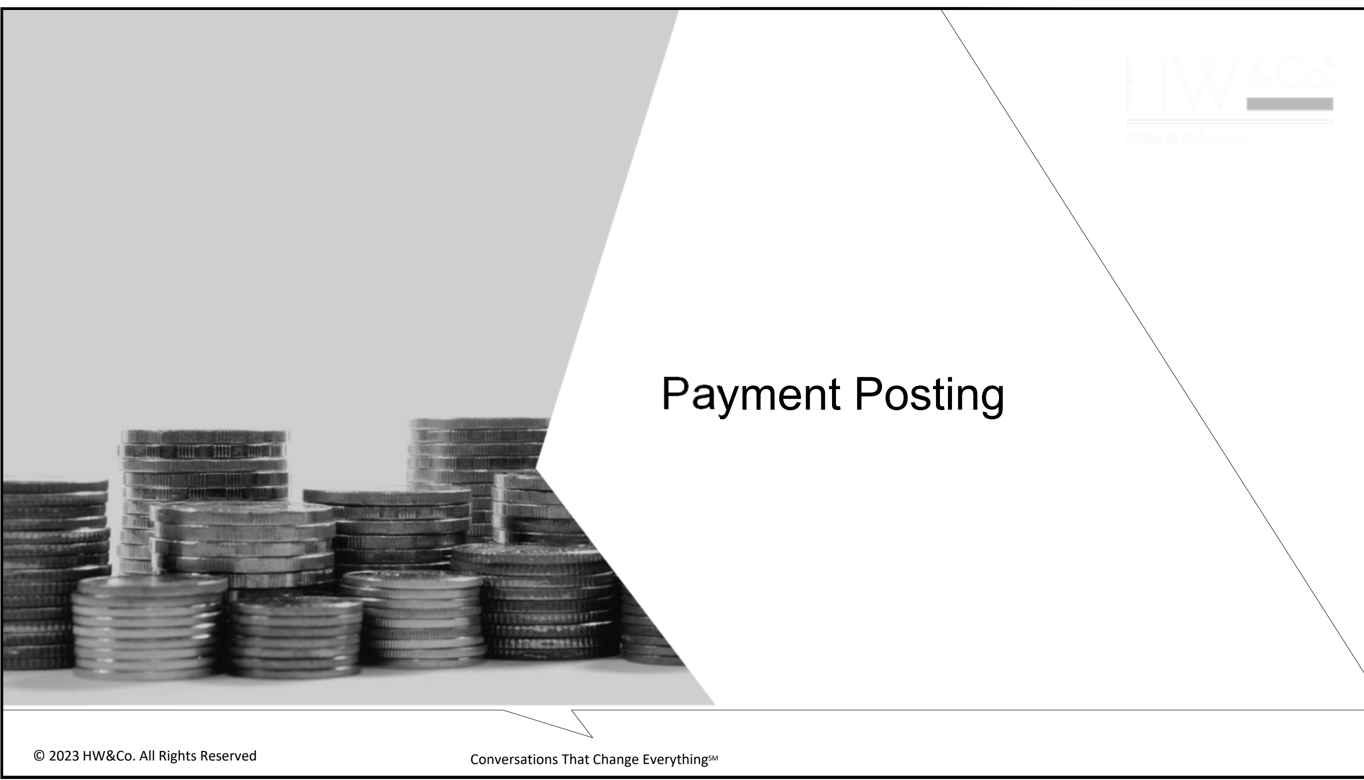

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The Importance of Accurate Payment Posting

Payment posting is one of the most important steps overall within the revenue cycle!

- Benefits include:
  - Accurate overview of Accounts Receivable
  - Ability to identify & address billing problems ahead of time
  - Accurate billing of secondary & Tertiary payers
  - Patient satisfaction
  - Ability to collect patient responsibility in a timely manner
  - It’s a win-win for both the facility and patients!

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Best Practice

Ensure the payment posting team has a thorough understanding of how to read and reconcile a Remittance Advice!

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Helpful Tips

- Understand the general types of adjustment codes and CARC codes.
  - Denied Claim
  - Zero Payment
  - Partial Payment
  - Reduced Payment
  - Penalty Applied
  - Additional Payment
  - Supplemental Payment
- Updates are made 3 times per year
- April, August and December
- The latest codes may be viewed at www.wpc-edi.com/codes

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Common Payment Posting Mishaps

- Payment posting provides a snapshot of a provider's financial picture. When payments are incorrectly applied, this may lead to a financial loss.
- Common errors may include:
  - Payment applied to the wrong patient
    - i.e., More than one patient with the same last name
  - Payment not applied at all due to a zero paid remit
  - Patient Responsibility not transferred to self-pay timely
  - Incorrect Adjustments
    - i.e., Part B therapy lines were denied due to inappropriate use of modifiers, but balance was adjusted off as a contractual adjustment.

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Helpful Tips Continued…

- Use the Aging when posting payments to ensure payments are applied to the correct payer, date of service, and patient account.
- Verify payment matches what is expected.
- Notify billing of payment discrepancies once identified.
- Watch for Zero paid remits.
- Remember…time is money! Reconciling accounts can be time consuming and costly.

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Effective Triple Check

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Effective Triple Check Process

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- Effective triple check process can provide:
  - Alignment and consistency between the care, documentation and the claim that is being submitted
  - A reduced risk of Medicare and Managed Care Audits
  - A "self audit" before an actual audit

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Areas of Focus in Audits

- ICD-10 Coding Accuracy
- Therapy service intensity justification
- Accurate coding of section GG of MDS (Functional Measures)
- Documentation support of daily skilled nursing care
- Mechanically altered diets and swallowing disorders
- Increased coding for depression
- Interrupted stay
- Use of IPA

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First Step to Effective Triple Check

- Identify key personnel who contribute to billing process
  - Director of Nursing
  - Business Office Manager
  - Biller
  - MDS Coordinator
  - Administrator
  - Therapy Department
  - Medical Records

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The Claim – Things to Confirm in Your Triple Check Meeting

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- Using the claim and the medical record, determine the following:
  - Is bill type correct?
  - Are dates of service correct?
  - Does name, date of birth, and MBI# on UB04 and MDS match CWF?
  - Is the date of admission correct?
  - Is the status code on the UB correct?
  - Verify hospital stay dates are correct
  - If re-admission, is QHS within 30 days?
  - If prior QHS is outside of 30 days, is prior SNF stay required? (Condition code 57 and Occurrence code 78.)

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Triple Check – Things to Confirm

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- Are ancillary charges appropriate?
- If so, are orders for ancillaries written and signed?
- Are physician certs and re-certs signed appropriately?
- Do therapy days on UB04 match the therapy days on the logs?
- Do therapy minutes on MDS match the therapy logs and documentation?
- Are HIPPS codes correct on UB?
- Are ARD dates correct on the claim?
- Are therapy orders and plan of care signed by physician?
- Is there an interrupted stay?
- Is principal diagnosis code on claim relevant to hospital stay or to a condition that arose during the hospital stay?

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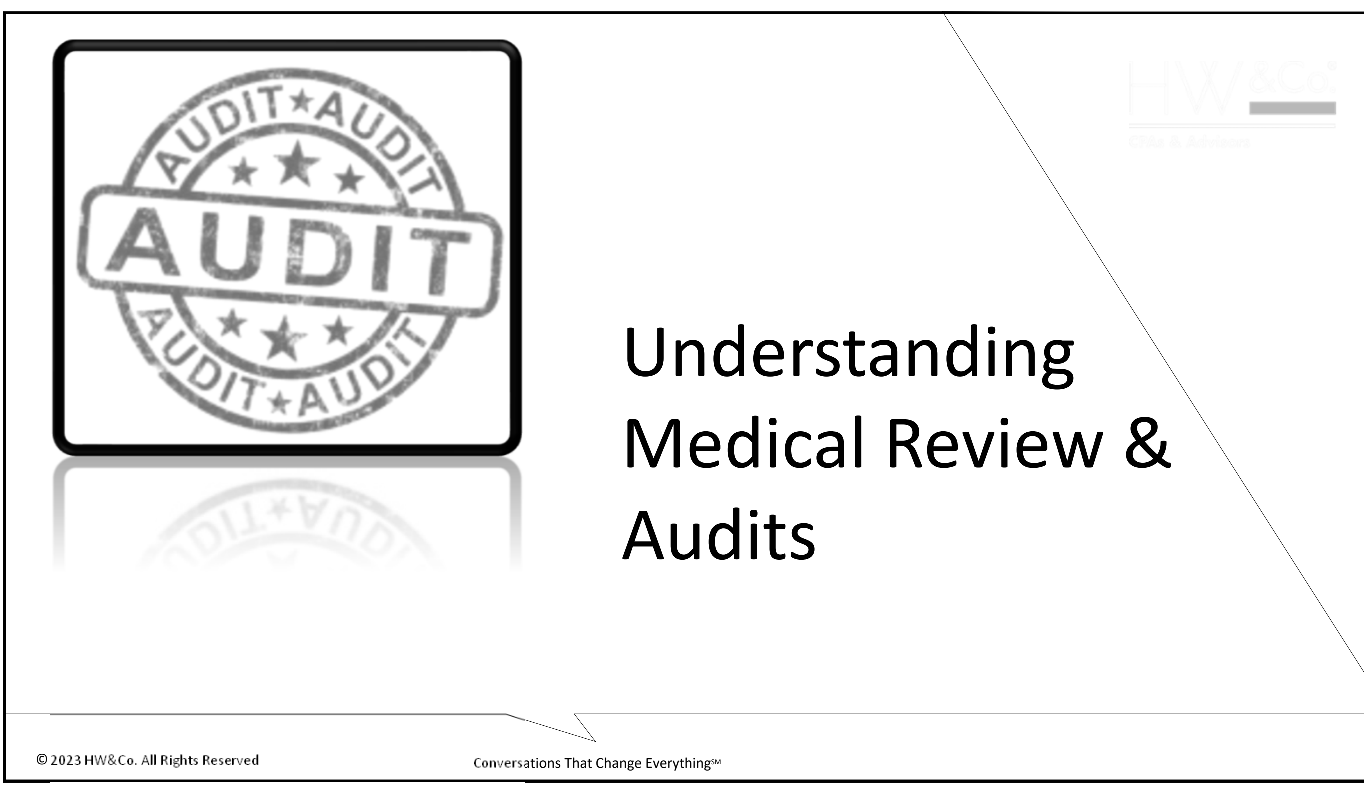

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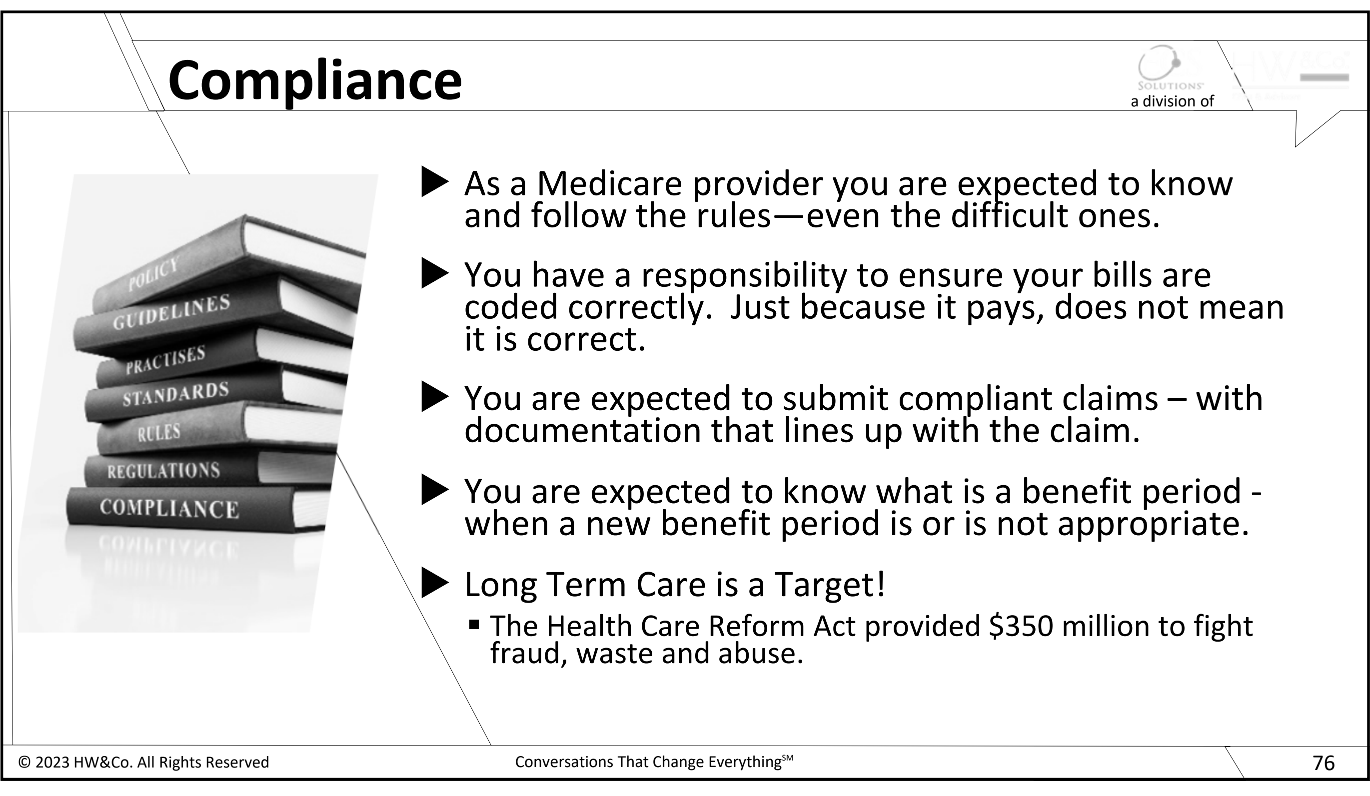

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Compliance Background

▶ CMS has implemented several initiatives to prevent improper payments prior to a claim being processed; and to recover improper payments.

▶ The government estimates that about 8.5 percent of all Medicare Fee-For-Service claim payments are improper.

▶ CMS employs several contractors to process and review claims in accordance with Medicare rules and regulations.

By hikingArtist.com

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Compliance *(and Retaining Revenue)* Starts With Admissions

▶ Administer a solid admissions process & obtain all required Medicare documents.

▶ Medicare Required Documents

- Request for Payment / Release of Information
- Release of Information
- Assignment of Benefits
- Medicare Verification
- MSP Questionnaire
- SNF ABN or Denial Notices
- Expedited Review / Generic Notices

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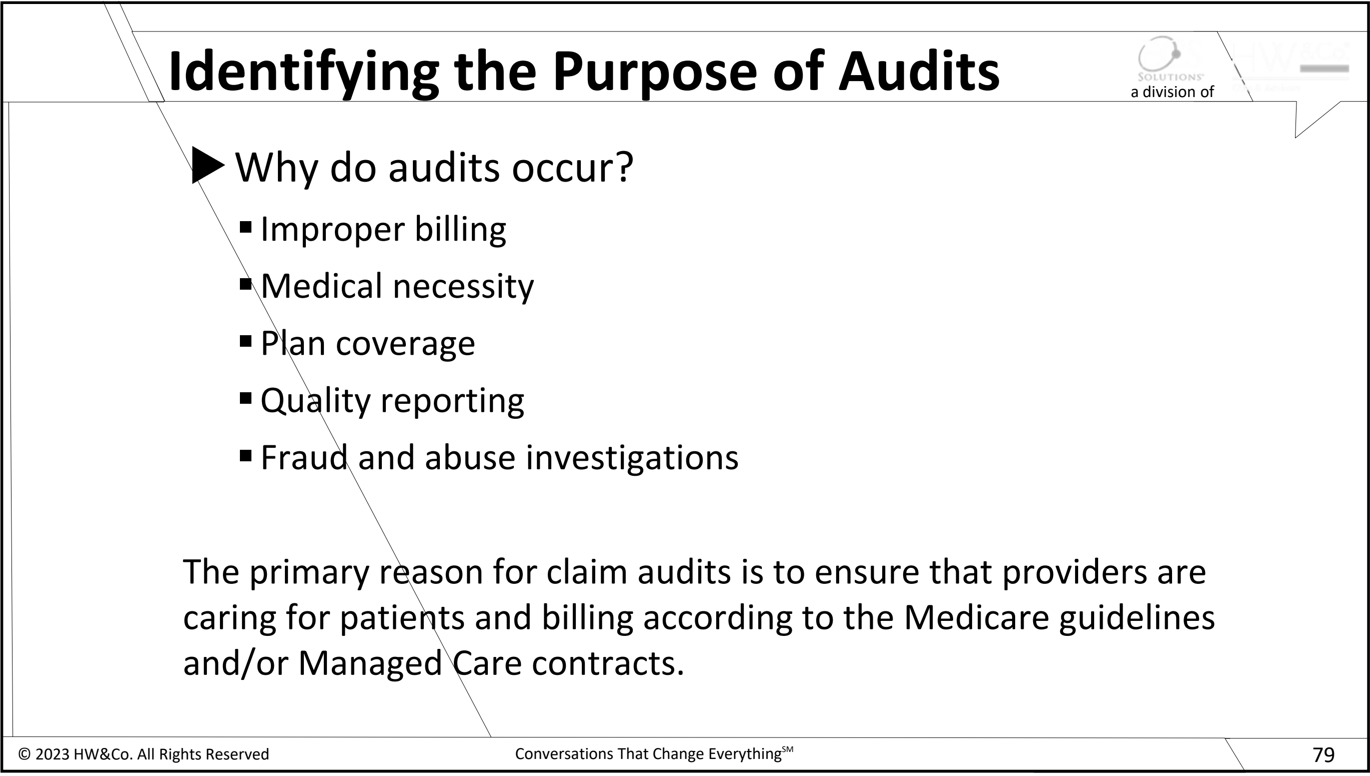

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Common Types of Audits

- Medicare Recovery Audit Contractors (RACs)
- Targeted Probe and Educate (TPE)
- Medicaid RACs
- Medicaid Integrity Contractors (MICs)
- Zone Program Integrity Contractors (ZPICs)
- Comprehensive Error Rate Testing (CERT)
- Payment Error Rate Measurement (PERM)

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Conversations That Change Everything℠

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Tips on How to Successfully Complete an Audit Request

- Be sure to obtain and copy all documentation requested.
- Include a cover letter indicating a list of all documentation included.
- Organize documentation in the order of which the audit requests it.
- Have clinician review it.
- Highlight important points and dates that support the claim.
- Meet the documentation deadline!
  - ✓ Make sure records are sent in plenty of time to arrive before the due date
  - ✓ Verify the address regarding where to send the data
  - ✓ Follow up to ensure records were received

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Is Your Facility Ready? Tips on How to be Prepared…

- Know the Medicare guidelines.
- Implement and use a strong triple check system to ensure accuracy of billing.
- Hire an outside Medicare expert to periodically review your medical records.
- Check physician certification and orders for compliance, signatures, and dates.
- Ensure documentation is accurate daily.
- Conduct a utilization review meeting to review residents' skilled needs on a weekly basis.

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National TPE in Progress

- Beginning in June 2023 Medicare Administrative Contractors (MAC) began a mandated 5 claim TPE review for each SNF provider unless they are already under review or a low utilization provider for service dates after 10/1/19.
- MACs will complete 1 round of probe and education for each provider
- Education offered will be individualized based on the claim review errors
- Claims with U07.1 will be excluded from the review

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Managed Care and Managed Care Contracts

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General Overview of Managed Care

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- Medicare Managed Care Organization (MCO) enrollment continues to increase at a monumental rate.
- MCO's are aligning themselves with Medicare and Medicaid at a lower cost to the beneficiary.
- Managed Care Plans can offer challenges to facilities.
  - Each MCO has different contract requirements
  - Different technical requirements for coverage
    - Many have no 3-day prior hospital stay requirement
    - Some plans differ in their definition of skilled care
    - Authorization requirements

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Types of Managed Care

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- The most common Medicare Managed Care Programs
  - Health Maintenance Organization (HMO)
    - Beneficiaries who opt to join an HMO choose a primary care physician who must be contracted when seeking medical care.
    - Most HMOs do NOT offer out of network benefits
  - Preferred Provider Organization (PPO)
    - A PPO is a group of doctors or hospitals that offer medical services at discounted rates as part of a specific network.
    - Beneficiaries have more freedom of choice
    - PPOs offer out of network benefits. Out of pocket expenses are normally higher.
  - Point of Service (POS)
    - A POS plan combines characteristics of the HMO and PPO plans.
    - Beneficiaries select a primary care physician
    - Beneficiaries who stay within the network have no deductible and minimal copays.
    - If beneficiary goes outside the network, the coverage becomes more like a PPO. Out of pocket costs are higher.

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How Managed Care Plans Work With SNFs

- Contracted providers must bill according to the contract provisions.
- Non-contracted providers should bill according to Medicare guidelines.
  - ✓ All Medicare required assessments should be completed but not submitted.

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To Contract or Not to Contract?

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- Upside:
  - The facility may gain a boost in census when contracting with a MAO that is prominent in the area.
  - The facility can negotiate rates.
- Downside:
  - A Medicare Advantage contracted provider, in many cases, agrees to accept less as payment for the services provided. Often, it is MUCH less.
  - Non-contracted providers are paid at the Medicare fee schedules, unless the provider's claim is less than the PDPM amount. If less, the MAO is only required to pay the billed amount.

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Best Practices to Note During the Admissions Process

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Verify insurance benefits and Medicare benefits.

- If patient is eligible for Medicare, obtain the Medicare number.
- Medicare requires an informational claim to be submitted even if member is enrolled in a MAO.
- Note any special billing instructions & communicate instructions to the billing department.

Obtain the preauthorization of stay.

- Ensure the ICD-10-CM diagnosis code on the authorization matches the reason for the SNF stay.
- Make certain pre-cert number is in the billing software system and communicated to the billing department.
- Communicate & ensure the clinical staff knows when to submit the authorization updates.

Keys to Success

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- Understand and know what's in the contract!
- Complete physician certifications and re-certifications as if the beneficiary is covered under the Medicare program.
- Review contract coverage and needs of the patient prior to admission to determine the cost of care.
  - i.e., Special DME equipment, high-cost medications, ambulance transport for follow-up appointments, wound care supplies, etc.
- Keep the billing team in the loop.
- Be prepared to appeal.

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Roles of Admissions, Business Office and Billing

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Collections Begin With Admissions

- Admission staff need to understand rules and guidelines of potential payers as clearly as the billing staff
- Admissions is responsible for educating beneficiary and/or family members with regards to their payment obligations

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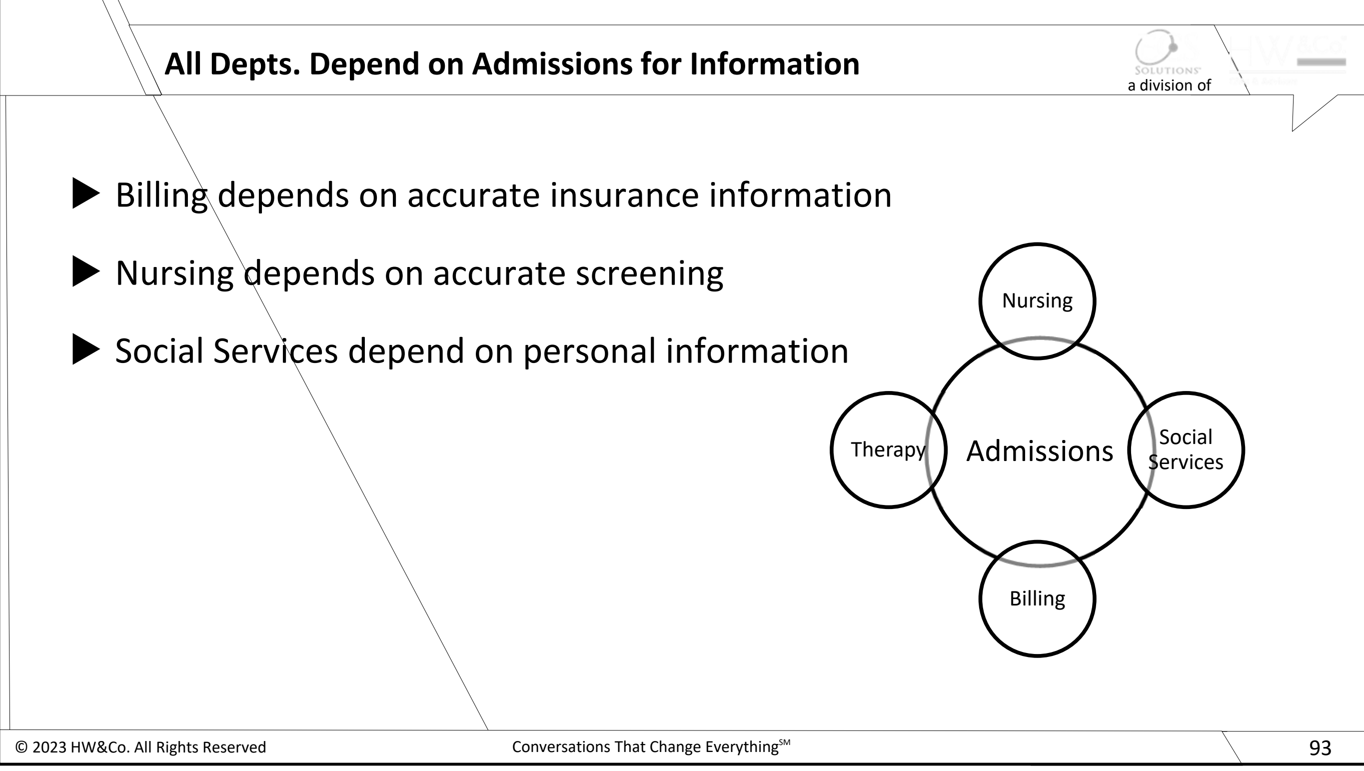

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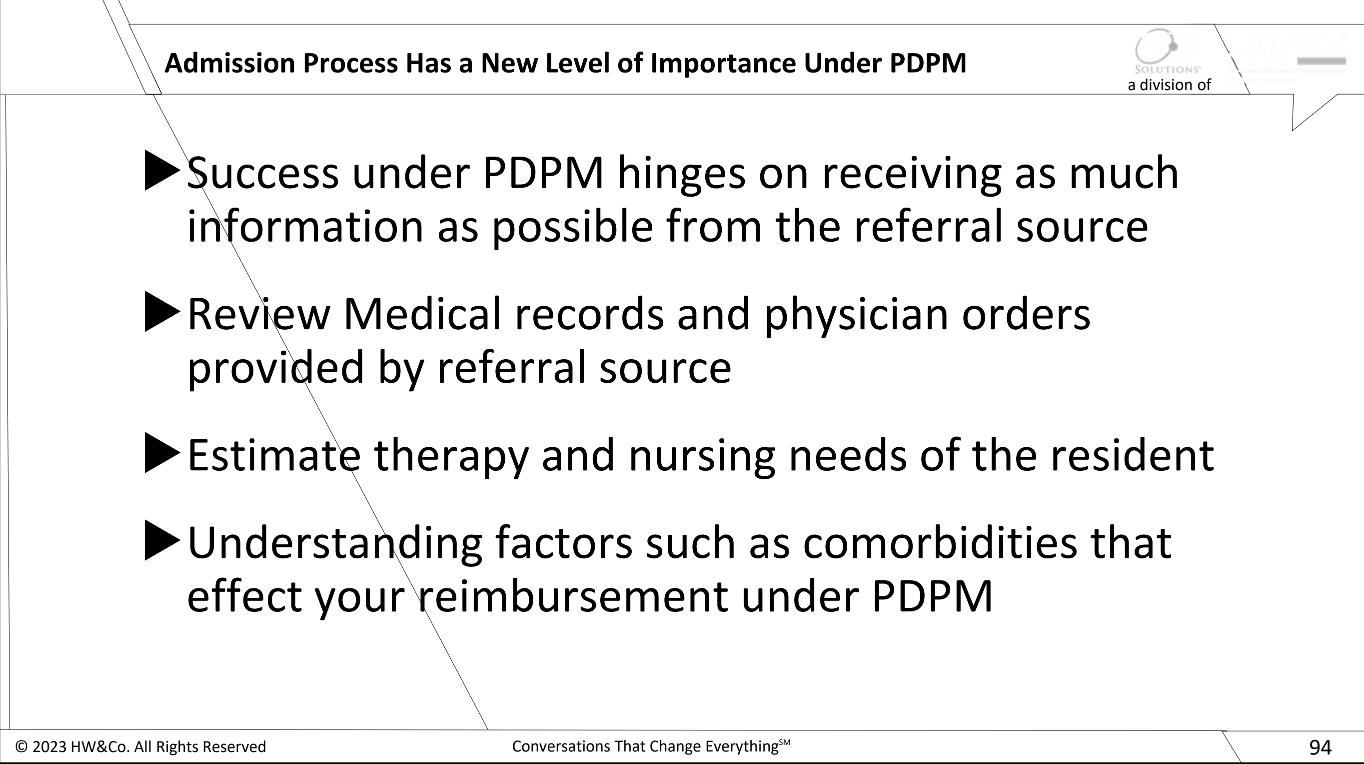

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Business Office

- Ascertain what insurances the resident may have to assist with their financial obligation
- Verify insurance coverage both Primary and secondary via available software or by telephone.
- Determine if the patient will meet Medicare or insurance coverage criteria
- Also shoulders responsibility for communication to resident and family regarding financial expectations.

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Biller's Role

- Participation in the triple check meeting
- Submission of compliant primary and secondary claims
- Follow up with payers on billed claims
- Assist with gathering information for additional development requests and other audits

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Training & Auditing New Staff Members

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- Invest in training of new staff members
- Audit the work of new staff members until a time where they can prove they have mastered a skill

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Questions?

Call or email us!

Phone: 614-734-1700
Email: cindy.dunne@hwco.com

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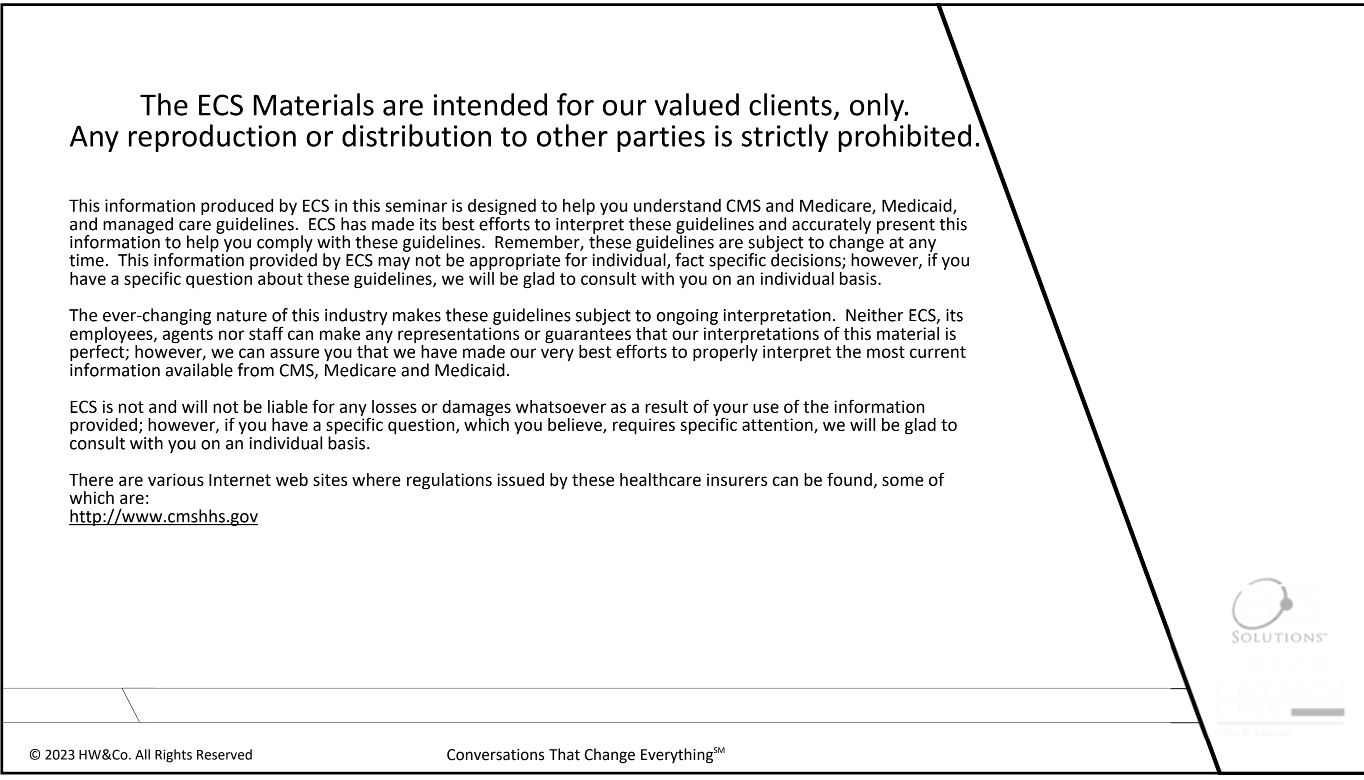

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