Eli's Rehab Report

Coding Corner: Denials on Part B SNF Claims? It May Be a Software Oversight

Heads up, hospital rehabs: This glitch could happen to you, too

The occasional Part B therapy claims for long-time residents in your skilled nursing facility may be falling through the cracks if you don't know where to catch them. Make sure the following situation isn't happening right under your nose -- and read the experts' advice on how to prevent this snafu.

Track Down the Right ICD-9s

Scenario: A long-time resident who was admitted to a SNF more than a year ago under Medicare Part A for a urinary tract infection (599.0, Urinary tract infection, site not specified) and dementia (290.21, Senile dementia with depressive features) has just had an onset of arthritis in his knees (715.16, Osteoarthritis, localized, primary; lower leg), which has impaired his ability to walk (719.7, Difficulty in walking) due to joint pain (719.46, Pain in joint; lower leg).

Nursing staff and the patient's family agree to start him on a therapy regimen to soothe the arthritis and help him keep walking. The patient should receive coverage for physical therapy under his Medicare Part B benefit -- but his claims are being denied.

Likely problem: The correct diagnosis codes may simply not be finding their way to the claim form. Why: "Sometimes the diagnoses are pulled from the SNF admission face sheet, which has nothing to do with why the patient is receiving therapy, especially if the patient was admitted more than a year ago," says **Christine Twombly, RN,** chief clinical consultant with Reingruber & Company in St. Petersburg, Fla.

That means that in the example above, 599.0 and 290.21 may be landing on the patient's Part B therapy claim -- which clearly have nothing to do with his physical therapy plan of care and will be denied.

Solution: The best way to make sure this mistake doesn't happen is to double-check the codes going onto the claim form and make sure they match up to the Part B episode. For the scenario above, the ICD-9s on the therapist's claim should read as follows, keeping the therapy/treatment diagnosis first, since the primary reason the patient needs therapy is the difficulty walking due to the pain and arthritis:

- 719.7
- 719.46
- 715.16.

Don't Keep Your Software on Autopilot

Billing software may be your best friend when it comes to productivity, but it doesn't hurt to periodically check in, especially in the case of a Part B claim for a long-time resident like above. "Coding the original admit diagnosis on a completely separate Part B claim often happens because the billing software automatically posts the ICD-9 from your face sheet to the claim -- and those new treatment diagnoses for the Part B therapy are not on the face sheet," Twombly says.

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If you're lucky, sometimes the original diagnosis will be correct. For example, a patient who was admitted after a stroke could need a round of therapy well into her stay, due to late effects of the stroke, says **Pat Trela, RHIA,** with PATrela Consulting in Quincy, Mass. "But then again, the patient could be experiencing something new, like a fracture, and there's no way the coder [or the software] would know this -- especially in really big SNFs."

Remember: "Although computer systems are a wonderful thing, the output is only as good as the data entered," says **Ron Orth, RN, NHA, CPC, RAC-C,** president of Clinical Reimbursement Solutions in Milwaukee. "At a minimum, ICD-9 codes should be reviewed monthly, prior to submission of their claims."

You should also make sure that the ICD-9s support the reason the patient is receiving therapy. Along those lines, be cognizant of any local coverage determinations for Part B therapy services, Orth says.

Kick Your Communication Into High Gear

Keeping everybody in the loop is the best way to ensure a mistake like reporting an irrelevant ICD-9 doesn't happen. Bottom line, "you need to get the right information to whoever's coding the records," Trela says. "It must be a team effort between the therapist, the billing office and the coder."

Best bet: Unless the therapists are contracted and doing their own coding, develop a process that ensures your therapy billing information gets to the coder. Perhaps at the end of each day, a therapist could report to the coder any new plans of care that were established that day.

To double-check the ICD-9 accuracy, once the coder is alerted of a new Part B therapy case, he could check the therapy 700 forms for the therapy diagnoses when it comes time to code, Twombly says. "You also want to make sure you're updating your software with the right codes," she adds.

Another way: If you have a large facility or multiple sites that make these suggestions more difficult to follow, don't worry: Trela cites an organization with several locations that faxes coders PT evaluations and physician referral forms or the therapy plans of care anytime a new round of treatment arises for a resident.

Hospitals, take note: The same billing snafu can happen in your facilities as well, Trela says, so be sure that your outpatient therapy department has a strong communication link with the facility coders and billers.

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