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MDS Alert

Medicare Part C: Make Sure You're on the Same Page With Medicare Advantage Plans

Take heed: Some plans may require frequent recertifications for skilled care.

Failing to nail down the right information when admitting a patient who may be on a Medicare Advantage plan can put your facility at a major disadvantage payment-wise.

Golden rule: Always "do an insurance verification before admission because problems can creep up with Medicare Advantage (MA) plans," warns Atlanta consultant **Darlene Greenhill.** "And if you don't take care of them in time, you might admit the person and find out you have all kinds of billing issues."

Examples: "Sometimes a family member thinks the beneficiary has traditional Medicare," says Greenhill, "but later you find out that the beneficiary is really in a Medicare Advantage plan," she says.

The opposite scenario has also been known to occur.

Also: The admissions staff should look at the Common Working File (CWF) to see how many days theperson has left in his benefit period. "The CWF may not always be accurate if another facility hasn't done its billing to the fee-for-service program for a patient on an MA plan, Greenhill says. "But it's important to check it."

Billing tip: "It's also a good idea for the billing office to verify the status of beneficiaries during the open-enrollment period" for MA plans, advises Greenhill. Open enrollment, which is the same for all plans, runs from Nov. 15 to Dec. 31, she says. And "beneficiaries can make one change to their plan from Jan.1- March 31." Greenhill works with one SNF that sends out a notice as part of monthly billing asking the resident or family/responsible party to inform the facility if the resident has any change in coverage.

Verify T hat the Plan Will Pay and I ts Requirements

Before admitting the person, call the plan to make sure it will actually pay for his care, Greenhill counsels. "Also ask whether the facility needs a contract with the MA plan [in order] to be paid for providing care to the beneficiary." That's vital to know because if the plan does require a contract -- and you admit the beneficiary without one -- "the plan can refuse to pay," cautions Greenhill.

She notes that she is working with a facility grappling with that situation. Don't forget to nail down the plan's precertification and recertification requirements. "Some plans require recertification every few days," advises Greenhill. And even though you have a beneficiary who continues to require skilled care, you may have to call the MA plan every few days to provide that information and have the person's skilled coverage recertified, she adds. If a facility has a lot of Medicare Advantage plan patients, it may need to dedicate a nurse to handling the precertification and recertification, Greenhill advises.

Another must-do: Find out if the plan wants Medicare MDS assessments. The plan may or may not want you to submit MDSs on the fee-for-service PPS schedule or want the MDS-generated RUG scores,Greenhill notes. "Some don't care anything about the MDSs but others do." Either way, she advises SNFs to go ahead and do the MDSs on the PPS schedule anyway and transmit them to the state. That's particularly important to do if you have a question about whether the person may not be in an MA plan or has some other type of insurance, which will be primary, she adds.

Perk: "Doing the MDSs ensures you'll have them if the MA plan or primary insurance denies coverage or payment. Some people have been known to change their MA plans in the midst of an open enrollment period, and the SNF provider

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doesn't know that until it tries to do the billing," Greenhill counsels. CMS recommends that "SNFs complete MDS assessments based on the Medicare cycle to protect themselves from potential payer change issues down the road," advises **Betsy Anderson,** VP of FR&R Healthcare Consulting Inc. in Deerfield, Ill. (See the related "What Do You Think" question and answer on page 68.)

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