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Payment: Nail Down These 2 SNF Billing Clarifications

Know what counts as a unit of rehab therapy.

SNFs will likely be more on the same page with their Part A billing come Aug. 1 when a new transmittal goes into effect. But SNFs should keep in mind that the clarifications will also help payers and auditors see if what you're billing is on the mark, according to **Victor Kintz, MBA, CHC, LNHA, RAC-CT, CCA**, managing director of operations for The Polaris Group based in Tampa, Fla.

For one, CMS Transmittal 2245 instructs that "in all cases" when completing an End of Therapy OMRA, you should "submit occurrence code 16, date of last therapy, to indicate the last day of therapy services (e.g. physical therapy, occupational, and speech language pathology) for the beneficiary."

In an additional update on its website, CMS further noted that you are allowed to bill only one occurrence code per claim. Therefore, "you would use the final date therapy provided in relation to the latest EOT OMRA applicable for the claim being billed," CMS states.

Implications: With occurrence code 16 being required, "a claims reviewer can now create a simple edit that will be able to determine if the number of rehab RUG and non-rehab RUG days are correct on the claim," says Kintz. "If not, the claim gets kicked out."

Transmittal Also Clarifies What Counts as a Unit of Therapy

The transmittal states that "for therapy services, that is revenue codes 042x, 043x, and 044x, units represent the number of calendar days of therapy provided. For example, if the beneficiary received physical therapy, occupational therapy, or speech-language pathology on May 1, that would be considered as one calendar day and would be billed as one unit."

Kintz notes that providers have for years been confused about how to define a unit. With the clarification, however, "a simple edit may now be created. One such edit could be if the number of billed therapy units exceed the number of rehab RUG days billed, then the claim is in error," he says.

Watch out: Due to the clarifications, "the claims reviewer (either pre or post payment) will now be able to better determine the accuracy of the claim, and potentially target providers who consistently bill incorrectly," Kintz says. "If the claim is in error for these items, the chances are good that there are other problems in that facility with either supporting documentation or claims accuracy for proper RUG billing."

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