MDS Alert

Reimbursement: SNFs: Focus On 10 Reimbursement Issues In 2015

Ask yourself these questions to gauge your facility's costly compliance risk.

How can you improve your facility's reimbursement and cash flow this year? What are the biggest reimbursement and compliance traps lurking ahead? These industry experts are weighing in.

In a Jan. 28 webinar, **Julie Bilyeu**, director of healthcare, and Lisa McIntire, senior managing consultant, of **BKD CPAs & Advisors** in Springfield, Mo, identified these 10 items as issues that facilities often struggle with and that can negatively impact reimbursement:

1. Formulate Your ICD-10 Plan

ICD-10 will be effective with your October 2015 services, "which will be here before you know it," Bilyeu said. "So you want to make sure that you're prepared for that change." You must be prepared and have a plan, and you must train and test.

Strategy: Think about all the things you need to have in place, such as forms and processes, and set timelines for completing each task. You shouldn't try to accomplish everything all at once, so break it up into steps, Bilyeu recommended.

Training should be a big part of your plan, Bilyeu stressed. Decide who in your organization needs to have training and how much training including billing/coding personnel and clinicians. But don't forget to ensure that contract therapists are receiving ICD-10 training, too.

2. Keep Part B Reimbursement on Your Radar

Problem: Nursing facilities often treat Medicare Part B like the "stepchild" and don't give the same attention that they give Part A reimbursement, for obvious reasons, McIntire noted. But if you aren't appropriately following up on your Part B billing, this could start building up and still cause a significant issue.

Unlike Part A claims, which Medicare either pays, rejects or denies in total, keep in mind that Medicare can pay Part B claims in part, McIntire said. A typical reason for Medicare to pay a Part B claim partially with deleted lines is a missing modifier.

Another issue: Beware of Medicare Administrative Contractors (MACs) improperly processing G codes, which can also cause payment problems, McIntire noted. And if you submit claims without occurrence codes, you may experience only partial payments for your Part B claims. Make sure that you include all relevant diagnosis codes pertaining to therapy services on claims, especially if you're in an area where your MAC applies local coverage determinations (LCDs).

Follow up on your claims in a timely manner, and be sure to adjust your claims that have denied lines in the Medicare system. Adjust your system for sequestration and the Multiple Procedure Payment Reduction (MPPR), because your software won't automatically make these adjustments and you'll need to make them manually.

"Otherwise, you're going to continue to incur your monthly therapy expense but you're not going to receive all the reimbursement you're entitled to, which from a therapy perspective could put you in an upside-down position," McIntire warned.

3. Prepare for Medical Reviews

CPT® 2023 American Medical Association. All rights reserved.

Just because you've received payments for your claims, that doesn't mean that reimbursement isn't still at risk, Bilyeu warned. In fact, there are several different types of post-payment reviews, such as those conducted by Recovery Audit Contractors (RACs) and Zone Program Integrity Contractors (ZPICs).

Additional Documentation Requests (ADRs) are prepayment reviews performed by your Medicare contractor, Bilyeu said. If your biller/coder sees a claim going into a SB6000 suspense status, this means your Medicare contractor has pulled that claim for an ADR. CMS can also request ADRs post-payment.

Tip: Have a point person who is responsible for handling the reviews, who will notify all the people who need to gather the documents to prepare for the review, Bilyeu advised. Make sure the information you're gathering is complete. For instance, make sure you're gathering all the MDS documents and assessments in the look-back period for your Part A claims.

4. Turn Around Bad Debt

To make sure you receive proper reimbursement for your Medicare Part A coinsurance bad debt, establish processes for tracking and capturing your bad-debt amounts throughout your fiscal year, McIntire said.

"Time and again, we see providers miss out on potential reimbursement or have reimbursement taken back upon a Medicare bad-debt audit," McIntire warned. "And usually it's due to just inadequate collection efforts, lack of tracking processes, or lack of understanding of what the rules really are."

Best bet: Capture and review your bad debt on a monthly basis to put yourself in a much better position at year-end, McIntire advised. Also, if you're in a state where Medicaid doesn't pay for Part A coinsurance, understand your state's particular requirements for appropriate denial of claims.

5. Avoid the Consolidated Billing Trap

The trap with consolidated billing that you might fall into is not having processes in place for tracking all the services from outside providers, Bilyeu cautioned. So when you receive a bill from an outside provider and you're writing a big check, don't let that payment go out the door without someone looking at the bill.

Make sure you know your provider responsibilities, as well as understand your contracts, exclusions versus inclusions, and the Medicare reimbursement rates, Bilyeu said. So when you receive a bill from an outside provider, you need to first determine whether you're responsible and then find out what the reimbursement will be. This can save you a significant amount of money.

6. Stay on Top of Accounts Receivable

"Without simple, clear processes, consistent follow-up and accountability, accounts receivable can quickly get out of control," McIntire cautioned. Although there are exceptions, you should follow certain guidelines to know what's reasonable according to billing type.

"For private pay, Medicaid and Medicare, you should see payment within 30 days," McIntire said. Medicare will pay 14 days from the day it receives a clean claim. If you notice that Medicare payments are building up on your aging, the most likely problem is not Medicare paying but a problem with knowledge and training in sending out clean claims.

Primary insurance or Medicare replacement plans should also pay within 30 days, if you're using an electronic clearinghouse, McIntire noted. But if you're still billing manually and following up via phone, the payment timeframe will be more like 60 days. And coinsurance claims could take 90 days.

Strategy: Hold monthly aging review meetings to keep up with your accounts receivable, McIntire suggested. Make sure key personnel like billers/coders and especially management attend these meetings.

7. Educate Your Staff

CPT® 2023 American Medical Association. All rights reserved.

"Education is your key to compliance, so it needs to be a priority," Bilyeu stressed. Education is often neglected for business office personnel, so empower them to seek training.

Provide resources to your staff, too, Bilyeu said. There are lots of resources out there, such as state Medicaid programs that provide training and email alerts, CMS listservs and Medicare Learning Network guides, and all Medicare contractors have listservs you can sign up for.

Most important: Make sure you invest in training when there are significant changes going on, like the ICD-10 transition, Bilyeu advised. External reviews of your billing or documentation can also be helpful to identify training gaps and other problems.

8. Improve Interdisciplinary Communication

Clean claims move through the payment process more quickly, but clean claims don't just happen by themselves, McIntire noted. Producing claims without errors takes a concerted effort by the interdisciplinary team.

"Clearly identifying who is responsible on your team for which function is a great starting point," McIntire noted. "And you need to round out the process with a pre-claims submission meeting, also known as the Triple Check meeting."

A Triple Check meeting should be your final step before claims submission. This meeting should include nursing, therapy, billing and anyone else who's involved in documenting information that ends up on the claim.

Deciding who is responsible for entering which items in the software is also essential, McIntire added. Establish set processes and deadlines for things like when you're going to import your therapy charges, when is the cutoff date for MDS assessments to be billed that month, and when to submit claims.

9. Keep Payor Requirements Straight

Start with preadmission, making sure that you double-check eligibility and whether the resident needs preauthorization, Bilyeu advised. Don't just rely on the fact that the resident has a Medicare card.

Also, review your contracts with payors every year, Bilyeu said. What are you being reimbursed? Is the payor reimbursing you the same as five years ago?

And make sure your billers are aware of any payors that have tight billing timeframes. Ensure that your clinicians understand level-of-care payment guidelines, too. If you're providing a higher level of care, you need to ensure that you're receiving proper reimbursement for it.

Timesaver: If you can invest in a resources like an electronic clearinghouse, as opposed to sending paper claims, this can increase turnaround time for claims payments and really speed up your cash flow, Bilyeu recommended. Follow-up is very important, too, so make sure you're checking on claims a minimum of every 30 days. Call within two weeks to make sure the payor received your paper claims.

10. Don't Put Compliance on the Back Burner

"If you've been involved in any kind of focused medical review process, you already know the significant amount of money that can be tied up in the appeals process," McIntire noted. Reviews can consume a lot of staff time, too.

McIntire offers the following practical questions to ask yourself to gauge your compliance risk:

- Do you have a workable, accessible compliance plan?
- Are you investing in ongoing staff training and development?
- Are you holding personnel accountable?
- Is someone with comprehensive billing knowledge, other than the person who prepared the claims, reviewing your claims before they're submitted to payors?
- Are you issuing appropriate denial notices, such as the SNF Advance Beneficiary Notice (ABN)?

CPT® 2023 American Medical Association. All rights reserved.

- Are assessments being missed or completed early or late?

Bottom line: "The key point to remember is that all roads lead to compliance in this environment," McIntire said. "So in the process of improving your overall revenue cycle, you always need to have an eye toward compliance."

CPT® 2023 American Medical Association. All rights reserved.