Reimbursement Tune-Up

Colorado Healthcare Association

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Data Overview

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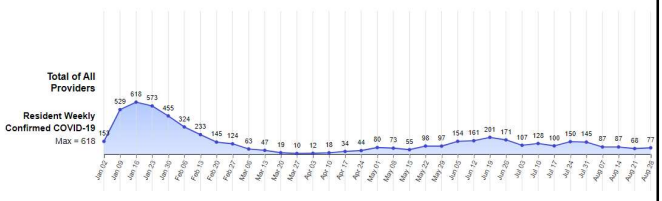

Covid Cases in Colorado SNFs 2022

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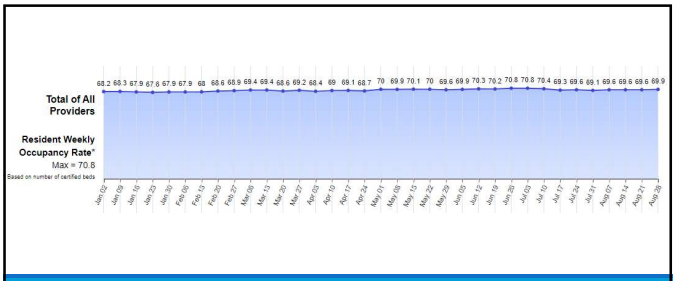

Occupancy in Colorado SNFs 2022

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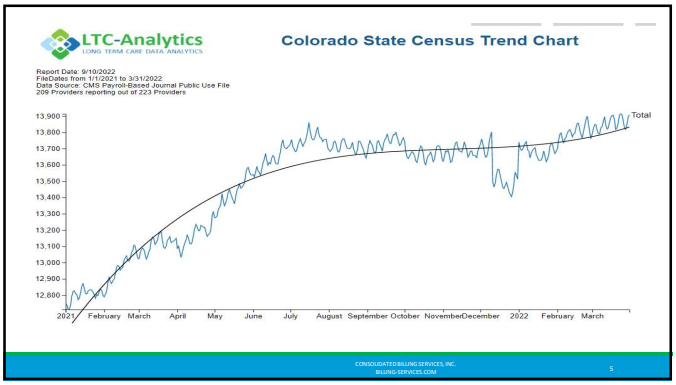

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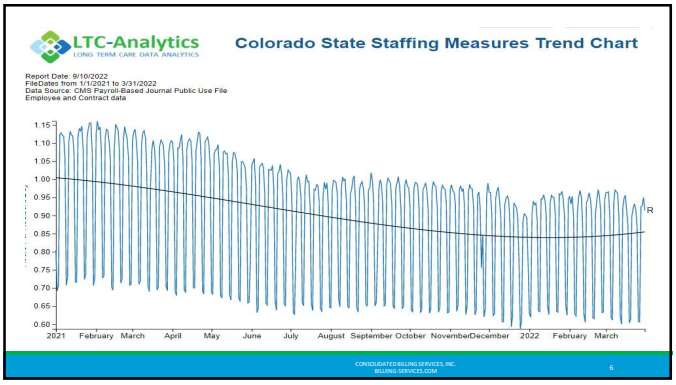

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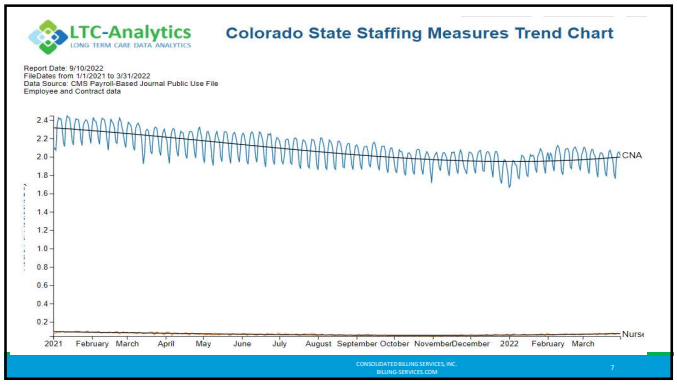

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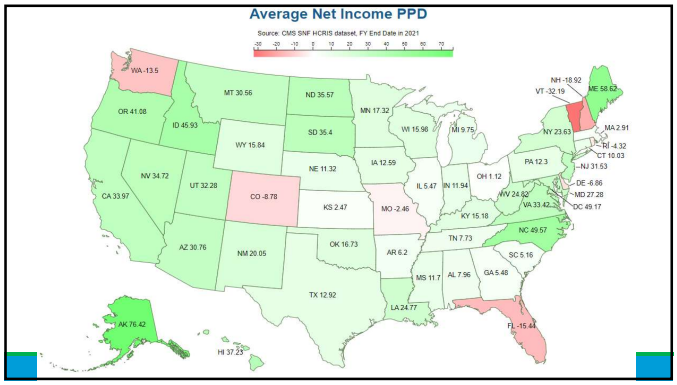

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PDPM

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PDPM Rate Increase FY 2023

Market Basket	3.90%
Forecast Correction	1.50%
Productivity Adj	-0.30%
Total	5.10%
PDPM Error	-2.40%
Final Payment	2.70%

- Market Basket Bases on Inflation in Healthcare costs
- Forecast Correction adjust prior period inflation to actual
- Productivity Adjustment
- PDPM transition error over 2 years

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Regional Wage Index Trend

CBSA	Area	NEW	2015	2016	2017	2018	2019	2020	2021	2022	Change	% Chg
	Colorado											
14500	Boulder, CO	URBAN	0.9774	1.0303	1.0207	1.0296	1.0226	1.0574	1.0471	1.0126	(0.035)	-3.29%
17820	Colorado Springs, CO	URBAN	0.9130	1.0060	0.9524	0.9540	0.9513	0.9651	0.9534	0.9692	0.016	1.66%
19740	Denver-Aurora-Lakewood, CO	URBAN	1.0198	1.0334	1.0355	1.0245	1.0183	1.0020	0.9942	0.9897	(0.004)	-0.45%
22660	Fort Collins, CO	URBAN	1.0149	1.0368	1.0091	0.9886	0.9826	0.9775	0.9914	0.9805	(0.011)	-1.10%
24300	Grand Junction, CO	URBAN	0.9615	0.9298	0.9605	0.9582	0.9348	0.9481	0.9157	0.8935	(0.022)	-2.42%
24540	Greeley, CO	URBAN	0.9403	0.9153	0.9303	0.9058	0.8988	0.8931	0.8945	0.9289	0.034	3.85%
39380	Pueblo, CO	URBAN	0.8301	0.8267	0.8530	0.8398	0.8364	0.8131	0.8027	0.8075	0.005	0.60%
99906	Rural Colorado	RURAL	0.9746	1.0003	1.0120	1.0075	1.0081	1.0086	0.9979	1.0297	0.032	3.19%

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Transfers From Acute Care

		Total			Percentage	
Location	Period	SNF	HHA	Total	SNF	HHA
State of Colorado	2019	16,854	13,359	30,213	56%	44%
	2020	12,347	12,197	24,544	50%	50%
	2021q3	11,323	11,904	23,227	49%	51%
Denver County, CO	2019	1,217	1,140	2,357	52%	48%
	2020	928	890	1,818	51%	49%
	2021q3	673	574	1,247	54%	46%

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Daily Transfers From Acute Care To SNF And HHA

Location	Period	SNF	HHA	Total
State of Colorado	2019	46	37	83
	2020	34	33	67
	2021q3	41	44	85
Denver County, CO	2019	3	3	6
	2020	3	2	5
	2021q3	2	2	4

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Transfers from Colorado Hospitals to Colorado SNFs

Data is 2021 Q1 through Q3

All Skilled Nursing Facilities

	All Conditions
Average Days of Episode	21
30-day Readmit Rate to Hospital relative to 13 counties in Colorado	#11
Average Unit Cost	$631.2
Average Episode Cost	$11,776.24
Case Mix Index (PDPM)	
	All Conditions
Nursing (N)	1.71
Physical Therapy (PT)	1.57
Occupational Therapy (OT)	1.55
Speech-Language Pathology (SLP)	1.46
Non-Therapy Ancillary (NTA)	1.29

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PDPM Revenue Drivers

Therefore, we need a robust compliance program

	Cat High	Cat Low	Rate High	Rate Low	PPD
Major Joint vs. Medical Management FM = 23	TC	TK	$ 226.27	$ 193.54	$ 32.73
Medical Management FM = 23 vs. 24	TK	TL	$ 193.54	$ 139.14	$ 54.40
SLP - Comorbidity	SD	SA	$ 35.71	$ 16.63	$ 19.08
SLP - Cognitive Status	SG	SD	$ 49.91	$ 35.71	$ 14.20
SLP - Mech Alt Diet & Swallowing Disorder	SI	SG	$ 86.35	$ 49.91	$ 36.44
Nrsg - Clinically Complex FM = 14 vs 15	CBC1	CA1	$ 153.09	$ 107.39	$ 45.70
Nrsg - Clinically Complex [Depression]	CBC2	CBC1	$ 177.09	$ 153.09	$ 24.00
Nrsg - Clinically Complex [Restorative]	PBC2	PBC1	$ 139.38	$ 129.10	$ 10.28

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Compliance Issues - General

- Reduction in care for financial reasons
  - Therapy
  - CMS has commented extensively on this topic
- Lack of daily skilled service
  - We have relied on therapy to fulfill the daily skill
- IPA use and abuse
- Poor resident outcomes
  - CMS audit

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Compliance Issues – MDS / Claims

- Incorrect primary diagnosis code
  - Does not support hospital stay
  - Bill's Blog; "Why are they here?"
- Incorrect MDS box checked
- Incorrect functional score
- Incorrect or wrong ICD-10 code in I8000
  - Code jamming
- Conflict between diagnosis codes on UB04 and MDS

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Auditing and Monitoring - PDPM

1. Daily Stand Up Meetings
2. Weekly Medicare Meetings
3. ICD-10 Coding Policy and Procedure
4. MDS Review
5. UB04 Claim Triple Check
6. Chart Audits

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Patient Drive Payment Model [PDPM]						
Key Risk Area	Source	Risk Level	Training, Policies Procedures	Monitoring Tool	Auditing Tool	Comments
Active Diagnosis	PDPM	High		MDS Review	Chart Audit	MDS I8000 Impacts SLP & NTA
BIMS Interview	PDPM	Med		MDS Review	Chart Audit	MDS C0500 Impacts SLP
Enteral Calories Count	PDPM	Low		MDS Review	Chart Audit	MDS K0710A & B Impacts NTA
HIV / AIDES Diagnosis	PDPM	Low		MDS Review	Chart Audit	Claim Impacts NTA
Mechanically Altered Diet	PDPM	High		MDS Review	Chart Audit	MDS K0510c Impacts SLP
Mood	PDPM	Low		MDS Review	Chart Audit	MDS D0300
Section I Clinical Conditions	PDPM	High		MDS Review	Chart Audit	MDS Ixxxx Impacts NRSG & SLP
Surgery in Hospital	PDPM	Med		MDS Review	Chart Audit	MDS Jxxxx Impacts PT & OT
Swallowing Disorder	PDPM	High		MDS Review	Chart Audit	MDS K0100 Impacts SLP
Vent / Trach	PDPM	Low		MDS Review	Chart Audit	MDS O0100 Impacts NRSG
Wound Staging	PDPM	Low		MDS Review	Chart Audit	MDS M0210B-F Impact NTA
Group and Concurrent Therapy	PDPM	Low		MDS Transmission Report	Chart Audit	Not to exceed 25% by discipline

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Revenue Cycle Management

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Revenue Cycle Management

What is It? How does the SNF Succeed?

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Revenue Cycle Management (RCM) Defined

- A wholistic multidisciplinary approach recognizing that information needed prior to admission has significant impact on collection
- Financial process of collecting payments for medical bills to generate revenue for a healthcare organization
  - Process that begins before a resident admission and ends when all claims are paid
- Combines administrative data, such as a patient's personal information, insurer name and treatment codes, with billing information and clinical information and documentation
- RCM involves numerous individuals and departments
- Centralized approach ensures more reliable reimbursement, compliance, and clinical processes

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Revenue Cycle Management assures providers are paid properly for all services rendered to the patient

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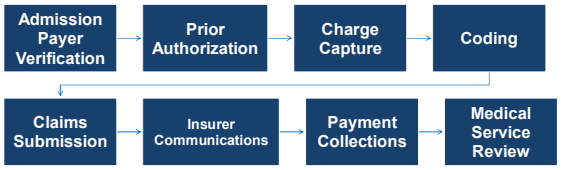
RCM STEPS



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What Happens if We Fail?

- High accounts receivable
- Not enough cash to pay bills or make payroll
- Reduced labor force
- Poor resident care
- Negative survey outcomes
- Lower paying managed care contracts
- Facility closure, displaced residents, staff layoffs

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What Happens if We Succeed?

- Low Accounts Receivable
- Good cash flow
- Improved staffing
- Better resident care
- Better surveys
- Better contracts
- Improved employee compensation

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Roles & Responsibilities

Admissions	Clinical/Payer Status
Business Office	Billing, AR, Collections
Nursing	Documentation, Certs
Medical Records	ICD-10 Coding
MDS Nurse	MDS Accuracy
Administrator	Team Leader

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Provider Relief Funds

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General Provisions

- $100 Billion appropriated to the Public Health and Social Services Emergency Fund (PHSSEF) for providers
- Purposes:
  - Health care related expense attributable to COVID-19
  - Lost revenue attributable to COVID-19
- Eligible providers?
  - Public entities
  - Medicare/Medicaid enrolled suppliers/providers
  - For-profit and not-for-profit entities specified by HHS that provide COVID-19 diagnosis, testing, or care
- Will be Administered by HHS
  - May be pre-payment, prospective payment, or retrospective payment
  - Consider most efficient payment systems practicable
  - Application includes statement justifying need and TIN
  - Can't reimburse expenses or losses that other sources are obligated to reimburse

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CARES Act/Provider Relief Fund

General Provisions

- Key CARES Act Provisions
  - Providing $100 billion in funding to providers;
  - Temporarily lifting the Medicare sequester through December 31, 2020;
    - Further lifted until April 1, 2022 @ 1% and July 1, 2022 @ 2%
  - Creating a 20% Medicare add-on payment for inpatient hospital COVID-19 patients;
  - Allowing flexibility for acute care hospitals to transfer patients out of their facilities and into alternative care settings in order to prioritize resources;
  - Aligning the 42 CFR Part 2 regulations on confidentiality and sharing of substance use disorder treatment records with HIPAA;
  - Supporting provisions for the health care workforce; and
  - Further expanding the use of telehealth.

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CARES Act Provider Relief Fund
Attestations – Terms & Conditions

- Specific Terms & Conditions - Core Provisions
- 1. The Recipient certifies that it:
  - provides or provided after January 31, 2020, diagnoses, testing, or care for individuals with possible or actual cases of COVID-19;
  - is not currently terminated from participation in Medicare or precluded from receiving payment through Medicare Advantage or Part D;
  - is not currently excluded from participation in Medicare, Medicaid, and other Federal health care programs; and
  - does not currently have Medicare billing privileges revoked.

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CARES Act Provider Relief Fund
Attestations – Terms & Conditions

- Specific Terms & Conditions - Core Provisions (cont.)
  - 2. The Recipient certifies that the Payment will only be used to prevent, prepare for, and respond to coronavirus, and that the Payment shall reimburse the Recipient only for health care related expenses or lost revenues that are attributable to coronavirus.
  - 3. The Recipient certifies that it will not use the Payment to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse.

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CARES Act Provider Relief Fund
Attestations – Terms & Conditions

- Specific Terms & Conditions - Core Provisions (cont.)
  - 4. The Recipient shall submit reports as the Secretary determines are needed to ensure compliance with conditions that are imposed on this Payment, and such reports shall be in such form, with such content, as specified by the Secretary in future program instructions directed to all Recipients.

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CARES Act Provider Relief Fund

Attestations – Terms & Conditions

- Unique General Term & Conditions
  - Section 202. Executive Pay. None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II (currently $197,300.)
  - Section 520. Pornography.
    - (a) None of the funds made available in this Act may be used to maintain or establish a computer network unless such network blocks the viewing, downloading, and exchanging of pornography.
    - (b) Nothing in subsection (a) shall limit the use of funds necessary for any Federal, State, tribal, or local law enforcement agency or any other entity carrying out criminal investigations, prosecution, or adjudication activities.

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OIG Activities

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OIG Activities – Spring / Summer of 2022

- Six "case studies" investigating SNF use of PRF monies and HRSA practices
- Audits of 30 SNFs investigating he the use of the targeted distributions
- Reporting periods 1 and 2

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OIG Oversight Authority

- References in CARES Act / PRF FAQs to OIG Role as well as DOJ
- OIG work plan

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OIG Work Plan

- Demands for "interviews" and production of financial data
- Tied to November 2021 entry in OIG work plan
- Appears limited to six "case studies"
- Targeted SNFs in Connecticut, Idaho, Massachusetts and South Carolina

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OIG Interview Process

- Separate interviews of facility leadership, staff (including Infection Preventionist) and "willing" residents
- Members of OIG interview team
- Facility leadership interviews focus on:
  - use of PRF funds in Reporting periods 1 and 2,
  - facility/company decision making about use,
  - impact of funding on care and
  - clarity of HRSA requirements
- Staff interviews focus on needs of facility during pandemic and use of PRF funds
- Resident interviews about facility practices during pandemic and whether needs met

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Supporting Documentation & Timing of Report

- Demand for production of documentation supporting reporting but not an "audit"?
- OIG will issue report in '23
- Referrals for enforcement & audits?

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OIG Audits HRSA – Phase 2 General Distribution

- OIG audit of HRSA – Phase 2 General Distribution
- Information sought from various health care providers (including SNFs) to determine whether:
  - Amounts were correctly calculated by HRSA
- Were supported by appropriate and reasonable documentation; and
  - Made to eligible providers
- OIG requests information and/or documentation provided to HRSA

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OIG Audits of 30 SNFs

- OIG "audits" of 30 SNFs for use of PRF monies
- Use of "targeted distributions" in Reporting Periods 1 & 2, including:
  - SNF "targeted" distribution
  - Infection control distribution

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Audit Detail

- Production of financial detail
- Production of policies and procedures
- Demand states 15 calendar day timeframe
- Potential recoupments and penalties

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CMS Waivers

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For the Compliance Officer

- Be aware of all waivers applicable to your providers.
  - Know the effective date of each waiver
  - Know the end date of each waiver
- Update your risk assessment to incorporate applicable waivers
- Update your monitoring and auditing program to incorporate key elements of each waiver
- Assure training programs are updated so that pertinent information is communicated to the correct employees

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Waivers for SNFs

- Waiver of three-day Qualifying Hospital Stay
  - Allows for a resident to be Medicare covered
- Waiver of Benefit period
  - Allows for greater than 100 days
- ESRD in a SNF
  - Allows for ESRD services to provided in the SNF rather than offsite
- Telehealth
  - Allows for physician visits in a SNF
- Waives the coinsurance and deductible for COVID 19 related services
- Requires Medicare Advantage plans to cover COVID 19 related lab testing

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3 Day Stay Waiver

- Emergency waivers of the QHS under 1812(f) of the Social Security Act
  - Applies to beneficiaries affected by the emergency
  - Preserves entitlement "under normal circumstances"
- CMS waives the QHS in order to provide "temporary emergency coverage"
- Applies to:
  - Beneficiaries who are dislocated
  - Or, otherwise affected my Covid-19

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3 Day Stay Waiver – How it works

- All beneficiaries qualify regardless of whether they have SNF benefit days remaining
- The beneficiary's status of "being affected by the emergency" exists nationwide
  - No need to verify individual cases

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3 Day Stay – When it applies

- Beneficiary may be discharged from the hospital early without three consecutive days
- Beneficiary may be admitted to the SNF directly from home
- Beneficiary may be admitted directly from hospital ER
- A current patient may be "skilled in place" without the need for a hospital stay

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Example 3 Day Stay Patient

- On July 7, 2020; Jane Doe, a long term Medi-cal resident developed signs and symptoms of COVID 19. These symptoms include a fever of 101.0, a dry cough, O2 sats of 87 and red eyes. A COVID 19 test sample has been collected but the provider does not have test results.
- Ms. Doe was moved into a quarantine area of the SNF in order to maintain infection control.
- Ms. Doe requires the skills of a registered nurse to monitor for signs and symptoms of COVID 19 as well as her changing health needs.
- Ms. Doe meets Medicare skilled coverage criteria on July 7, 2020. Her physician signed an initial Medicare certification of skilled care on July 8, 2020, to be effective July 7, 2020
- Tests results were received on July 10 showing Ms. Doe is positive for COVID 19. A 5 day MDS is completed on July 11 and with a primary diagnosis of U07.1 she falls into a Medical Management category.
- The Nurse wrote an admission note stating that Ms. Doe was placed on Medicare skilled care due to sign and symptoms of COVID 19 and the Physician for the protection of the residents both at the facility and at the hospital requested that she remain at the SNF.

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Benefit Period – 100 Days +

- Authorizes renewed SNF coverage without starting a new benefit period
- Only applies for those beneficiaries who have been delayed or prevented by the emergency itself from commencing or completing the process of ending their benefit period thus renewing their SNF benefits
- To qualify for the benefit period waiver, it must be demonstrated that a beneficiary's continued receipt of skilled care in the SNF is in some way related to the PHE.
  - One example would be when a beneficiary who had been receiving daily skilled therapy, then develops COVID-19 and requires a respirator and a feeding tube.
- Note that beneficiaries who do not themselves have a COVID-19 diagnosis may nevertheless be affected by the PHE. For example, when disruptions from the PHE cause delays in obtaining treatment for another condition.

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Benefit Period – Always Skilled

- The benefit period waiver would not apply to those beneficiaries who are receiving ongoing skilled care in the SNF that is unrelated to the emergency
  - A scenario that would have the effect of prolonging the current benefit period and precluding a benefit period renewal even under normal circumstances.
  - For example, if the patient has a continued skilled care need (such as a feeding tube) that is unrelated to the COVID-19 emergency
- The beneficiary cannot renew his or her SNF benefits under the section 1812(f) waiver as it is this continued skilled care in the SNF rather than the emergency that is preventing the beneficiary from beginning the 60 day "wellness period."

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Benefit Period – Golden Rule

- A SNF resident's ongoing skilled care is considered to be emergency-related *unless* it is altogether unaffected by the COVID-19 emergency itself
  - That is; The beneficiary is receiving the very same course of treatment as if the emergency had never occurred
- The Provider should compare the course of treatment that the beneficiary has actually received to what would have been furnished *absent* the emergency.
- Unless the two are exactly the same, the provider would determine that the treatment has been affected by – and, therefore, is related to–the emergency.

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Don't Forget - Medicare Coverage

- The patient must meet the requirements of skilled care
- The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel
- Services are ordered by a physician
- Services are rendered for a condition for which the patient received inpatient hospital services or for a condition that arose while receiving care in a SNF for a condition for which he received inpatient hospital services;
- The patient requires these skilled services on a daily basis
- As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF.
- The services delivered are reasonable and necessary for the treatment of a patient's illness or injury

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Medicare Documentation

- Physician must certify and re-certify the need for skilled care
- Claims for skilled care coverage need to include sufficient documentation to enable a reviewer to determine whether:
  - *Skilled involvement is required in order for the services in question to be furnished safely and effectively; and*
  - *The services themselves are, in fact, reasonable and necessary for the treatment of a patient's illness or injury, i.e., are consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, and accepted standards of medical practice. The documentation must also show that the services are appropriate in terms of duration and quantity, and that the services promote the documented therapeutic goals.*

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Compliance Risks Related to Waivers

- You will get audited!
- Physician certifications
- Daily documentation of skilled care
- Nexus to COVID 19.
  - Why was a QHS stay not necessary

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Colorado Medicaid

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Medicaid Rate Components

- Direct Health – Adjusted for Acuity
- Indirect Healthcare – Not adjusted for acuity
- Admin & General – Flat rate based on Beds
- FRV – Appraisal every 4 years
  - Allows for additions
- Provider Tax / Quality

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Healthcare Costs

- RNs, LPN, CNAs, Restorative Aides
- Quality Improvement, Infection Preventionists
- Nursing Case Manager
- Patient Care Coordinator
- Staff Development personnel
- Feeding assistants
- Registered Dietician
- MDS Coordinator
- Activities personnel
- Van drivers
- Medical records, HIM
- Central supply
- Social worker
- Admission coordinator
- Life enhancement Specialist
- Payroll taxes, benefits, workers comp, training for HC positions

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Healthcare Cost

- Medical Director
- Professional Liability Insurance
- Infectious Waste Disposal
- Copier lease
- Purchase Rental depreciation interest and repair expense associated with Healthcare equipment and medical supplies
- Raw Food
- Non prescription drugs
- Vaccinations
- HC Equipment & Supplies
- Motor vehicles
- Licensed or certified consultant fees

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Healthcare Costs

- Healthcare Costs - Purchase, rental, depreciation, interest, and repair expenses associated with health care equipment and medical supplies used for health care services such as nursing care, medical records, social services, therapies and activities.
- Motor Vehicles - Purchase or rental of motor vehicles and related expenses to the extent that they are used to transport residents to activities or medical appointments. Such use shall be documented by contemporaneous logs if there is dual purpose. HC equipment, medical supplies Motor vehicles Licensed or certified consultant fees
- Consultant fees for appropriately licensed and/or certified nursing, medical records, registered dieticians, resident activities, social workers, pharmacy, physicians and therapies. Allowable HC amounts do not include any related travel expense

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Healthcare Cost

ACTIVITIES

- Must have a direct relationship to residents, such as providing entertainment, games and social opportunities. Security guards and hall monitors do not qualify as activities personnel

VAN DRIVERS

- To the extent that they are used to transport residents to activities or medical appointments. Such use shall be documented by contemporaneous time logs if there is a dual purpose.

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Healthcare Costs

- Employees that perform duties or roles defined as HC and duties or roles defined as A&G per the regulations [Combined Staff]
- Contemporaneous time records or time studies are required for employees with dual health care and administrative duties to verify time spent performing health care duties.
- If no contemporaneous time records are kept or time studies performed, total salaries, payroll taxes and benefits of personnel performing health care and administrative functions will be classified as administrative and general

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SNF Consolidated Billing

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What is SNF Consolidated Billing?

Why do we Care?

- For a Medicare Part A Patient the SNF is responsible for the entire bundle of services.
- Prior to SNF CB the SNF would bill inpatient services while each supplier would bill Medicare Part B for ancillary services:
  - Laboratory
  - X-ray
  - Enteral Nutrition
  - Other
- The SNF Part A stay was essentially billed in bits and pieces
- Much like to the Hospital ER today!

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SNF Consolidated Billing

Basic Requirement

- The skilled nursing facility (SNF) consolidated billing provisions place with the SNF itself the Medicare billing responsibility for most of its residents' services.
- Part A consolidated billing requires that an SNF must include **on its Part A bill [UB-04]** almost all of the services that a resident receives during the course of a *Medicare-covered* stay, other than those services that are specifically *excluded* from the SNF's global prospective payment system (PPS) per diem payment for the covered stay.
- Please note the actual language focuses on the SNF billing Medicare and not how the SNF pays outside suppliers
- Unless SNFs bill for all charges on their UB-04, CMS has not idea the cost of caring for a SNF Part A resident

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SNF CB Today

SNF Consolidated Billing

- Requirement that all Medicare covered services rendered to the SNF Part A resident be billed by the SNF [bundled] unless they are specifically excluded
- Requirement that PT, OT and ST services identified by CPT code and provided to Part B patients in a Medicare certified bed of the SNF be billed by the SNF
- Basic principle has not changed since 1998
- SNF Consolidated Billing rules are not impacted by the new PDPM payment model effective October 1, 2019

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General Principle

The SNF is responsible for all

Medicare covered services

Rendered to

RESIDENTS of the SNF,

Unless the item has been

Specifically excluded

From the SNF bundle

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Step 1: What Is a Medicare Covered Service?

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Medicare Covered Services

Medicare services covered in a SNF include:

- Bed / board in semi-private room
- Drugs & biologicals
  - Must be FDA approved
  - Or, used in hospital prior to admission
- Diagnostic x-rays
- Diagnostic lab
- X-ray, radium & radioactive isotope therapy

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Medicare Covered Services

Continued

- Surgical dressings, splints, casts
- Prosthetic devices
- Leg, arm, back and neck braces, trusses, artificial legs, arms and eyes, including adjustment, repairs and replacements
- PT, OT, SLP
- Hemophilia clotting factors

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Medicare Non-Covered Services

- Private duty nurse
- Bed / board in private room
- Services that are not reasonable and necessary for the patient's illness or injury
- Transportation by other than ambulance
- Ambulance transportation that is not medically necessary
- Hearing aides and auditory implants
- Dental services

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What Is Reasonable & Necessary?

- If the service or supply had been billed directly to Medicare for payment,
  - Would the item or service be covered?
  - Would Medicare have paid the claim?
- Is the service or supply excluded in the Medicare National Coverage Determination Manual, CMS 100-3?
- Is there a local coverage decision that addresses the service or supply?
- The CWF edit process first checks for SNF CB bundling.
  - If the item is bundled the SNF; CWF does not verify medical necessity

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Drugs – Off Label Use

- Medicare pays for off label use in certain circumstances[CR 6191 – 10/24/08]
- Drug is covered if use is listed on authoritative compendia:
  - American Hospital formulary
  - NCCN drugs and biologicals
  - Thomson Miromedex DrugDex
  - Clinical Pharmacology
- Contractors shall recognize medically accepted indication as those that:
  - Are favorably listed in one or more of the above
  - Or, contractor determines from a review of peer reviewed literature it is medical accepted
  - Unless; CMS determines use is not accepted

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What Is Reasonable & Necessary?

- We need to assume that services and supplies meet the standard of medical necessity unless we have clear convincing evidence to the contrary
- What does not meet the reasonable and necessary standard?
- Medicare Program Integrity Manual [Section 3.6.2.2]
  - Is it safe and effective?
  - Is it not experimental or investigational?
  - It is appropriate including the duration and frequency?
  - It is furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the beneficiary's condition or to improve a malformed body member?
  - Is it furnished in a setting appropriate to the beneficiary's medical needs and condition?
  - It was ordered and furnished by qualified personnel?
  - Meets but does not exceed the beneficiary's medical need?

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Step 2:
When is a Patient
NOT
a Patient for
SNF Consolidated Billing

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Start of Resident Status as Inpatient

- A Medicare beneficiary is a SNF inpatient when they are physically admitted to a skilled nursing facility as Medicare Part A inpatient
  - The patient needs to be at the SNF
  - The patient needs to be assigned a room
  - Admission paperwork should be complete

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End of Resident Status as Inpatient

1. When patient is admitted as an Inpatient to:
   - A Medicare participating hospital
   - A Critical Access Hospital (CAH)
   - As a resident of a different SNF
2. Or, patient is discharged from SNF and not readmitted to any SNF by midnight on day of departure
   - Patient is formally discharged
   - Patient departs from the SNF (LOA)
   - Discharge is effective at the time they departed the SNF

Note: Patient remains a resident of SNF until admitted to new facility on same day of discharge

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End of Resident Status as Inpatient

3. Hospital Outpatient
   - Patient receives certain limited outpatient services from a Medicare participating acute care hospital or CAH which:
     - Are "Exceptionally Intensive", and,
     - That lie "well beyond the scope of care that a SNF would ordinarily furnish", or,
     - Are "Emergency Services"
4. Ends When:
   - Patient receives services, under a plan of care from a Medicare participating Home Health Agency

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Billing for Leave of Absence

- Part A beneficiaries **not** in the SNF at midnight are on a "Leave of Absence" or "Interrupted Stay"
  - Depends on length of absence [3 day rule]
- SNF PPS payment is not made to the SNF
- SNF Part A benefit day is **not** applied
- CB regulations do **not** apply
  - Services provided outside the SNF can be billed directly to Medicare (Carrier, FI or DMERC - depending on the service) on any day designated a LOA
  - LOA days may occur for *medical or social reasons*

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Interrupted Stay Billing [UB-04]

- Less than 3 consecutive days
- Bill monthly claim and Type of Bill as per regulations
  - Nothing new
- Bill Span code 74 for LOA days
- Bill for days in month less LOA days
- Include Rev Code 0022 as normal
- Include Rev Code 180; no charges
- Include Occurrence Code 50 with ARD
  - ARD can be any date
- Payment schedule continues from day of admission

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LOA or Interrupted Stay

- The common working file looks at span code 74 in determining whether to bundle services to the SNF
- It is imperative to properly complete the UB-04 when the resident is not physically present at midnight
- For hospital outpatient services that cross midnight; it is imperative the hospital timely and correctly bill Medicare Part B

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Step 3:
Services Excluded From SNF Bundle

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Consolidated Billing

5 Ways to Exclude a Service or Supply

1. Items provided by outpatient hospital and "Lie well beyond the SNF Scope of Care" [Cat 1]
2. Services when rendered to specific beneficiaries [Cat II]
3. Additional items rendered by certified Providers [Cat III]
4. Items that are not covered under Part A because they are preventive or screening and are therefore excluded from the SNF bundle [Cat IV]
5. Federal Law Exclusions - professional services not covered in SNF

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CMS Exclusion Files 2021

- FI / MAC File – applies to institutional claims billed on UB-04
  - Codes listed = 1,337
  - Category 1.f are inclusions
- Carrier File 1 – Professional Services
  - Excluded codes = 7,599
- Carrier File 2 – Professional Component [Modifier 26]
  - Excluded codes = 995
- Carrier File 3 – Ambulance Services
  - There are 13 ambulance codes; these are not excluded from SNF CB
- Carrier File 4 – Therapy Services
  - There are 88 therapy codes bundled to the SNF under Part B

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Hospital Outpatient

Institutional - Major Category I

- Services must be provided by Hospital Outpatient Department of a Hospital or CAH
- Must be billed on claim form UB-04
  - TOB 13X, 14X or 85X
- This is a place of service exclusion
- Only certain HCPCS codes are excluded in each category
- For category ambulatory surgery [1.f] CMS identifies inclusions within a range
- When these services are provided; the status as a SNF inpatient is temporarily suspended
- Computerized Axial Tomography (CT Scans) [1.A]
- Cardiac Catherization [1.B]
- Magnetic Resonance Imaging (MRI) [1.C]
- Radiation Therapy [1.D]
- Angiography, Lymphatic and Venous Procedures [1.E]
- Ambulatory Surgery Involving the Use of an operating room [1.F] & [1.I]
  - Inclusions are given on the list rather than exclusions
- Emergency Services [I.G]
- Ambulance for renal dialysis [Cat I.H]
  - Social Security Act 1888(e)(2)(iii)

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Hospital Outpatient

Institutional - Major Category I

- In addition to items identified by code, most items are excluded from the SNF if they are directly related to Category I services and billed with the same:
  - Place of Service (POS) and,
  - Line Item Date of Service (LIDOS)
- This may include anesthesia and drugs (revenue codes 037x, 0255, 027x, and 062x) when billed with excluded procedure
- CMS should be excluding all services where LIDOS matches regardless of revenue code

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What Is Hospital Outpatient?

Institutional - Major Category I

- Must be admitted as an outpatient
- Billed using TOB = 13x, 14x or 85x (CAH) on CMS Form UB-04
- To be an outpatient:
  - Person not admitted by hospital as inpatient
  - And, is registered on the hospital records as an outpatient
  - And, receives services and not just supplies
    - May be either diagnostic or therapeutic
    - Diagnostic services may be furnished by hospital "under an arrangement"

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Services to Specific Patients

Institutional - Major Category II

- Services provided to specific beneficiaries by Renal Dialysis Facility [ESRD]
  - Provided in renal dialysis facility
  - Provided in SNF, SNF may not be paid for supplies
  - EPO or Aranesp are excluded when provided by ESRD
  - Must be billed by RDF on TOB 72x
- Beneficiaries who have elected Hospice
  - Must be billed using TOB 81x or 82x
- Excluded by Statue:
  - Home Dialysis supplies & equipment [Cat II]
  - Self-care home dialysis support services [Cat II]
  - Institutional dialysis services and supplies [Cat II]
  - Erythropoietin (EPO) / Aranesp for ESRD patients [Cat II]
  - Hospice care related to a patients' terminal condition [Cat II.B]
- CMS publishes a list of applicable HCPCS that qualify

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Beyond Scope of SNF Care

Institutional - Major Category III

- Services excluded when rendered by certified provider [Not a SNF]
  - Chemotherapy Items
  - Chemotherapy Administration Services
    - These codes are only excluded if they occur with the same LIDOS as excluded chemotherapy agent
  - Radioisotope and their administration
    - These codes are excluded when used in cancer treatment
    - New codes added 1/1/04
  - Selected Customized Prosthetic Devices
- Social Security Act 1888(e)(2)(iii)
  - Chemotherapy items [Cat III.A]
  - Chemotherapy Administration [Cat III.B]
  - Radioisotope services [Cat III.C]
  - Customized Prosthetic devices [Cat III.D]
    - Provided during stay in SNF
    - Intended to be used after discharge from SNF
- Statue identifies range of codes
- Gives Secretary authority to add codes

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Preventive & Screening Services

Institutional - Major Category IV

- Since services are NOT for the diagnosis or treatment; they are not covered under Medicare Part A
  - Must be billed by SNF on TOB 22X to be excluded
  - Mammography
  - Vaccination for pneumococcal, Flu or hepatitis B
  - Vaccine administration
  - Screening Pap smear and pelvic exam
- Colorectal screening services
- Prostate cancer screening
- Glaucoma screening
- Diabetes screening
- Cardiovascular screening
- Initial Preventative Physical Examination
- Abdominal aortic aneurysm screening
- COVID 19 Monoclonal Antibodies

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Professional Services

Carrier File 1 & 2

- Exempt Practitioner Services:
  - Physicians' services
    - (which include anesthesia per AB-99-90)
  - Physicians' assistants working under a physician's supervision
  - Nurse Practitioners & Clinical Nurse Specialists working in collaboration with a physician
  - Certified Nurse-Midwives
  - Qualified Psychologist
  - Certified Registered Nurse Anesthetists

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Summary

- Basic principle related to items bundled to the SNF
  - Medicare covered services
  - Resident of the SNF
  - Not specifically excluded
- Numerous categories of excluded services
- Thousands of HCPCS codes are excluded from the SNF bundle
- SNF relies on other providers to submit correct and timely Medicare claims

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SNFCB Common Problems

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Ambulatory Surgery Center

Facility Fee

- Bill's Care Center sends Jane Smith to an Ambulatory Surgery Center for the insertion of a cardiac pace maker
- The surgery is outpatient and Ms. Smith returns before midnight on the day of departure
- The ASC bills the SNF for HCPCS #33208 for $15,000
- The SNF does not have an under arrangement agreement with the ASC.
- The global code is used by the ASC
  - This appears to the SNF as a professional service
  - According to several MACs; the ASC should use the TC modifier
- HCPCS billed by the ASC are generally for the technical component and are bundled to the SNF
- See OIG report December 17, 2010
- The SNF is required to pay the agreed upon amount
- Highest Cost HCPCS # 69930 "Implant Cochlear Device" $35,229.50

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Hospital Outpatient Surgery

Outpatient Surgery

- Bill's Care Center sends Jane Smith to a Hospital Outpatient facility for the insertion of a cardiac pace maker
- The surgery is outpatient and Ms. Smith returns before midnight on the day of departure
- The hospital bills the SNF for HCPCS #33208 for $15,000
- The SNF does not have an under arrangement agreement with the hospital.
- The hospital should bill this entire service to Medicare directly
- This is a category I.f exclusion
- The SNF is not required to pay the agreed upon amount
- If ASC; bundled to the SNF
  - $8,754.16

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Hospital Outpatient

Facility Fee

- Bill's Care Center sent resident John Doe to the hospital for an x-ray of the leg
- The hospital bills the SNF for CPT 73590
- The hospital is billing a technical fee.
- Professional fees would be billed by the physician on form 1500 with a modifier 26
- The Hospital generally expects payment based on OPPS
  - Not the physician or other fee schedule
- The global code is generally billed by the Hospital
  - This appears to the SNF as a professional service
  - Hospitals are not required to bill with a modifier
- The SNF is responsible for the technical portion the X-ray.

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Radiology Company Billed SNF Incorrectly

Professional / Technical Services

- ABC SNF had a portable x-ray company do a chest x-ray for patient Jane Doe.
- X-ray company billed SNF using HCPCS 71045.
- The x-ray company did not use a modifier
- The x-ray company insists the SNF pay the Medicare applicable fee schedule for the global code.
- The SNF has an under arrangement agreement to pay the Medicare applicable fee schedule.
- Diagnostic tests are often separated into a technical and professional component
- The professional component of diagnostic test is not bundled to the SNF
- The professional component must be submitted to the Part B MAC with a modifier of 26 to indicate "professional component"
- The technical component of diagnostic test is the responsibility of the SNF
- If the x-ray is performed in physician's office it is bundled to the SNF
- If x-ray performed in outpatient hospital or CAH - Refer to Major Category I exclusions under Institutional Services

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SNF Sent Resident to Cancer Center

Treatment / MRI

- ABC SNF sent patient to the cancer center for outpatient treatment for brain cancer
- The cancer center did an MRI and billed CPT 70450 using modifier TC to the SNF
- The SNF and the cancer center have an under arrangement agreement at the Medicare allowable fee schedule
- Diagnostic tests are often separated into a technical and professional component
- Professional component of diagnostic test is NOT bundled to the SNF
- The professional component should be submitted to the Part B MAC with a modifier of 26 to indicate "professional component"
- The technical component of the diagnostic test may be billed to the SNF

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SNF Billed by Supplier

No HCPCS or CPT Code

- ABC SNF sent patient to physician office for routine visit
- Physician office billed SNF for professional services and supplies
- Physician office did not bill SNF using CMS 1500 form. Rather, physician office sent a statement
- The SNF does not have an under arrangement agreement with the physician office.
- If billed by the Hospital [TOB = 13X]
  - Services and supplies may be excluded with other Category I excluded services
  - Some are excluded based on revenue code and LIDOS
- If billed by supplier
  - HCPCS code is required code in order to determine status
- We suggest returning all claims missing CPT or HCPCS for non-payment

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Services Provided Are Not

Reasonable and Necessary

- ABC SNF sent patient to cancer center for routine treatment
- Cancer center provides treatment to patient that is not covered by Medicare
- SNF does not have an under arrangement agreement with SNF.
- Medicare only covers "reasonable and necessary" services for the patients illness or injury
- It is possible to deny payment to the supplier if you believe Medicare would not have covered services if they had billed directly to Medicare
- This is not official guidance from CMS but rather our opinion

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Vision Services

- SNF sends patient Jane Doe to optometrist for routine eye exam.
- Optometrist bills SNF for routine eye exam using CPT code 92014
- Optometrist bills SNF $1500 for treatment of macular degeneration With drug Ranibizumab Using HCPCS J2778
- SNF does not have an under arrangement agreement with optometrist
- The professional service CPT code 92014 is not bundled to the SNF.
- The medication CPT code J2778 Is bundled to the SNF
  - Rate is $322.85 / .1mg
- The SNF is required to pay at the agreed upon rate

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Vision Services

Off label use of drug

- Jane Doe goes to lunch with family while out of the facility they go to an optometrist appointment.
- Optometrist bills SNF for treatment of macular degeneration with Avastin injection on statement with drug name and no HCPCS
- SNF does not have an under arrangement agreement with optometrist
- Is the SNF responsible for paying for the Avastin?

- Avastin (becavizumab) is an FDA approved drug for treatment of select cancers and when used for cancer J9035 is excluded.
- Medicare has approved off label use for some ophthalmologic use.
- The dosages for this type of use is individually compounded and each FI/MAC determines the correct HCPCS code to use and the pricing.
- Coverage determination is also subject to diagnosis.

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Blood Products

- ABC SNF sent patient Jane Doe to the cancer center for follow up chemotherapy.
- Cancer center billed SNF for:
  - Chemotherapy drug HCPCS J9395
  - Chemo therapy administration HCPCS 96425
  - Clot factor vii proconvertin HCPCS 85230
- The SNF does not have an under arrangement provision in place

- The Chemo Admin and Chemo drug are excluded
- Many blood products are bundled to the SNF and are excluded from SNF Bundle Effective 10/1/21]
  - Factor VII
  - Factor XIII
  - Factor IX
- S.3233, the Hemophilia SNF Access Act, introduced January 28, 2020 Proposed a carve-out of CB for charges related to certain blood-clotting factors Effective October 1, 2021

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Hospital Outpatient using Wrong Revenue Code - *Evaluation and Management*

- SNF providers receiving claims from Hospital Outpatient clinics for wound care services
- HCPCS G0463 Hospital OP Clinic Visit
  - Should be billed with revenue code 510
  - Hospitals are billing with revenue code 761 for a treatment room
  - Hospitals occasionally use revenue codes 760 & 762

- On July of 2014, CMS excluded G0463 for outpatient bill types 13x and 85x billed with revenue code 0510 for dates of service on or after January 1, 2014
- E&M codes, representing the hospital's "facility charge" for the overhead expenses associated with furnishing the professional service itself, are excluded from SNF CB
- Claims processing Manual Chapter 6 20.1.1.2

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Dermatology Clinic

Unknown visit

- SNF resident leaves campus with family member to unexpected and undisclosed dermatology visit
- Has in-office skin sample collected for wound care grafting.
- Total charge is $40,000
- Dermatology clinic bills Medicare for HCPCS Q4226 and is denied with code 190
- Dermatology clinic bills SNF
- No Under Arrangement is in place
  - No notice of services provided
  - No prearranged pricing
- SNF is responsible to pay for HCPCS Q4226
- Payment amount is the agreed upon price
- Counter Argument: there is no under arrangement agreement in place and therefore the service is not covered by Medicare and not bundled to the SNF

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Stereotactic Body Radiation Therapy

CWF Exclusion

- On July 9, 2015, ABC sends SNF resident to outpatient radiation therapy
- SNF is billed for CPT codes 77435
- SNF Billed at $4,990 / Unit
- SNF does not have an under arrangement agreement in place
- Stereotactic Body Radiation Therapy 2015
  - CPT 77373 & 77435
- On July 9, 2015, CMS excluded these codes retro for 2014.
- Not listed in CMS Help Files until 2016
- CMS did not update files
- www.SNFCB.com shows $150,000 in correctly bundled to SNF

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Telehealth Bundling Error 2020

CWF Exclusion

- On April 9, 2020, St Mary's Care Center schedules a telehealth visit for Patient Jane Doe.
- Patient cannot be sent to physician office due to COVID protocol
- Physician bills Medicare and has claim denied with code 190 [bundled to SNF]
- SNF is billed for CPT code 99441
- SNF does not have an under arrangement agreement in place
- CMS did not correct CWF edits for telehealth services until July 2020
- Until July 2020;
  - 99441, 99442, 99443 Telehealth incorrectly bundling to SNF starting March 1, 2020
- SNF should not pay physician for telehealth services
- Physician should rebill Medicare
- SNF should bill for originating site fee CPT Q3014 as it is excluded from SNF CB

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COVID Monoclonal Antibody Treatments

CWF Exclusion

- On December 1, 2020, ABC SNF provided COVID positive resident with Monoclonal Antibody
- The Drug is provided for free from the state
- The administration is provided by a certified infusion therapy company
- The infusion therapy company bills Medicare Part B where the claim is denied with code 190 [bundled to SNF]
- The infusion therapy company bills the SNF
- SNF does not have an under arrangement agreement in place
- The administration of Monoclonal antibody is excluded from the SNF bundled
- CMS did not implement CWF edits to allow these claims to be paid for a SNF inpatient
- CMS correction not scheduled to take place until April 2021 update

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Overnight ER Visit

Interrupted Stay LOA

- ABC Care Center sends resident Jane Doe to emergency room at 11 pm on 5/5/19
- Patient is hallucinating and cannot respond to commands
- Patient is transported to ER by ambulance
- Patient is treated at the ER and returned by ambulance at 5 am the following day on 5/6/19
- The Ambulance company billed Medicare for each transport but the return transport was denied with code 190 [bundled to SNF]
- The ambulance company appeals the denial and loses the appeal
- The ambulance company bills the SNF for the return trip from the ER
- The ambulance company billed the trip from SNF to ER to Medicare Part B and was paid
- Why was the return ambulance trip bundled to the SNF?
  - Did the hospital bill the ER visit to correctly show services on both 5/5 and 5/6?
  - Did the SNF bill for the night of 5/5/19?
  - Did the SNF correctly bill with span code 74?
- New ambulance edits went into effect on 4/1/19
  - Ambulance claims with modifier NH or HN will process only if there is qualifying hospital claim on file

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What Else?

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Medicare Bad Debts

- Provider incurred $10,460,369 in Medicare Bad Debts in 2021
  - Of that, $6,799,244 was reimbursable on the cost report
  - Unreimbursed bad debt is $3,661,125
- How much additional was disallowed during desk review?

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New Bad Debt Standards

- The new regulatory requirements specify a timeframe of 120 days for timely billing of Medicare Co-insurance
- They also specify what date the timeframe is calculated from. They state that the provider must issue the bill "on or before 120 days after the latter of one of the following:
  - The date of the Medicare remittance advice that is produced from processing the claim for services furnished to the beneficiary that generates the beneficiary's cost sharing amounts;
  - The date of the remittance advice from the beneficiary's secondary payer, if any; and
  - The date of the notification that the beneficiary's secondary payer does not cover the service(s) furnished to the beneficiary.

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Staffing Five-Star	Score/Total		Score/Total		Score/Total		Score/Total	
Staffing time period	2022Q1		2022Q1		2022Q1		2022Q1	
Turnover time period	2020Q3-2022Q1		2020Q3-2022Q1		2020Q3-2022Q1		2020Q3-2022Q1	
Total Nurse Staffing	40/100		100/100		10/100		90/100	
RN Staffing	60/100		100/100		10/100		90/100	
Weekend Nurse Staffing	20/50		50/50		5/50		45/50	
Total Nurse Turnover	50/50		50/50		50/50		50/50	
RN Turnover	50/50		50/50		50/50		50/50	
Administrators Departing	30/30		30/30		30/30		30/30	
Total Score	250/380[S3]		380/380[S3]		155/380[S3]		355/380[S3]	
Five-star Rating	★★★★ 4.0		★★★★★ 5.0		★ 1.0		★★★★★ 5.0	
Average RN	**Hours**	**HPRD**	**Hours**	**HPRD**	**Hours**	**HPRD**	**Hours**	**HPRD**
Mon-Fri	42.89	0.76	48.13	3.50	136.79	2.74	50.11	1.38
Sat-Sun	29.38	0.52	29.88	2.07	97.51	1.95	36.02	1.00
Turnover		**Turnover rate**		**Turnover rate**		**Turnover rate**		**Turnover rate**
Nursing Staff		32.70%		0.00%		0.00%		0.00%
RNs		22.20%		0.00%		0.00%		0.00%
Administrators		0.00		0.00		0.00		0.00

New Five Star Staffing Matrix

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Five Star Users Guide

Table 3

Table 3
Point Ranges for the Staffing Rating (maximum possible score = 380 points)

1 star	2 stars	3 stars	4 stars	5 stars
< 155	155 - 204	205 - 254	255 - 319	320 - 380

Note: These cut points are applied after any necessary rescaling of the staffing score to have a maximum possible value of 380 points. The rescaled score is rounded to the nearest integer. Cut points for each of the six measures that contribute to the total staffing Score are shown in Appendix Table A2.

Scoring Exceptions

The following are exceptions to the scoring rules (described previously) for assigning the staffing rating:

- Providers that fail to submit any staffing data by the required deadline will receive a one-star staffing rating for the quarter.
- Providers that submit staffing data indicating that there were four or more days in the quarter with no RN staffing hours (job codes 5-7) on days when there were one or more residents in the nursing home will receive a one-star staffing rating for the quarter.
- CMS conducts audits of nursing homes to verify the data submitted and to ensure accuracy. Facilities that fail to respond to these audits and those for which the audit identifies significant discrepancies between the hours reported and the hours verified will receive a one-star staffing rating for three months from the time at which the deadline to respond to audit requests passes or discrepancies are identified. If repeat audits identify the same discrepancy, the timeframe for the staffing rating downgrade may be extended.

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Sources of Information

SNFCB.com

LTC-Analytics.com

LTC-Pathways.com

Billing-services.com

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