



## Eyeing SNF services: On the lookout for RAC audits

After months of speculation, it appears that the Recovery Audit Contractors (RAC) are finally turning their attention to SNFs.

Although hospitals remain the focus, three of the four regional contractors have posted issues they are looking at that involve SNFs on their websites.

“While SNF claims currently represent a small percentage of the RAC audit reviews, the RACs are starting to look at more and more SNF services,” says **Rachel Suddarth, Esq.**, an attorney with Hancock, Daniel, Johnson & Nagle, PC, in Richmond, VA. “We anticipate that the SNF focus will continue to grow in the future and recommend that facilities begin preparations for RAC audits as soon as possible.”

### RAC issues of concern

Each contractor gets to set its priorities for its specific region, and so far regions A, C, and D have an issue they

are examining that SNFs should be aware of. These issues are as follows:

- **Region A** (Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut, New York, New Jersey, Pennsylvania, Maryland, and Delaware) is looking at clinical social work services rendered during a SNF stay that are not separately payable under Medicare Part B due to inclusion in the bundled PPS payment
- **Region C** (Virginia, West Virginia, North Carolina, South Carolina, Georgia, Mississippi, Tennessee, Alabama, Florida, Arkansas, Louisiana, Texas, Oklahoma, New Mexico, Colorado, and Puerto Rico) is looking at ambulance claims

**“We recommend that each SNF designate someone in the facility to check the RAC contractor’s website once every week or so to see if new approved issues have been added.”**

—Rachel Suddarth, Esq.

for SNF-to-SNF transfers that are not separately payable under Part B because the SNF doing the discharge should be paying the ambulance provider and receiving reimbursement under bundled fees

- **Region D** (Alaska, California, Oregon, Washington, Nevada, Idaho, Montana, Wyoming, Hawaii, Utah, Arizona, North Dakota, South Dakota, Nebraska, Kansas, Iowa, and Missouri) is reviewing payments for SNF services provided to Medicare Part A beneficiaries that are included in a bundled prospective payment

“The current RAC audit targets focus on improper claims for services that should have been covered by the SNFs’ bundled Part A payment,” says Suddarth. “This focus should not come as a surprise to facilities as bundled payments have been a focus of other types of audit reviews in the past.”

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HCPPro

## RAC audits

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### RAC to the future

SNFs should also note that the RAC auditors are regularly adding new audit targets to the list of approved audit issues on their websites. The RACs have a good deal of flexibility in choosing their audit targets, but they do have to get preapproval from CMS prior to embarking on new targets, Suddarth says.

“We recommend that each SNF designate someone in the facility to check the RAC contractor’s website once every week or so to see if new approved issues have been added,” she says.

The four websites where the regions post their approved issues are:

- **Region A:** [www.dcsrac.com/IssuesUnderReview.aspx](http://www.dcsrac.com/IssuesUnderReview.aspx)
- **Region B:** [racb.cgi.com/Issues.aspx](http://racb.cgi.com/Issues.aspx)

- **Region C:** [www.connollyhealthcare.com/RAC/pages/approved\\_issues.aspx](http://www.connollyhealthcare.com/RAC/pages/approved_issues.aspx)
- **Region D:** [racinfo.healthdatainsights.com/Public1/NewIssues.aspx](http://racinfo.healthdatainsights.com/Public1/NewIssues.aspx)

In addition to bundled payments, Suddarth says she anticipates that the RACs may expand reviews into two high-risk areas: proper billing for rehabilitation services and whether the SNF patient had a qualifying three-day hospital stay prior to admission.

“The three-day qualifying stay could be a huge issue for SNFs,” she says. “To some extent, SNFs are at the mercy of the hospital’s documentation to demonstrate the patient had a three-day qualifying stay. If the RAC reviews the hospital’s documentation and determines that the hospital stay was not medically necessary, or that it did not meet the qualifying criteria for some other reason, the SNF’s reimbursement may also be at risk.”

### Demonstration differences

Although the permanent RAC program still places providers at risk of repayment demands, providers should know that CMS has made significant changes to the program since its inception as a six-state demonstration project, says Suddarth.

“Under the demonstration program, RAC auditors could look at any issue they wanted, and they typically followed the money by going after high-dollar inpatient hospital claims,” she says. “Now, CMS has required that the RACs get preapproval for audit targets and requires that the RACs look at all types of Medicare providers and claims, not just high-dollar inpatient hospital services.”

This is important for SNFs because even though the RACs currently remain focused on hospitals and inpatient admissions, they will eventually have to turn their focus to SNFs, physicians’ offices, and other providers.

CMS has also imposed limits on the number of records the RACs can request from providers—a stark contrast from the demonstration program, in which RACs

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were free to request as many records as they wanted from targeted providers, Suddarth says.

The record request limits vary by facility type and size, but you can determine the maximum a RAC auditor can ask you for by visiting [www.cms.gov/RAC/Downloads/DRGvalidationADRLimitforFY2010.pdf](http://www.cms.gov/RAC/Downloads/DRGvalidationADRLimitforFY2010.pdf).

### Real-life example

Having the list of approved issues is also a difference from the demonstration program that helps providers know what they can expect. However, RAC auditors do have some leeway for fishing for obvious outliers, which is how two Florida SNFs recently received RAC audits, according to **Diane M. MacGregor**, A/R consultant and owner of BottomLine Solutions, LLC, in Cape Coral, FL.

"Two facilities I consult for have seen RAC audits so far, and both dealt with Part B claims," MacGregor says. "The more interesting one was for the facility that billed too many units of speech therapy."

As soon as the SNF got the audit request, it was clear a mistake had been made, she says. Not only had it billed multiple units of a speech code for which only one unit per day was allowed, but it had also billed the wrong code.

"It was easy to respond to the request, though," says MacGregor. "We just fixed it and informed them we had been overpaid but the whole claim wasn't invalid."

However, the matter didn't stop with the correction, she says. "There are still some kinks in the system as we ended up receiving an overpayment after we corrected the claim. We asked the RAC auditor to take back the extra payment, but they said it was up to the fiscal intermediary [FI]. We called the FI, and they said they weren't involved with what the RAC does."

MacGregor is still trying to pay the extra \$200 back. "We don't want the facilities to keep something that doesn't belong to them," she says. "I'm sure it'll get straightened out, and this wasn't a common occurrence, but it shows there is still a bit of a disconnect between the RAC auditors and CMS."

If you are subject to a recoupment and have the financial ability to have the entire amount recouped via a

remittance advice, that would be the best tracking method for both the provider and the FI, says MacGregor, as it's a more effective way to ensure you have an accurate audit trail to prevent duplicate requests or recoupments.

One good piece of news for SNFs is that the RAC process is very similar to other medical reviews. "They asked for the review, we followed their timelines and the regular Medicare appeals process, and everything else went just like a regular FI review," MacGregor says.

### Continued preparation

RACs may not be hitting SNFs hard yet, but it is clear that medical reviews are here to stay, says Suddarth.

"RACs are just one more layer of auditing in today's aggressive audit arena," she says. "The Medicare and Medicaid programs are chronically underfunded, and unfortunately, the federal and state governments have decided that audit reviews represent a great new funding stream. This is the first time we have seen audits being used to fund programs rather than check for compliance. On top of that, the RACs are paid on an incentive basis, so the more they bring in, the more they are paid."

The RACs are incentivized to find against the provider in questionable cases, whereas in the past the provider may have been okay, Suddarth adds.

Due to the huge amounts of money the RAC program has brought into Medicare, the federal government has decided to expand the RAC audits to state Medicaid claims, Suddarth says. Soon CMS will be taking bids on Medicaid RAC contractors, and facilities may start seeing Medicaid RAC audits later in the year.

"Medicaid RACs may hit SNFs and nursing homes even harder because so much long-term care funding comes from state Medicaid programs," Suddarth says.

CMS released the proposed rule for Medicaid RACs November 5, 2010, setting the stage for the targeted April implementation date. The use of Medicaid RACs is another initiative put forth by CMS as part of the Affordable Care Act, which was implemented in 2010. According to the rule, states must have established Medicaid

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## RAC audits

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RAC programs by December 31, 2010, which is when state plan amendments were due to CMS. The programs must be fully implemented by April 1, 2011. This will force providers to tighten up their processes for accurate coding and medical necessity as it relates to Medicaid.

But if you're doing things correctly, RAC audits shouldn't be your downfall, MacGregor explains.

"If you're auditing your documentation and logs for accuracy all along, you should catch most of the mistakes before a RAC auditor does," she says. ■

### What to do in a complex review

Despite their time-consuming nature, if your facility receives an additional documentation request (ADR) from your Recovery Audit Contractor (RAC) as part of a complex review, there's no need to panic. But there are some critical steps that your facility should immediately take, advises **Rachel Suddarth, Esq.**, an attorney with Hancock, Daniel, Johnson & Nagle, PC, in Richmond, VA. Those steps, in sequential order, are as follows:

- 1. Make sure the RAC is permitted to request the record.** If the RAC has exceeded the record request limit, the SNF has the right to decline submission. For that reason, it's important for SNFs to keep track of the number of records their RAC is allowed to request per 45-day period. On January 28, 2010, CMS revised the ADR limits.
- 2. Make sure the RAC's ADR is based on an approved issue.** Each RAC's website lists the reimbursement issues approved by CMS and thus deemed reasonable causes of an ADR. In most cases, when a SNF receives an ADR, it will be for an approved issue, Suddarth says. However, it is important to note that RACs are occasionally permitted to request documentation based on an issue that has yet to be officially accepted by CMS, she adds. "When they're trying to get a new issue approved, they can go ahead and request a limited number of records on that issue ... but if I got something that wasn't on the website, I certainly would contact the RAC and ask, 'Do you have authority to look at this?'"
- 3. Make sure your staff is prepared to submit the records to the RAC on a timely basis.** If a SNF does not get the requested records back to the RAC within 45 days, the RAC can assess an automatic denial. Facilities can contact their RAC and ask for an extension, which Suddarth says is typically granted. "So if a SNF is really feeling overwhelmed and they don't think they can get those records out in 45 days, they need to call the RAC—or we prefer

writing to them or e-mailing them, some traceable format—and get written confirmation back that they have a record extension."

- 4. Make copies of all documentation that will be sent to the RAC.** Should a SNF wish to appeal a denial, possessing copies of all documentation will leave the facility prepared to do so.
- 5. Do your best to send out only the necessary documentation in an organized fashion.** A SNF needs to make sure it's sending the RAC all required materials, but nothing more, Suddarth says. "We've heard of facilities that just get bogged down and copy every piece of paper in the medical record. Well, probably not all of that is relevant, and you're probably sending them more than they're entitled to," she says. SNFs are only required to send the RAC the record documentation that relates to the specific claim and service in question—and they should send it in one organized package, Suddarth adds. "I can tell you that if you send the auditors a nice, neat package where you've highlighted the documentation that supports your claim, you're going to get a much better result than if you just send them a mess of paper," she says. The easier a SNF can make it for a RAC to recognize compliance, the better.
- 6. Institute an internal tracking system.** SNFs need to be able to track when they received record requests, when the documentation was sent, and when the first-level appeal is due. "If you're in the situation where you have multiple denials at the same time, it's going to be critically important to know what's due when," Suddarth says. RAC tracking software is available, but an Excel® spreadsheet works well too, she adds. The key is finding a system that maintains a high level of organization for your SNF in regard to RAC documentation requests.

## Learning curve accompanies MDS 3.0 therapy changes

The transition period is over, but that doesn't mean everyone is fully up to speed on billing for therapy services under the MDS 3.0, says **Kate Brewer, PT, MBA, GCS, RAC-CT**, president of Progressive Rehab Solutions in Hartland, WI, and vice president of Greenfield (WI) Rehabilitation Agency, Inc.

"There is a learning curve with the MDS 3.0," says Brewer. "It's good to be through the transition process, which was challenging for everyone. Now we can start focusing on really learning 3.0 and mastering that."

A lot of facilities have already figured out how to follow the rules of the MDS 3.0, so now is the time for SNFs to learn how to optimize their billing and capture the reimbursement for all the services they are providing, Brewer explains.

"MDS 2.0 was around for years, and people were still always looking for ways to improve," she says. "It's probably going to be at least a year before people are close to as comfortable with 3.0 and are taking credit and getting paid for everything they are doing with residents."

### What's new with therapy?

According to Brewer, there are three main differences in the MDS 3.0 in terms of billing for therapy services:

1. The limitation of concurrent therapy
2. The elimination of Section T
3. Alteration to short-stay assessment rules

"The changes all mean that it will be difficult to make as much money from your therapy services from the start," says **Bonnie Foster, RN, BSN, MEd**, a long-term care consultant in Columbia, SC. "To keep up, SNFs are going to have to hire more therapists, but unfortunately there aren't a lot of qualified therapists available out there to hire right now."

### Going one-on-one with patients

Maybe the most dramatic of the changes is the limitation of concurrent therapy. The MDS 3.0 allows

concurrent therapy to be with a maximum of two patients (as opposed to up to four in the past), and time spent doing concurrent therapy must be divided among the two patients, Foster says.

"Concurrent therapy isn't as cost-effective anymore," she says. "If you're counting 30 minutes of concurrent therapy on the MDS for a resident, you can only bill for 15 of those minutes."

The changes bring therapy services under Part A more in line with Part B therapy billing, Brewer says, noting that the rules are changing to try to improve patient care. "CMS wants you spending more time with residents, and concurrent therapy was being used too often when not necessary just to be able to bill for more minutes," she says.

Providers will need to ensure that their documentation clearly demonstrates how therapy services were provided. "You'll also want to clearly document which therapy is being provided concurrently and what is being done individually so you can be credited for the right amount of minutes, now that they are looked at differently," Brewer says.

### T is for terminate

Section T of the MDS was previously used to estimate how much therapy a resident would receive in the first 14 days of a SNF stay. But under the MDS 3.0, that will no longer be allowed as CMS found that the estimation was often much higher than the amount of therapy patients actually received, Foster says.

"Facilities were shooting high and were often unable to meet the goals," she says. "It was leading to higher RUG payments than what should have been allowed."

The change means SNFs must submit a start of therapy Other Medicare-Required Assessment (OMRA) with an ARD five to seven days from the start of therapy and an end of therapy OMRA one to three days from when therapy is completed, Brewer says.

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## Therapy changes

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“It’s going to put a lot more pressure on SNFs to get in five days of therapy on the initial assessment period for residents to qualify for a rehab RUG,” says Brewer. “Under the new look-back period, therapy must be provided five times every seven days to qualify for a medium or higher rehab RUG.”

That’s a big difference from being able to qualify for a high rehab RUG initially with a therapy evaluation and one 45-minute session if you estimated a high frequency of therapy, she adds.

“You’re going to have to offer therapy seven days a week to meet these requirements,” says Foster. “If a resident is admitted late on a Friday or declines therapy one day during the week, there’s no way to get the five-day requirement in if no one is providing therapy on weekends.”

This doesn’t mean every resident needs to be offered therapy seven days a week. However, it does mean you’ll need to either have therapists on call or add more staff if you don’t already have weekend coverage, Brewer says.

“It’s going to be tough in some rural areas that have a tough time finding therapists or therapy contracting

services,” says Foster. “But it’s really the only way to meet regulations that residents must maintain or attain. You can’t expect a resident’s health to revolve around a five-day workweek.”

### Are you sure you can’t stay awhile?

The third change to the MDS 3.0 for therapy is to the short-stay rules, Brewer says.

To be considered a Medicare short-stay resident and to be able to use the special RUG-IV short-stay rehabilitation therapy classification, the assessment must be a start of therapy OMRA, the resident must have been discharged from Part A on or before day eight of the Part A stay, and the resident must have completed only one to four days of therapy, with therapy having started during the last four days of the Part A stay, according to the *RAI User’s Manual*.

For a complete list of the eight conditions that must be met to use the short-stay assessment, read Chapter 6 of the *RAI User’s Manual* starting on page 6-12, Brewer says.

“The more you use short-stay assessments, the more comfortable you’ll get with them,” she notes. “They seem confusing, and there will be bumps along the way, but they are useful once you know what you’re doing.”

### Recreational change

One other change with the MDS 3.0 that’s related to (but not tied to) traditional therapy is the opportunity to get credit for recreational therapy minutes, Foster says.

“Facilities have been using recreational therapy in the past, but now they have the option to gain reimbursement from it if residents have a physician’s order,” she says. “It has to be more than an activity program like Bingo, though. Hiring a recreational therapist can benefit SNFs now financially while adding some fun for the residents.”

But because it’s new, the amount of reimbursement for recreational therapy is not yet clear. It will be interesting to see how its RUG score looks, Foster says. ■

### Share your knowledge

The goal of this newsletter is to keep our readers informed. We hope each issue provides valuable insight that helps you understand the complex world of long-term care billing.

But there’s no reason we can’t learn from you, too!

Experience is valuable, and with limited educational resources available to billers, peer-to-peer communication can go a long way. For this reason, we invite you to share your knowledge in an effort to help other long-term care billing professionals. Readers will greatly benefit from hearing about your billing and coding stories and experiences.

To share a simple or complex billing experience that you think will help readers better understand a specific topic or general challenge, please contact Associate Editor Justin Veiga at [jveiga@hcpro.com](mailto:jveiga@hcpro.com) or 781/639-1872, Ext. 3933.

## Default billing: A 'last resort' option that comes in handy

The term itself has negative connotations in the industry, but default billing isn't the worst option to salvage your reimbursement in some cases.

"People try to avoid using default billing at all costs, but there is a time and place for it," says **Missy Tiekem**, vice president of operations for Consolidated Billing Services, Inc., in Spokane, WA. "While it's most commonly thought of as a last resort for late assessments, it can also be useful in other instances."

Default billing is when you submit a claim at the lowest RUG rate that your facility receives. Because no facility wants to receive reimbursement at the lowest rate, default billing is typically frowned upon. But you shouldn't look down on it, especially when it's default billing or no billing, says **Maureen McCarthy, RN, BS**, director of Medicare compliance and education for National Healthcare Associates and president of Celtic Consulting in Connecticut.

### When to use default billing

Default billing is not used when you aren't able to submit an MDS on time, contrary to the belief of many in the field, says McCarthy. When you are unable to submit an MDS on time, it may affect your survey, but it shouldn't affect your payment.

"Some people have a false impression that if they submit their MDS late, they have to do a default billing claim and will lose out on reimbursement. But as long as the MDS was completed on the correct dates, your payment will be fine," says McCarthy. "Default billing is more for when you don't fill out the MDS on time rather than being based on when you actually submit it."

Facilities can't use default billing if the initial MDS assessment wasn't completed because, to bill at all, you must at least be following regulatory guidelines, which means an MDS completed by day 14, McCarthy notes. However, you may collect a payment at the default level for a resident who had an MDS completed but was either early or late (i.e., outside the allowable window of ARDs).

A common example of when a facility may use default billing is if it didn't realize a resident had Part A benefits at admission, says McCarthy. The nurses may have completed the initial MDS, but no one completed any additional MDS in the first 14 days because it was thought to be unnecessary (e.g., the resident's family thought they had managed care or private insurance). If the facility then realizes the patient was eligible for Part A benefits,

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### All things Medicare billing

Are you looking for a single resource that contains everything you need to know about Medicare billing in a long-term care facility? Look no further.

*The Complete Guide to Long-Term Care Medicare Billing* is hot off the press and it provides an abundance of information related to filing Medicare Part A and Part B claims. This book will help you and your staff:

- Correctly file no-pay bills and benefits exhaust claims
- Complete the UB-04 accurately
- Apply expert insight and insider tips with regard to consolidated billing
- Understand and comply with the billing changes under RUG-IV and the MDS 3.0

*The Complete Guide to Long-Term Care Medicare Billing* also includes dozens of important forms and other helpful tools, such as:

- Specific UB-04 examples
- RUG-IV classification chart
- RUG-IV 2011 rates and wage index
- ADL calculation chart

Written by **Frosini Rubertino, RN, CRNAC, C-NE, CDONA/LTC**, this book is packed with valuable, up-to-date information that will help your billing staff on a routine basis!

For more information about *The Complete Guide to Long-Term Care Medicare Billing*, visit HCPro's website at [www.hcmarketplace.com/prod-8391](http://www.hcmarketplace.com/prod-8391).

## Default billing

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it may be too late to have completed the MDS assessment for those days. Instead of losing out on reimbursement, the facility can at least get the default rate for the resident's time before catching up. It can then complete the MDSs and receive the appropriate RUG rate for the rest of the stay.

"The best way to avoid this problem is to perform full benefit verification upon admission," McCarthy says. "Look at the Common Working File to make sure the patient doesn't have a different insurance. This should also tell you the termination date and effective date so you can make sure the insurance is active during the entire stay."

There are many other reasons that an MDS may not have been filled out in a timely manner, says Tieken, although most of the other reasons are due to issues more in the control of the SNF, such as:

- A lack of training
- Poor tracking of Medicare schedules
- Miscalculation of days

"Clinicians have to schedule residents for their assessments to make sure each one is done on time," Tieken says. "The clock starts ticking as soon as residents are admitted, and if you're not organized and sticking to MDS schedules, things will get missed."

Having electronic tracking systems that tie into your documentation and billing systems helps get everyone on the same page, she says, but because not everyone is using electronic methods yet, coming up with a tracking system that works for your facility is a must.

"I always recommend that people bring resident MDS calendars with them to the weekly Medicare meetings to try to prevent errors," says Tieken. "This way you may catch if you should have done an [Other Medicare-Required Assessment] for a change of condition or if you were counting your days wrong all along." Facilities can also use the MDS schedule tool that Medicare offers at [www.wpsmedicare.com/part\\_a/education/mds\\_calendar.xls](http://www.wpsmedicare.com/part_a/education/mds_calendar.xls).

"One simple thing to do is to always have two people checking schedules and MDSs," says Tieken. "A director of nursing or someone in a similar role should be ensuring MDS schedules are followed, just as someone should be checking that all billers' claims are going out correctly."

The other more accepted way of using default billing is for short-stay residents. "If a patient is in your facility for 24–72 hours, you may not have collected enough information to complete a full MDS assessment, especially now with the loss of utilizing information collected during the hospital stay," says McCarthy.

Using the default rate instead of a higher RUG rate can cost a facility \$300 or more per day, she says.

"It's too much pressure on MDS coordinators to do a 38-page assessment on all residents coming through right off the bat, so you only do full assessments when you need to, like for Medicare Part A–covered residents," says McCarthy. "When residents expire or are transferred from your facility after a day or two, you may not have had time to do the full assessment, which means default billing might be your best option if you later find out the resident was covered by Part A."

If, however, you performed extensive rehab and/or nursing services on the resident during that short stay (services that would qualify for one of the higher RUG categories), it may still be worth doing the full MDS if you have the data, McCarthy adds.

### How to bill it

Billing for the default rate is the easy part, Tieken says. "You're just putting PA1 or AAA-00 as the RUG category on the claim to indicate default payment and including the assessment date you should have used," she says.

From the billing standpoint, there isn't much that is different from submitting any other claim, Tieken notes. "You just need to know how many days the default payment is good for."

Billers are also normally the ones to realize a default payment is going to be necessary, she says. "It's typically caught when the biller goes to submit a claim and realizes there is an MDS missing."

The biller must then go back to the nurse to have him or her submit a corrected MDS for the time period in question, Tieken says. Because the RUG will be at the default rate, the correct MDS won't have to be as detailed as the full MDS. They will need to document why the MDS was late.

One issue to be aware of with default billing, however, is that using it too often can raise red flags with Medicare.

"If your facility is using a lot of default billing, it's the same as if all your bills show nothing but high RUGs," says Tieken. "Most facilities probably use default billing once every six months or so; more than that and you may be an outlier, especially if it's in cases where it wasn't a short-stay resident." ■

## Pulled in every direction: Stress management for billers

Stress: Everyone has it, and every job causes it. But each workplace has its own stressors and complexities that present different challenges.

For billers, the most common cause of workplace stress is having so many balls in the air at all times that it's difficult to ever stop juggling, says **Patsy Reynolds**, director of long-term care reimbursement for Community Health Partners in Springfield, OH.

"Billers are constantly being pulled in every direction, especially in facilities where the business office manager is also the biller," Reynolds says. "In a centralized billing office, one of the biggest stress factors is trying to obtain everything you need from the facility to complete your billing timely and accurately because so many things go into creating a clean claim."

### The evolving role of a biller

The roles of a biller can be numerous, says **Karen Connor**, vice president of reimbursement for Post Acute Consulting in Grafton, MA. "A lot of people think that at the end of the month, billers just push a button and generate all the bills. But we're working in the most regulated industry in the country, and getting the bills out is only a small part of many billers' roles."

While there may have been a time when billers really were just focused on getting bills out, with changes in funding and reimbursement rules over the years, especially the change to once-per-month SNF billing, billers have had

to take on more tasks. Connor says long-term care billers are often balancing the following responsibilities:

- Submitting claims
- Managing cash flow
- Following up with collections
- Tracking the facility's census
- Dealing with all accounts receivable (AR) issues
- Checking for correct documentation
- Verifying resident insurance
- Answering resident/family questions

"Billers often are doing the job descriptions of three or four people," Connor says. "It's not uncommon to have only one or two people in the business office in large facilities, and the smaller departments are often the overlooked ones."

All the roles add up to a lot of stress and a big risk for burnout if not dealt with properly, says Reynolds.

"Burnout is a possibility if you do not use good time management," she says. "Billers need to learn that working 12- to 14-hour days every day does not necessarily accomplish any more than working their eight-hour day. By being organized and focused, you can complete tasks that are necessary to ensure you are maintaining AR efficiently."

Billers who are successful are very organized, Reynolds adds. "That doesn't mean they have a perfectly neat desk; it means that they have processes and they follow them."

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## Stress management

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Creating a monthly calendar for each biller to follow can be a tremendous asset, Reynolds says. “There are certain things that are done daily throughout the week. I tell the billers my expectation is not that they necessarily accomplish the task on that day, but that they accomplish all tasks by end of week. This lends some structure to their time,” she says.

A monthly calendar will help billers track when bills need to be sent to the different insurers, as well as making sure time is set aside to accomplish their other tasks.

“If you don’t set aside time for following up on aging accounts and a day each week to manage the census and posting cash, things will slip through the cracks,” says Connor. “Putting in place policies and procedures and following them will help keep everything on track.”

## Communication across levels

When billers feel buried with work, it’s important they don’t feel isolated as well, Connor says. “Billers

have to feel comfortable speaking with their administrators and managers. There may be ways to reduce workload or get the education on how to handle some of the issues, but if no one speaks up, everything will continue to pile up,” she explains.

Being short-staffed can create an even more stressful environment because the work still all has to get done, so more work is falling on the billers who are there, Reynolds says. “It’s the responsibility of the manager to know his or her staff well enough to detect the signs of stress, and it is the biller’s responsibility to acknowledge the stress when asked about it,” she says. “Oftentimes the biller just needs to vent, so it is very important that the manager have an open-door policy and that staff feel like the manager is approachable. It’s also very important for managers to roll up their sleeves and help when help is needed.”

There is a set time period in each facility when bills must be posted, and being short-staffed or overworked doesn’t give you an extra day to do so, Connor says. If a lot of the documentation you’re getting is missing information, or if you’re being asked to answer phones and speak with residents’ families while trying to close the books, it’s going to be even more difficult to get everything done in time.

That’s when it falls on management to help out, says Connor. Sometimes this can be as simple as setting aside time to be available to speak with families so billers aren’t being constantly interrupted. It could also mean speaking with clinical staff about providing clearer documentation so there aren’t as many questions when everything gets to the biller. Other times the administrator might get on the phone and call families directly to ask about unpaid bills, as opposed to the biller making continuous follow-up calls. But often it’s simply about providing the support and education a biller needs, says Connor.

“Billers need access to training,” she says. “The rules of the game are always changing. Whether it’s updated software systems, new payers, or changing payer rules,

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if a biller isn't always learning, they are going to fall behind."

The switch to the MDS 3.0 is a good example of this, Connor says. Although billers were originally told that, being more of a documentation issue, it wouldn't affect them too much, there are so many new modifiers that they are struggling to figure out which one goes with which assessment.

"When you add in that a lot of facilities switched their software to accommodate MDS 3.0, it's like billers

have a whole new working environment overnight," says Connor.

Reaching out to state biller associations or even networking with other billers in area SNFs can be a big help, Reynolds says.

"Sometimes just knowing that you aren't the only ones having the problems can be a huge relief," Connor explains. "It's easy to feel like you're on an island in a small billing department, but there are so many people in the same boat who can offer help." ■

## BALTC Q&A

*Editor's note: This month's "Q&A" was modified from the HCPro book The Complete Guide to Long-Term Care Medicare Billing, written by Frosini Rubertino, RN, CRNAC, C-NE, CDONA/LTC. For more information or to order, call customer service at 800/650-6787 or visit [www.hcmarketplace.com/prod-8391](http://www.hcmarketplace.com/prod-8391). To submit a question for upcoming issues, e-mail Associate Editor Justin Veiga at [jveiga@hcpro.com](mailto:jveiga@hcpro.com).*

### **Q** How can my facility best manage our triple-check process for Medicare Part B claims?

**A** The goal of the Medicare Part B triple-check process is to ensure that Medicare is billed accurately and timely for all allowable incurred costs your facility has acquired under the Medicare program.

The facility will be responsible for implementing the Medicare triple-check process monthly to verify that claims are accurate prior to submission to the fiscal intermediary (FI). The facility each month will verify all Medicare claims prior to submission.

The Medicare triple-check process should be completed by an interdisciplinary team, usually composed of the following individuals: administrator, director of nursing, MDS coordinator, facility rehabilitation director or designee, business office manager, and medical records and central supply. The Medicare triple-check process will ascertain and document key items for each Medicare claim

using the Medicare triple-check audit tool, which will be completed by the business office manager and filed within the month-end closing reports.

Each of the participants should complete each of their respective key items for the Medicare Part B triple-check process prior to getting together in a scheduled, formal meeting. Those items are as follows:

#### **Business office manager and medical records:**

1. Verify that the principal diagnosis code on the UB-04 and diagnosis sequencing on the UB-04 agree with the medical records face sheet

#### **Business office manager:**

1. Verify that the covered service dates on the UB-04 agree with the dates of service that are being billed and match the census covered days
2. Verify that the patient financial file has a completed and signed MSP form

#### **Business office manager and central supply:**

1. Verify that all appropriate ancillary charges are reflected on the UB-04. Ancillary charges may include the following:
  - Surgical dressing supplies
  - Urologicals
  - Prosthetic devices (catheter, colostomy supplies, etc.)

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**BALTC Q&A**

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- Laboratory
- Radiology

**Business office manager and facility rehab director:**

1. Verify that the HCPCS code on the UB-04 matches the HCPCS procedure performed per log or grid
2. Verify that the modifiers (GO, GP, GN, KX, 59) on the UB-04 correctly match the treating therapy, therapy cap limits, and NCCI edits
3. Verify that the number of minutes and units on the UB-04 correctly match the therapy log and grid
4. Verify that the occurrence codes on the UB-04 correctly describe the current patient service dates
5. Verify that the value codes on the UB-04 are correctly coded and summed
6. Verify that the revenue codes on the UB-04 are correctly coded for the type of procedure or supply being billed

**Business office manager and director of nursing:**

1. Verify that the certification and recertification have been signed and completed by the attending physician according to Medicare guidelines
2. Verify that all orders and clarification orders have been written and signed by the attending physician for all services being billed

**Facility rehab director:**

1. Verify that rehabilitation services are stated on physician orders
2. Verify that evaluation includes prior level of function
3. Verify that clinical documentation notes progress warranting continued skilled intervention

**Administrator:**

1. The role of the administrator is to chair the triple-check meeting and ensure that the process is completed by the facility each month prior to Medicare Part B claims being submitted to the FI or Medicare Administrative Contractor. Participation in the Medicare triple-check will allow the administrator to monitor communication effectiveness of facility processes between the interdisciplinary team. ■

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