December 2019 | Volume 21, Issue No. 12

# Billing Alert for Long-Term Care

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## ADR process must change to reflect PDPM's clinical focus

Clinical characteristics of patients rather than the volume of services provided drive reimbursement in The Patient-Driven Payment Model (PDPM). It only makes sense then that auditors will now conduct a more clinical-focused pre- and post-pay medical review.

"The additional documentation request (ADR) process under PDPM is going to be like no other audit program we've ever known before," says **Reta Underwood,** Medicare specialist and president of Consultants for Long Term Care.

To attain accurate PDPM reimbursement, SNFs must ensure the medical record and MDS completely capture the patient's acuity. As such, auditors will review the medical records with much more scrutiny than they did in RUG-IV, says Underwood.

However, many providers have not updated their ADR processes for PDPM, leaving them unprepared should a review entity conduct a pre- or post-pay review.

The process is no longer as simple as cross-referencing therapy minutes listed on the MDS with those in the service logs as was the process in RUG-IV.

If you're not ready to back up all of the clinical data included on the MDS, you increase the likelihood that the review entity will re-coup or deny payments, says Under-wood.

The good news is there is time to prepare. With just a few months of claims submitted in the PDPM system, medical review entities are likely just starting to get the audit wheels turning. Now is the perfect time to create or up-date your ADR process to make it PDPM ready. Reviewing and updating your process will increase your chances of a favorable outcome and ultimately protect your revenue integrity.

### Know what auditors will look for

An ADR is a request for medical records so that auditors can conduct a medical review and determine whether a claim should be paid. The first step in updating your ADR process to consider what auditors will now look for in the new reimbursement model. Because audits in the new reimbursement system are new for everyone, it's impossible to predict exactly what auditors will focus on. However, you can use what you do know about PDPM to make some pretty good guesses, Underwood says.

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The Final Rule says that anything on the MDS that generates the Health Insurance Prospective Payment System (HIPPS) code should be included in the plan of care.

"If I'm an auditor and want to make sure the claim is justified, I'm going to look at the pieces that drove the HIPPS calculation and how it's incorporated into the care plan, and cross-reference that everything is on it," Underwood explains.

From there, Underwood expects auditors to review the daily skilled notes to ensure all the clinical conditions and services provided were described in the medical record.

Auditors will also scrutinize the ICD-10 codes coded on the MDS and claim. Accurate PDPM reimbursement re-quires SNFs to provide clinical documentation detailing the patient's clinical acuity and precise ICD-10 codes that reflect those conditions.

Medical record documentation submitted in response to an ADR must support the ICD-10 codes coded on the MDS, especially those related to major reimbursement drivers, such as the primary diagnosis, comorbidities (CC) that impact the non-therapy ancillary, and nursing component, Underwood says.

Although PDPM reimbursement relies on clinical documentation and ICD-10 coding in a way that SNFs have never experienced before, there are a few audit triggers that remain the same in PDPM.

Auditors will continue to look for documentation showing medical necessity and that the patient met the requirements for a skilled level of care. Those criteria do not change in PDPM, Underwood says.

It's also important to note that many of the same requirements that triggered a technical denial in RUGs-IV will continue to do so in PDPM, says **Stacy Baker, OTR/L, CHC, RAC-CT,** director of audit services for Proactive Medical Review & Consulting, LLC.



SNFs must continue to have in the medical record:

- Physician certifications/recertifications completed accurately based on guidance from Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, "Physician Certification and Recertification of Services," §§40 - 40.6
- Proof of physician visits as outlined in 42 CFR, 483.40 Physician Services
- Documentation from the hospital stay supporting those conditions that require extended care in the SNF

The shift to reimbursing SNFs based on the clinical acuity of patient and the importance of clinical documentation makes it impossible to respond to an ADR without input from the interdisciplinary team (IDT).

## Involve the IDT

In order to win a favorable ADR adjudication in PDPM, the IDT needs to conduct an in-depth review of the clinical documentation included in the submission packet to:

- Ensure documentation supports all conditions and services reported on the MDS, especially sections that drive reimbursement. In RUG-IV, 33 MDS items impact payment, but in PDPM, there are well over 100 items on the MDS that can potentially impact payment, Baker says.
- Confirm ICD-10 codes are accurate and comply with RAI Process coding guidelines, Underwood says.

This is a major shift from the RUG-IV system in which many SNFs relied on billers to collect the material for the submission packet. For PDPM, providers need to update their policies to include the IDT, says **Barbara Reimer,** consultant with the Fox Group.

"Billers or other non-clinical staff may not understand what parts of the clinical records will best support billed services, or what clinical documentation the medical review entity wants to see," says Reimer.

Additionally, providers who relied on therapy contractors to respond to ADRs, should consider bringing the ADR process in-house because therapy is only one small piece of what auditors will look for, says Underwood.

In PDPM, it is imperative for clinical staff to play a more active role in determining and reviewing the medical records and contributing to supporting materi-

als (i.e., cover or statement letters) sent in the ADR packet. Clinical staff, especially the MDS coordinator and nurse assessment managers, know what documentation is required to support the MDS and can include it in the documentation packet submitted for review.

Update your documented ADR process to formally out-line the IDT team members who may participate in the ADR response and their responsibilities, says Underwood.

IDT team members who may participate in the ADR process include:

- MDS coordinators
- Therapy providers
- Nursing staff
- Social Services / Case management
- Dieticians/dietary staff
- Physicians and/or nurse practitioners

The clinical IDT should review the records prior to submitting to the review entity and determine whether the SNF should include additional clinical information not included in the formal request but will support the services provided, Reimer says.

In addition to clinical staff, consider listing that compliance officers, medical records staff, and administrators will be called on as needed to facilitate the ADR response.

## Designate a person to receive and check for ADRs

SNFs may receive an ADR from any one of several medical review entities (i.e., CERT, UPIC, RA, MACT, TPE Notification letters) that may notify you via fax, postal mail, or electronic systems, Baker says.

"You do not want to have a recoupment because the notice was in the wrong mailbox or set aside by someone who did not understand it's purpose," Baker says.

The designated person should check the Direct Data Entry at least weekly to see if there are any suspended claims with a request for an ADR in the system. You can see claims with an associated ADR under location S B6000 or S B6001 of the DDE, says Reimer.

It's also a good idea to make anyone who checks the mail, fax, or email aware of what ADR correspondence looks like so that they can deliver it to the correct individual in case the review entity sends the notice to a general inbox, address, or phone number.

Identify a back-up person to receive ADR requests in case the primary person is out of the office, especially if he or she is taking extended leave (e.g., maternity or paternity leave).

## Select a person to project mange the ADR response process

The person identified may be someone from billing or the business office, medical records, or a member of the clinical team, such as the MDS coordinator. The individual will:

- Request the medical record
- Distribute the medical record and ADR information to the appropriate member of the IDT for review
- Coordinate meetings to discuss the response
- Track and help gather additional documentation IDT members determine should be included in the submission packet
- Sets hard deadlines and follows up with all team members to ensure the on-time completion of reviews and deliverables, such as the cover letter
- Reviews the packet to verify all information requested is included and that it is well-organized (see next section for organization tips)
- Mails, faxes, or submits the packet as indicated by the review entity

The importance of this role cannot be emphasized enough. Effective project management is critical to meeting the turnaround requirement specified in the ADR. Check with the review entity, but most require you to send the records within 45 days.

If you do not submit the packet within that time frame, you will receive an automatic denial. Additionally, the more quickly you submit the documentation for review, the quicker you will receive a response and payment during pre-payment reviews. If favorable, you'll know that you can keep that payment, Baker says.

## Create tools to ensure you have all the information required for an ADR

Enlist the help of the MDS coordinator or other members of the IDT to create a few tools that will facilitate the collection and review of documentation that must be submitted in the ADR, suggests Underwood.

Consider creating:

- Medical record outline that describes where critical information is in the medical record.
- Checklist of documentation that each member of the IDT should either review or ensure is in the file

With a solid ADR process in place, you know the right people are involved in contributing to the materials in the submission packet. However, if your packet is confusing or difficult for the auditor to read, you may hurt your chances of a favorable outcome.

### Submit a well-organized packet

ADR submission packets should be well-organized so that the reviewer can open it up and find the key records that support the claim with ease.

Baker recommends that SNFs organize the documentation behind a cover letter in the following order:

- Physician oversight documentation, including SNF certification/recertification, progress reports, signed/dated orders. Additionally, the cover letter should highlight the physician's support of all active conditions reported in Section I of the MDS because patient conditions are the primary driver for reimbursement under PDPM.
- MDS assessment(s), followed by other critical records that are clearly identified such as care plans, nursing notes and assessments, medication and treatment records, diagnostic testing, etc.
- Therapy documentation, including evaluation, progress reports, discharge summary, daily treatment notes, and service log matrix
- Other patient-specific information pertinent to the review such as hospital records including proof of surgical procedure(s), and other conditions potentially captured in the look-back period.

"We find that organizing the letter by bullet points and noting specific documentation found in the record to support the HIPPS code is best," Baker says.

Also ensure that the documentation is legible. This means any handwriting (if present) can be read, and that all photocopies are clear and facing in the same direction.

When you send the packet, maintain a copy for your records and keep email and fax confirmations that you sent it.

Once you submit your packet, it may feel like your job is done. However, it's a good idea to investigate what may have triggered the ADR. If there is a systemic issue, involve the appropriate individuals to address it so that you do not receive additional ADRs, an outright denial or targeted review later down the road, Underwood says. ■

## Use accounts receivable reports to uncover system and process issues that may lead to inaccurate claims

The phrase, "Cash is king" rings true for providers. Without positive margins and healthy cash flow, your ability to operate and provide excellent care to patients suffers. That's why many billers monitor the accounts receivable report (A/R) with an eye toward optimizing cash flow.

In these first few months of the Patient-Driven Payment Model (PDPM), billers need to be extra vigilant when reviewing the A/R report. The new payment model required massive changes to billing software programs as well as internal processes for completing the MDS. As providers navigate these changes, they face an increased risk for submitting inaccurate claims, says **Olga Gross-Balzano, CPA, NHA, PMP,** a manager with BerryDunn.

The A/R report is an excellent tool for identifying systems or process issues that prevent billers from submitting clean claims, says Gross-Balzano.

Variances or large balances on the A/R report can be warning signs that there is:

- An error in how your billing software calculates charges, payments, billed days, or submits the bill
- A breakdown in internal communications or processes

"If a biller sees a discrepancy on the A/R report, they must investigate it and find out whether it was an isolated incident or a much larger issue that may have a significant impact on cash flow," says Gross-Balzano.

Recognizing and resolving red flags on the A/R report is essential to financial success in the new payment environment says **Stefanie Corbett, DHA,** post-acute regulatory specialist for HCPro, Inc.

"With the implementation of PDPM, some facilities may project and book greater revenue, making it even more important to have effective A/R processes in place to quickly identify and resolve discrepancies that may impact cash flow," says Corbett.

Providers will surely be happy to see bigger margins, but it also means that they have more financial risk to manage.

Resolving these errors protects your cash flow in the short and long term. On a daily basis, you know that your cash-flow projections are accurate, which supports the SNF's operations. In the long-term, correct claims reduce the risk for reviews and audits.

Investigating what causes red flags on the A/R report can be daunting, but Gross-Balzano and Corbett reveal a few common culprits that providers should check as soon as they notice errors.

## Validate system set up

Providers did a lot of work to prepare for PDPM, but billers and finance staff need to review the A/R report each month after posting to ensure there are no quality issues.

If you see large variances or balances, confirm the following is correctly set up in your billing software:

**Medicare pricers.** Review the A/R report and dig into why there are discrepancies between what you bill and what Medicare paid. Differences in reimbursement monies may be a sign that the system is not calculating charges or expected payments accurately.

This can either be an error in the software, but before reaching out to vendors, it's a good idea to confirm that you have the correct pricers and rates loaded into your system.

"I've seen many providers who have put the component base rates in the wrong order," says Gross-Balzano.

Medicare will process the claim with the correct pricers, and providers with misordered pricers will see a discrepancy in balances.

Billers should work with finance and IT teams to ensure the appropriate team loaded rates correctly.

If you confirm that you have the correct pricing rates in the system, reach out to your software vendor to further investigate and remedy the issue.

**Number of billed days is accurate.** Large variances on the A/R report may indicate an error in either how the system calculated or billed the number of co-pay days.

If you see balances more than $200-$250, check the number of days were both accurately counted and pulled onto the claim correctly, Gross-Balzano says.

Calculating the number of days covered by Medicare Part A is often straightforward, but billers should take extra care if a patient is subject to the Interrupted Stay Policy (ISP).

"The ISP is new with PDPM, and there is some confusion among providers with how to calculate and bill those days," says Gross-Balzano.

To ensure that days subject to the ISP are calculated and billed correctly Gross-Balzano suggests that billers:

- Understand how the ISP works and impacts a Medicare Part A-covered patient's benefit days. The ISP combines multiple SNF stays into a single stay in cases where the patient's discharge and readmission occurs within the three-day interruption window, according to CMS. The three-day interruption window starts with the calendar day of discharge and includes the two immediately following calendar days, ending at midnight.
- Ensure that whomever is responsible for updating the daily census understands the ins and outs of the ISP rules and knows how to apply those rules.
- Work with software vendors to understand how the software calculates days covered by the ISP. Some systems exclude the days depending on the census code entered (i.e, leave of absence, discharge and readmission, and bed hold), and others require you to manually calculate and enter the days.

If you confirm that the billing software accurately counted the number of covered days, but there is still an issue, check to see whether the system billed the days correctly.

### Questions Comments & Ideas

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– Tami Swartz, Content Manager

For example, if a patient is admitted on September 30, Gross-Balzano has seen some systems erroneously count that as an unbilled day on the October claims.

**Reduce overpayments.** If your A/R aging report shows overpayments from Medicare, it could again be an issue with rate set up, miscalculated co-pay days, or incorrectly billed days.

Work with finance to resolve any systems issues causing overpayments because you will have to report those to CMS on the quarterly Medicare Credit Balance Report Form CMS-838.

"Any credit balances over $25 must be included on the report. CMS requires providers to list each claim, the amount of overpayment, and an explanation of why that money has to be paid back," Gross-Balzano says, adding that the next report is due in January. (Note: CMS instructions advise to "Submit a completed CMS-838 to your financial intermediary within 30 days after the close of each calendar quarter).



A pattern of overpayments may trigger a review or audit, so it's critical that billers flag and investigate the cause for overpayments that appear during their monthly review of the aging A/R reports.

Even if the credit balances on your A/R report do not exceed $25, billers still try to determine the cause of the issue to ensure it will not result in a larger compliance is-sue, Gross-Balzano says.

## Update value-based purchasing adjustment files

Smaller balances or overpayments on the A/R report may also be a sign that you do not have the most up-to-date value-based purchasing adjustment loaded into your billing software.

In August 2019, CMS reported that they found an error in the calculation of the value-based purchasing adjustments and issued new files.

"Many providers have not loaded the most recent files from the Certification and Survey Provider Enhanced Reporting (CASPER) system. If you have the old files, the reimbursement on the claim may not be correct," Gross-Balzano says.

This is only the second fiscal year that CMS will issue value-based purchasing incentives. After CMS applies the market basket and QRP adjustments, it processes the value-based purchasing adjustment, says Corbett.

"MDSCs may access their facility's quarterly confidential feedback reports in the QIES and CASPER systems to determine their value-based purchasing adjustments," Corbett says.

CMS will update the adjustments annually. SNFs should have a process in place that alerts billers that the new re-ports are loaded in the system. This way, billers can en-sure that the billing software processes the adjustments correctly.

## Open the lines of communication

Changes to the MDS post-claims submission may also cause the A/R report to show substantial balances, variances in payments, and over payments.

If the MDS coordinator updates the MDS after the biller issues the claim, the A/R report will usually show a variance if the case-mix category for that patient changes and no longer matches what is on the claim, Gross-Balzano says.

Before PDPM implementation, it was probably safe to assume you could process the bill if the MDS coordinator submitted the MDS, and the system confirmed receipt and generated a Health Insurance Prospective Payment System (HIPPS) code. In these early days of PDPM, that may not be the case.

Billers should anticipate that MDS coordinators may make more changes to the MDS as they adjust to new PDPM requirements, Gross-Balzano says.

Proactively check in with MDS coordinators about the status of the MDSs. Before filing the claims and confirm that they do not plan to go back and revise them.

The triple check process provides a great way for billers to get a final confirmation from the MDS coordinator and other IDT members that all of the information on the claim is final and accurate, Corbett says.

However, many facilities either do not utilize the triple check as a best practice, but it is the best way for SNFs to prevent claims errors and mitigate financial risk.

The triple check is especially critical for SNFs that have remote or centralized billing offices where the billers may not have regular contact with MDS coordinators and other IDT members, Gross-Balzano says.

In such set-ups, the triple check may really be the only time that the biller can validate the information on the claim with all stakeholders.

Although billers should look out for these warning signs as the industry transitions into PDPM, they should always dig deeper into line items on the A/R report that do not look or feel quite right.

CMS updates the Medicare rates and pricers and value-based purchasing adjustment files on a regular schedule, which may cause these same issues and put your cash flow at risk. ■

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– Tami Swartz, Content Manager

## Best practices for ongoing consolidated billing compliance: Invoices

Although the skilled nursing facility (SNF) prospective payment system (PPS) was implemented to remedy widespread billing problems in the sector, the reimbursement methodology—and its consolidated billing (CB) requirements for facilities and their business partners—has come with its own host of challenges.

Since the inception of PPS, the Centers for Medicare & Medicaid Services (CMS) has identified several major problematic SNF practices related to consolidated billing.

Figure 11.1 summarizes some of the top CB problem areas CMS has pegged, as well as the potnetial solutaitons that can be explored.

Because of the numerous and diverse factors that dictate each resident's specific course of care and the overwhelming variety of potential billing and payment expectations that SNFs are often left to parse for relevance on a case-by-case basis, facilities should develop a thorough process for validating invoices from outside service partners—a move that can complement the selection of appropriate payment arrangement documentation, reveal the stability of inter-setting partnerships, and fuel overall billing success.

Due to the complexities of consolidated billing, knowledge gaps on its finer points and a lack of general best practices can often permeate settings across the entire care continuum. Therefore, SNFs shouldn't blindly accept the accuracy of invoices from outside entities seeking reimbursement for services they rendered to a beneficiary during a Part A SNF stay.

For these reasons, a SNF should not pay any invoices until they have been carefully reviewed and validated by trained staff members.

Important Note:

A valid invoice should include the following:

- Invoice number
- Beneficiary name as it appears on the Medicare insurance card
- Dates of service with corresponding HCPCS codes
- Description of services

- Charges for each HCPCS code

Reminder:

If a provider (e.g., a physician office) has delivered a service that has both a technical and professional component, and this entity directly rendered both aspects, it should still bill the SNF only for the technical component. Thus, this should be the only portion of the service charged on the invoice. The outside renderer is responsible for seeking reimbursement for the professional component from Part B directly.

## Verifying invoices

A simple but robust invoice verification process can promote regulatory compliance and successful receipt of earned revenue. Failure to implement such a process may result in the submission of inaccurate claims. Thus, consistent invoice validation is central to complying with Medicare billing rules, minimizing denials, and preventing overpayments.

To avoid paying for services beyond their scope of responsibility and/or the agreed-upon pay rate, SNFs are encouraged to implement the following five-step process for verifying invoices from outside service partners:

1. Review the invoice as soon as it arrives to ensure that it pertains to a beneficiary who resides in the facility. If it doesn't, notify the vendor immediately so that it may instead bill the appropriate entity and prevent a delay in payment for another provider.
2. Determine whether the beneficiary was in the midst of a Part A stay at the time that the service was provided.
3. Determine whether each item on the invoice is included in or excluded from consolidated billing by comparing the list of corresponding HCPCS codes to the current MAC Update files for both Part A and Part B plans.
4. Determine the Physician Fee Schedule amount (using either CMS' search tool or the rates listed on the website of your facility's designated MAC), paying special attention to the professional and technical components of a given service whenever applicable. As a reminder, SNFs are responsible only for billing Medicare (through the consolidated bill) and paying a physician or other rendering entity for the technical component of a service.
5. Review the specific payment terms in the arrangement your facility has created with the service renderer, and pay the invoice accordingly.

Let's put these steps into action using Table 11.1, an excerpt from a hypothetical invoice sent by an oncology office that's under contract with the receiving SNF. This contract specifies that the SNF will pay the outside provider at the Medicare allowable amount for services it renders to the facility's residents during Part A stays.

Based on the process just described for verifying invoices, the SNF would assess the accuracy of the oncology invoice as follows:

**Steps 1 and 2:** Verify that the beneficiary was in the midst of a Part A stay at the SNF on 9/10/19, the date on which the services in question were provided.

**Step 3:** Determine whether each individual service listed on the invoice is included in or excluded from consolidated billing:

**Item 1.** *70450 (CPT Code) CT Scan, Head / Brain; w/o contrast material—Although this service is generally a category I.A. exclusion, it is considered an inclusion in this case because it was performed at the physician's office rather than in the outpatient department of a hospital. This charge now becomes the responsibility of the SNF, which must pay the office for the service from the regular PPS rate.*

**Item 2.** *J9265 (HCPCS II Code) Injection, Paclitaxel, 30 Mg—In the specified dosage, paclitaxel is excluded from consolidated billing and should be billed by the physician directly to Medicare.*

**Item 3.** *73560 (CPT Code) X-ray exam of knee, 1 or 2—Although the technical component of this X-ray is included in SNF consolidated billing, the professional component is not. Thus, the SNF is responsible for reimbursing the physician for the first component from its PPS rate, and the physician must bill Part B directly for the latter.*

**Item 4.** *73070 (CPT Code) X-ray exam of elbow—Again, the technical component of this X-ray is included in consolidated billing, but not the professional component. Although the SNF is responsible for reimbursing the physician for the first component from its PPS rate, the physician must bill Part B directly for the latter.*

**Table 11.1 Excerpt From Sample Invoice**

| MMDDYY | Place of Service | CPT/HCPCS | Charges | Units |
|---|---|---|---|---|
| 091019 | 11 | 70450 | 425.00 | 1 |
| 091019 | 11 | J9265 | 600.00 | 2 |
| 091019 | 11 | 73560 | 45.00 | 1 |
| 091019 | 11 | 73070 | 45.00 | 1 |
| 091019 | 11 | 72170 | 45.00 | 1 |

**Table 11.2 Key Information Retrieved Through the Sample Invoice Verification Process**

| HCPCS Code | Charge Billed to Facility | Medicare Allowable Amount SNF Will Pay to Oncology Office |
|---|---|---|
| 70450 | $425.00 | $87.16 |
| 73560 | $45.00 | $23.12 |
| 73070 | $45.00 | $21.98 |
| 72170 | $45.00 | $21.22 |
| J9265 | $600.00 | N/A—Excluded from CB |
| Total Owed by SNF | | $153.48 |

**Item 5.** *72170 (CPT Code) X-ray exam of pelvis—As for the previous two services, the technical component of this X-ray is included in CB, but not the professional component. Although the SNF is responsible for reimbursing the physician for the first component from its PPS rate, the physician must bill Part B directly for the latter.*

**Step 4:** Identify the Medicare allowable amounts for the applicable parts of the four HCPCS codes that were determined in the previous step to shoulder the SNF with at least partial reimbursement responsible using the Physician Fee Schedule Look-Up Tool on the CMS website. Click "Start Search." Once you've reached the Search Criteria page, enter the correct year, then select "Pricing Information" and "List of HCPCS codes" under the next two prompts.

After choosing "Specific Locality" under the third prompt, enter your four HCPCS codes of interest. Select "All Modifiers" and the appropriate locality. Verify this search criteria for accuracy. Click "Submit."

From the list of charges that appears, identify the values the SNF is responsible for paying. These should be located in the "NON-FACILITY PRICE" column.

For the three codes with multiple components, the SNF should only reimburse the oncology office the amount listed in the corresponding TC row, as this constitutes the pay rate for the technical component of the given service.

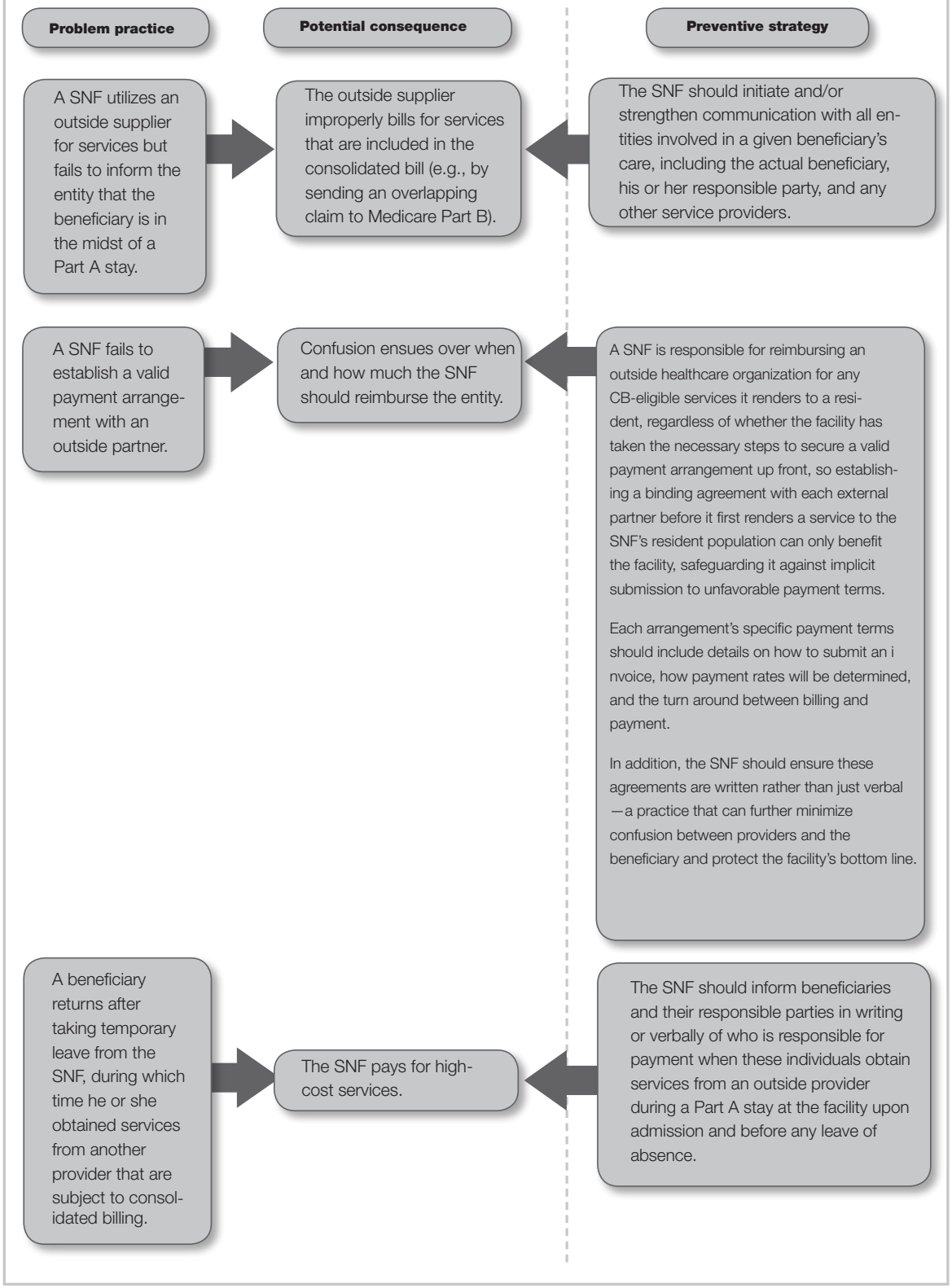
Key information culled from this process is summarized in Table 11.2. Note that the Medicare allowable amount for a given services differs according to the paying provider's geographic region. Consequently, the amounts listed in the table below are for the purposes of this example only. SNFs should verify that they are consulting the rates set by their designated MAC to avoid errors related to invoice verification and payment.

**Step 5:** Based on the findings of this verification process, the SNF is only responsible for paying $153.48 of the $1,160.00 that was originally invoiced.

The gulf that can exist between invoiced and due reimbursement underscores the importance of performing a thorough invoice verification process before rendering payment to an outside provider, which may not be well-versed in the rules of SNF consolidated billing.

Form 11.1 can help SNFs identify and fulfill all applicable steps of this process and track invoice-related correspondences with outside service partners on an episode-by-episode basis.

## Figure 11.1 Strategies for Avoiding Top CB Problem Practices



## Implementing a triple-check process for invoice reviews

Nothing can take the place of effective invoice validation, a process that often requires input from a broad range of facility staff members. To foster group discussion and collaboration—practices that are essential to ensuring claim accuracy—invoice reviews should occur during major staff meetings (e.g., the facility utilization meeting) using any reputable process and format that suits the SNF's specific needs.

One such invoice review process is the triple-check, a time-tested internal auditing strategy used by proactive long-term care providers to facilitate billing accuracy and compliance the first time a UB-04 claim form is submitted. As its name suggests, triple-check is a layered verification process that involves staff members from billing, nursing, and therapy departments, the three core disciplines required to submit a clean claim.

A solid triple-check system is designed to internally audit claims prior to submission and can decrease a facility's chances of being audited by a Medicare contractor. The process can also eliminate the typical culprits behind faulty claims, which include:

- Technical errors (e.g., inaccurate modifiers or an incorrect assessment reference date)
- Process errors (e.g., those related to data entry)
- Documentation errors (e.g., inconsistencies between documentation and MDS or improper sequencing of diagnosis codes)

A group meeting is usually the most successful and efficient platform for discussing the roles that various departments and individual staff members will play in the triple-check process and for cross-checking tasks related to these designated duties before submitting claims each billing cycle.

In addition, developing an in-house checklist tool that specifies each individual's responsibilities can aid the team in performing more efficiently and ensure that team members cover all tasks necessary to submit clean, accurate, and timely claims on a regular basis. ■

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## Form 11.1 Consolidated Billing Form

**Consolidated Billing Tracking Form**

Vendor Name _____

Resident Name _____

Date(s) of Service _____

Completed By _____

1. Resident was on Medicare? ☐ Yes ☐ No
   If No, return invoice to vendor indicating resident was not on Medicare Part A at the time of service.
   If Yes, continue to question 2.

2. Per SNF CB Annual Update File, the service is to be included in SNF Part A Consolidated Billing (CB)?
   ☐ Yes ☐ No
   If No, return invoice to vendor indicating that the service is not part of SNF CB.
   If Yes, continue to question 3.

3. Medicare Fee Schedule amounts:

| | | Charge | Fee Sched. | Approved | Date | GL Code |
|---|---|---|---|---|---|---|
| HCPCS 1 | | | | | | |
| HCPCS 2 | | | | | | |
| HCPCS 3 | | | | | | |
| HCPCS 4 | | | | | | |
| HCPCS 5 | | | | | | |
| HCPCS 6 | | | | | | |
| HCPCS 7 | | | | | | |
| HCPCS 8 | | | | | | |
| HCPCS 9 | | | | | | |
| HCPCS 10 | | | | | | |
| Total Billed | | - | | | | |
| Total Payment | | | - | **AP-Please pay only this amount.** | | |

4. Submitted for approval to _____ Date _____
   *Once approval has been issued, and GL codes are indicated, please return to the individual listed above.*

5. Submitted to Accounts Payable for remittance on _____ _____(initials)

**Accounts Payable Information**

Amount Paid _____ Check # _____ Comments _____

Date Paid _____

*Once payment has been issued, please complete this section and return to the person listed above*

Prepared by FR&R Healthcare Consulting, Inc. 2014