AMBR JOURNAL

OCTOBER 2019 | Vol. 1 No. 3

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PDPM shakes our world

Association for Medicare Billing and Reimbursement for Long-Term Care

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DEPARTMENTS

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AMBR Journal (ISSN 2641-9319) is published quarterly by HCPro, 35 Village Road, Suite 200, Middleton, MA 01949. Subscription rate: $155/year for membership to the Association for Medicare Billing and Reimbursement for Long-Term Care.

DIRECTOR'S NOTE

Never fear, AMBR is here!

We have reached the time of change and challenge in the long-term care (LTC) reimbursement world: CMS' Patient-Driven Payment Model (PDPM) is upon us. I have no doubt that many of you are worried about how your facility will fare and how this change will affect business as usual. In times of change and challenge, a support network is critical. I'd like to think **AMBR** can be that network for you.

We have covered PDPM extensively. AMBR is home to a wealth of resources on this topic, including (but certainly not limited to) advice and analysis on:

- Enhancing your pre-admission process
- THe billing process
- Strategies for anticipating changes to your therapy contracts
- Guidance on ICD-10 coding under PDPM
- Information on consolidated billing requirements under the new model
- Tips for calculating your reimbursement
- Best practices for understanding the midnight transition to PDPM

And don't expect our coverage to stop just because implementation is upon us. We want to hear from you on how the transition is going. We will be asking for your feedback so we can tailor your AMBR membership to include resources and analysis that offer the answers and advice you need.

When you have such an important challenge ahead of you, collaboration is a must. Please feel free to reach out to your peers via our *new online forum* or *reach out to me* if you need a topic covered. **AMBR is here for you.**

A networking first: Meet your peers face-to-face

This year marks many firsts for AMBR: A flashy journal, a new name and look, added resources and committees, and this month, we'll sponsor our first in-person event with a special track for LTC

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billing and reimbursement professionals, including the C-suite, revenue cycle, business office, administrators, and MDS coordinators.

The *Revenue Integrity Symposium* (RIS) will be held October 15–16, 2019, at the Renaissance Orlando at SeaWorld in Orlando, Florida. Good timing, right?

Patient-Driven Payment Model (PDPM) is upon us, and we are less than one month away from phase 3 requirements (if they go into effect, stay tuned!). CMS has just updated the RAI Manual, and now is the perfect time to extend your warm weather just a bit with a trip to sunny Orlando!

The full agenda and any other information you might is readily available to you at *hcmarketplace.com/ris2019*. **(Use your AMBR member-exclusive discount code, MEMBERSAVE, when you register to attend.)**

In this issue

First, we have advisory board member and HCPro LTC regulatory specialist **Stefanie Corbett, DHA,** provides a sneak-peak about her upcoming session at RIS. Corbett will be speaking about consolidated billing requirements under PDPM. Having worked with her for years on various books, articles, and webinars, I know that this will be an invaluable session. You might know Corbett from her fantastic boot camps she teaches—they range from *Medicare* to *billing* to *PDPM* and *regulatory updates*.

Our opening story dives into the future of MDS. As we all know, PDPM marks another evolution for MDS and its coordinators. This is a wonderful piece on how roles and goals are changing within SNFs as CMS mandates almost too many changes to keep up with!

It's undisputed that PDPM is a massive shift in the industry, so our next article identifies the little-known risks and opportunities PDPM provides SNFs. Five experts weigh in on the subject to help you navigate the new patient-driven reimbursement climate.

Our next two articles cover what else—billing! Protect your bottom line by forecasting profitability at admission: experts Corbett and AMBR advisory board member **Reta Underwood, RAC-CT, C-NM, QCP,** weigh in on the topic.

And of, course, we have the latest installment of our Consolidated Billing Made Simple series, which discusses how to effectively manage relationships with outside patients and external service providers to avoid costly billing errors.

There is truly a wealth of information and practical guidance packed into this issue's Journal. We hope you learn, enjoy, and benefit. And remember, AMBR is with you as we enter the brave new world of PDPM! AJ

Sincerely,

Tami Swartz
Director of Content, AMBR
tswartz@hcpro.com

NOTE FROM THE SPEAKER

Consolidated billing requirements under PDPM

By Stefanie Corbett, DHA

The ***Revenue Integrity Symposium*** **(RIS)** brings together some of the industry's leading experts to train on the most relevant, hot-button issues in long-term care (LTC). It also helps establish a sense of community between providers, fostering opportunities for networking and relationship-building. This year's symposium will be held October 15–16 in Orlando.

All the session topics look interesting and there are great speakers on the agenda. To me, they are all must-attend sessions! I want to attend as many as possible as I enjoy learning with and from other experts, as well as providers, in the industry.

On day one, I will present the session "PDPM Implications for Senior Management," which will help providers operationalize Patient-Driven Payment Model (PDPM) requirements by evaluating key processes and implementing best practices.

On day two, I present the session "Consolidated Billing: Impacts on Reimbursement Under PDPM." With so much focus on the new payment model and discussions about key revenue-drivers, providers must also be aware that high costs of care are often associated with clinically complex residents. I will discuss ways to implement strategies to effectively project expenses during the preadmissions process.

When I am not learning and networking at RIS, I am looking forward to enjoying the Florida sun. I hope to carve out time to enjoy Universal Studios while in Orlando.

I hope you'll join me at RIS. **AJ**

Editor's Note:

Corbett is HCPro's post-acute regulatory specialist, as well as a health policy educator, consultant, researcher, and author. She is also an AMBR Advisory Board member.

AMBR members get an additional $100 discount. Professionals wishing to earn support from program administrators to attend the 2019 Revenue Integrity Symposium may adapt our justification letter proposal.

Renaissance Sea World, Orlando, Florida

MDS poised to take on quality in PDPM

The onset of the Patient-Driven Payment Model (PDPM) marks another evolution for the MDS and MDS coordinators. In this new iteration, CMS brings back the original intent of the MDS as a tool for care planning while also continuing its use to capture clinical information that drives reimbursement and quality measures.

PDPM represents a paradigm shift for Medicare Part A reimbursement whereby the patient's clinical conditions and care needs determine reimbursement, not the number of therapy minutes provided. MDS coordinators must now focus on the unique clinical characteristics and collaborate with the interdisciplinary team to develop a customized care plan for each patient.

The emphasis on patient-driven care may represent a welcomed change for many MDS coordinators, says **Jennifer Gross, BSN, RN-BC, RAC-CT, CPHIMS**, senior healthcare specialist with PointRight, Inc.

"PDPM will draw the role of the MDS coordinator back towards a clinical coordinator. Recently, our role has been whittled down to just getting the MDS submitted so that the facility can bill. PDPM offers the opportunity to leverage the MDS coordinators' nursing skills and clinical capabilities to develop an appropriate plan of care for each resident," says Gross.

This creates opportunities for savvy MDS coordinators to enhance the SNF's quality ratings by modifying individualized care plans and identifying and correcting facility-wide issues and risk areas. Preventing adverse patient outcomes will improve your scores for the quality reporting program (QRP), traditional quality measures (QM), and in the future, Five-Star Ratings, says **Maureen McCarthy, RN, BS RAC-MT, QCP-MT, DNS-MT, RAC-MTA**, president and CEO of Celtic Consulting.

This evolution of the MDS coordinator's role will be a win-win for facilities, who should also see a boost to their bottom lines. Ultimately, higher quality scores will result in higher

PDPM payments and revenue opportunities through other CMS initiatives, such as value-based purchasing.

What goes around comes around: The link between PDPM reimbursement and quality

With the recent implementation of the PDPM, SNFs are focused on the immediate implications of the new payment model. To guarantee financial success, SNF providers must broaden their perspective to understand and support how quality measures and outcomes will impact reimbursement.

"One of the things we've heard over and over from CMS is that outcomes are going to protect everybody. If you have a shorter length of stay, if you have less therapy than before PDPM, as long as your outcomes are still as good as they used to be and they're as good or better than your peers, you'll be okay. Reimbursement and quality measures really overlap in PDPM," says **Melissa Sabo, OTR/L, CSRS,** COO of Gravity Healthcare Consulting.

CMS is very clear that payment and quality are now intertwined. In fact, in the *Fiscal Year 2020 Payment and Policy changes for Medicare SNF* (CMS-1718-F) final rule fact sheet, CMS says: "This final rule is part of our continuing efforts to strengthen the Medicare program by better aligning payment rates for these facilities with the costs of providing care and increasing transparency so that patients are able to make informed choices."

According to CMS, the final rule reflects changes to the following programs in order to shift Medicare payments from volume to value:

- SNF payment policy under the SNF Prospective Payment System (PPS). SNFs are now rewarded for providing individualized care as opposed to therapy minutes. "In RUG-IV, 90% of the time, rehabilitation was driving the reimbursement train. Now, in PDPM, we have to look at the diagnosis and conditions. And it's not just about capturing them for reimbursement. You have to follow up on those issues," McCarthy says.
- SNF Value-Based Purchasing Program (VBP). In 2018, the VBP Program began awarding SNFs with incentive payments based on their quality measure performance for all-cause hospital readmissions. "We have an opportunity to gain up to 2% on our Medicare reimbursement and the possibility of being fined up to 2% on our Medicare reimbursement based off of our hospital readmission rates from the previous year," says **Rosana Benbow, RN, CCM, CIC, DNS-CT, RAC-CT**, consultant with Leading Transitions Post-Acute Care and Staffing, LLC.
- SNF Quality Reporting Program (QRP). Currently, QRP only impacts reimbursement if SNFs do not transmit the data. CMS levies a 2% penalty to the SNF's fiscal year's annual market basket percentage update.
  However, CMS will further tie reimbursement to quality measures in FY2020 with the adoption of two new quality measures in an effort to improve the interoperability of health information to improve quality and safety. The new measures are: Transfer of Health Information to the Provider-Post-Acute Care and Transfer of Health Information to the Patient-Post-Acute Care.
  SNF providers should also be aware of further QRP/reimbursement CMS plans for the next two-to four years. "Starting last year, CMS began collecting data from Section GG. They will continue to do so

through 2020 or 2021, and then they will aggregate the data across providers and tier us based on our outcomes on Section GG. Whoever has the best outcomes is going to get a bonus and whoever has the worst outcomes, is going to take a penalty starting in 2021 or 2022 they haven't decided when yet," says Sabo.

In addition to these quality-related programs, PDPM is an outgrowth of several other larger government and CMS initiatives that put quality at the center of patient care, such as the IMPACT Act and the Affordable Care Act, says Benbow.

The MDS coordinator's position within the facility and unique knowledge and skills will be the key to maximizing the connections between quality and care planning, MDS accuracy, and reimbursement. With these four elements functioning optimally in PDPM, SNFs will come out ahead in the new payment model.

How PDPM sets MDS coordinators up to make a difference on quality

In PDPM, MDS coordinators can significantly influence quality because they will be more aware of their patients' conditions and needs. The MDS coordinator must capture the patient's primary diagnoses, comorbidities, and functional status completely on the MDS to optimize their PDPM payments for that patient.

To obtain this information, MDS coordinators must constantly monitor the documentation provided by physicians, therapists, nurses, and other members of the clinical team.

Unfortunately, in most SNFs, the clinical documentation does not provide the level of specificity that will drive PDPM reimbursement.

In the July issue of the *AMBR Journal,* the article, "The evolving role of the MDS coordinator: Clinical documentation improvement set to become a main focus in PDPM" discussed the need for MDS coordinators to engage in clinical documentation improvement (CDI) activities to ensure they have the documentation required to complete the MDS. It will be up to the MDS coordinator to query providers for additional clinical information, McCarthy says.

They must also frequently review documentation to determine whether the patient experienced any changes in condition that would trigger an interim payment assessment (IPA).

Because they will be in and out of the records so frequently, MDS coordinators will become aware of potential issues that may affect QRP and QM measures, says Benbow.

PDPM affords MDS coordinators the time to address the quality issues they identify. PDPM requires SNFs to perform an initial Medicare assessment and a discharge assessment. With fewer assessments to complete, MDS coordinators can dedicate that time CDI activities and improving quality measures.

"Although CMS says they're reducing the burden by decreasing the frequency of the assessments, I think they're really shifting the burden. Instead of scheduling and submitting so many assessments, MDS coordinators will spend more time improving documentation, coordinating care across the disciplines, and improving quality measures," says Benbow.

The bottom line is that PDPM will require MDS coordinators to be in the patient's records so much more, which will facilitate better care planning, MDS accuracy, reimbursement, which ultimately will result in higher QRP and QM scores.

Quality starts with well-coordinated care

In PDPM, the value of the care provided matters more than the volume of services provided. As such, MDS coordinators must focus on the

unique conditions and resulting care needs of each patient.

"The original I think the real strength of PDPM is that you can no longer say, 'We're caring for Mrs. Smith very well because we're giving her 720 therapy minutes a week. The real key to providing good care is to look at each patient individually, not just their therapy needs. And that goes back to the original primary role of the MDS coordinator—to drive the care plan and facilitate interdisciplinary communication to achieve care goals and outcomes," Gross says.

As MDS coordinators review medical record documentation, they can recognize patients with certain signs and symptoms or changes in condition and coordinate the appropriate intervention (e.g., nursing, therapy, dieticians). Having the correct care will enhance outcomes and enhance discharge outcomes scores, McCarthy says.

Flagging residents in need of care interventions keeps them in the SNF rather than discharging them only to have them re-hospitalized, which is a quality measure that impacts value-based purchasing.

"You have to find the sweet spot where you're giving them enough care and services that they have great outcomes and they stay out in the community for 30 days after you discharge them," McCarthy says.

Additionally, MDS coordinators will be able to identify patients with conditions or issues that may trigger quality measures earlier in their stays. The initial Medicare assessment sets the base per diem rate for the patient's entire Part-A covered stay. To get accurate reimbursement, it is critical that SNFs have all the clinical information about the patient by Day 8 of their stay. They can no longer wait until day 10 or 14 to discover a condition; otherwise, they risk losing reimbursement dollars.

More complete clinical information will allow MDS coordinators to be more proactive in coordinating the appropriate care for patients.

"It's the easiest time to be proactive as we're assessing a patient to identify that we have an issue with the quality measure and then put some corrective actions in place," says Benbow.

MDS coordinators will also be able to impact facility-level changes in the post-PDPM environment. As MDS coordinators review medical records, they will likely notice clinical trends that impact outcomes and quality measures overtime.

> **"Although CMS says they're reducing the burden by decreasing the frequency of the assessments, I think they're really shifting the burden."**
>
> *—Rosana Benbow, RN, CCM, CIC, DNS-CT, RAC-CT, consultant with Leading Transitions Post-Acute Care and Staffing, LLC*

"If I find that I have a creep up of my Medicare patients with pressure ulcers, I probably have the same creep up in my other payer sources as well," says McCarthy.

MDS coordinators should work with directors of nursing, quality staff, and other appropriate parties to confirm whether there's an issue across the facility and put appropriate corrective actions into place. Once clinical practices are strengthened and the quality issue is resolved, QRP and Five-Star ratings in those areas should improve.

Additionally, screening for gaps in clinical skills that impact quality ratings will take on increasing importance as SNFs

capitalize on the higher PDPM payment rates associated with providing more complex services for high-acuity patients, says Sabo.

For example, many SNFs to not offer IV services, but doing so is a revenue opportunity in PDPM. Although there will be an increase in costs for equipment and medications, there will be a substantial return on investment because IV treatments increase the nursing and non-therapy ancillary case-mix components, Sabo says.

"The MDS coordinator, director of nursing, and administrators need to ensure there is appropriate training before offering IVs, and then they need to follow up after training to ensure that they're being performed and documented appropriately. It shouldn't have an impact on your quality measures if everything is done correctly," Sabo says.

If MDS coordinators notice documentation describing complications or negative outcomes due to the IV, they can address it before it impacts quality measures.

In addition to systemic issues, MDS coordinators may pick up on smaller-scale items that can be addressed with training. Once per week or per month, provide training to the interdisciplinary team on those topics, Benbow suggests.

MDS accuracy is critical to PDPM and quality success

The importance of MDS accuracy for both PDPM and quality reporting cannot be emphasized enough. The SNFs success largely relies on the MDS coordinator's ability to accurately translate the information from the patient's charts onto the MDS, Gross says.

Understanding the drivers and data sources for QRP and QM reporting is no easy feat. There are more than 30 MDS measures that inform QM and more than 20 MDS measures reported on Nursing Home Compare alone.

MDS coordinators are well-positioned to impact QRP and QM scores because it leverages their knowledge of the MDS.

"As the MDS experts, the MDS coordinators know better than anyone else in the SNF which MDS items will trigger quality measures," says Benbow.

Consider section G of the MDS. MDS coordinators will want to verify that CNAs are assessing patients properly during the initial assessment and capturing the activities of daily living correctly in their documentation. Having a complete and accurate section G is critical to quality measures because it establishes the patient's baseline level of function from which any improvement in outcomes will be determined. This impacts discharge scores and short-term stay QMs, Gross explains.

Additionally, strong MDS knowledge will help avoid coding mistakes that can negatively impact quality ratings.

"For instance, if a patient has a fall, a skilled MDS coordinator knows that a major injury as a result of a fall is a fracture, dislocation, or a head injury with altered consciousness or subdural bleed. If the patient has other injuries, like stitches, that's not considered a major injury by the MDS definition. If you do not understand the coding, and you miscode the major injury, you're going to take a hit on your quality when you didn't need to," McCarthy explains.

MDS coordinators are already tuned into to quality measures because in many facilities, they already oversee the QRP program. Depending on the facility, they may also be the only ones who know how to read the quarterly review and correct reports, understand the reporting periods, and understand the drivers for each metric, McCarthy says.

They also know the data they're reporting in the MDS that impact QRP. For example, as of last year, the QRP

requires MDS coordinators to report on the MDS whether the clinical team performs drug regiment reviews and alerts the physicians to any potential drug interactions.

"Any MDS nurse knows how they're answering that question on a regular basis. If they haven't had time before to dig into how their answers translates into the QRP, they will have time now," Benbow says.

Tying reimbursement and quality

Most MDS coordinators already approach their job with a resident-first attitude. Ensuring high-quality care is the primary goal, but optimizing revenue is a close second.

As MDS coordinators evaluate the care needs for patients, they want to identify high-earning residents and ensure the documentation to support their conditions is in place.

For example, many MDS coordinators will likely pay more attention to signs and symptoms of swallowing disorders because it's a reimbursement opportunity in PDPM. The SNF will receive the most accurate payment by having the condition documented in the record, but the MDS coordinator will have to follow up with speech therapy and a physician for further evaluation and treatment. This will benefit the patient and ultimately result in better outcomes and quality measures, McCarthy says.

Additionally, MDS coordinators will face situations where the best actions to enhance quality measures will have a negative impact on reimbursement or vice versa. Navigating these situations requires a MDS coordinator with a solid understanding of how quality and reimbursement overlap with one another, says Sabo.

"Think about wounds. Having more wounds and worse wounds is bad for quality measures, but it is good for PDPM reimbursement. Some may think, 'Well, they're paying me if I have wounds, so they want me to have wounds." Sabo says.

That is how reimbursement worked in the RUG-IV payment model where CMS financially incentivized SNFs to provide therapy. The paradigm is different in PDPM.

"CMS doesn't want you to have wounds, but if you do, they want to appropriately reimburse you for it," Sabo says. "MDS coordinators should still pursue the quality measures because if a wound is able to be resolved, then we should not receive as much reimbursement for it under PDPM. And, that's a good thing because that means we helped the patient."

When looking for reimbursement opportunities, MDS coordinators should focus on care that benefits patients but does not directly impact a QM or QRP measure.

"Things like respiratory treatments seven days a week. That's a great value add for a respiratory patient. They get the services they need and have increased face to face time with the respiratory therapist. That's a win for the patient and at the win for the facility because it will promote reimbursement," Sabo says.

MDS coordinators as ambassadors of quality

As MDS coordinators become comfortable in the PDPM evolution of their roles, they can become ambassadors for quality and the overall RAI process.

"We have the opportunity to incorporate all of those different parts of the RAI process into our daily functions and help the interdisciplinary team understand how the RAI process affects quality, reimbursement, and the plan of care. If everyone understands how all of these functions interact, you will see improvement in each of those areas," Benbow says. **AJ**

Experts uncover little-known risks and opportunities in PDPM

After much anticipation and preparation, the Patient Driven Payment Model (PDPM) is officially here. Over the next few months, SNF providers will realize the outcomes of their planning and operational changes and gauge their success. As thorough as your readiness plans have been, PDPM reimbursement is extremely complex because there are so many payment drivers. With so many intricacies, it's impossible for SNFs to be prepared for every PDPM eventuality.

The Association of Medicare Billing and Reimbursement asked five long-term care experts to share key PDPM opportunities and risks that SNF providers may not have considered leading up to the transition.

From the impact on quality to revenue opportunities during the transition to the importance of standardized processes, our panel of experts provide tips and advice across several PDPM-related topics that will better position your SNF as you experience the first few months of the new payment model.

Meet the experts:

Dan Ciolek, associate vice president, therapy advocacy at the American Health Care Association (DC)

Jayne Warwick, director of market insights, PointClickCare (JW)

Craig Fukushima, MBA, NHA, partner with The Fox Group, LLC (CF)

Kris Mastrangelo, president and CEO of Harmony Healthcare International (HHI) (KM)

Todd Selby, attorney with Hall, Render, Killian, Heath & Lyman, P.C. (TS)

Q | What PDPM compliance or financial challenge are SNFs least prepared for?

DC | PDPM has moved the compliance goal-posts. Under the Resource Utilization Groupings (RUGs) model, most audit and compliance efforts were directed at the documentation supporting therapy minutes and Minimum Data Set (MDS) section G Activities of Daily Living item scores. This was because nearly 93% of resident days were classified in rehab case-mix groups. Under PDPM, each of the five case-mix components (physical and occupational therapy (PT/OT), speech-language pathology, nursing, and non-therapy ancillary services (NTA)) are independently priced. Under this model, there is a substantially potential upside in payments in the nursing and non-therapy ancillary components, and auditors will likely pay much more attention to the documentation supporting these areas than in the past.

Additionally, because many of the MDS items used for PDPM are also used for the Skilled Nursing Facility Quality Reporting Program (SNF QRP), auditors will likely evaluate a provider's quality scores to identify who to target for review. If providers have not done so already, they should

perform a deep self-assessment of the quality of their supporting documentation and quality score trends in these expanded areas of compliance risk. Initiate documentation improvement and care delivery training efforts in the identified weak areas.

JW | During the changeover to PDPM, they really need to pay close attention during the transition. The data collection periods for the PDPM assessments will start before October 1. For PDPM assessments with a reference date of October 1, data collection begins on September 25, so they need to be prepared. This means making sure that they have primary diagnoses correctly linked to a clinical category for payment for every Medicare Part-A covered resident and any chart reviews for non-therapy ancillary evaluation done before then.

They also need to remember that anyone admitted within the PDPM data collection start (between September 25 and 30) will still need that RUG-IV score for the billing period before PDPM begins. Do not end up with default rates if you don't have to.

Homes will need to monitor their use of therapy minutes, their quality measures (QMs) and their overall reimbursement. CMS will target homes with a material drop in therapy utilization, a significant identified trend in QMs or those with a material increase in case-mix index(CMI). SNFs will need to clearly indicate if they made business decisions affecting their case mix that support the changes in order to defend and keep their monies. If you see your QMs changing, make sure there is a respective QAPI program in place to address the problem.

CF | SNFs have had over a year to prepare for the implementation of PDPM, and based on what I've seen, they have been diligent in their efforts to train their staff and implement the systems to handle the change on October 1st of this year. My concern lies with those providers who struggled under the old RUGS-IV system, not just from the clinical perspective but also in the area of billing and documentation. Issues such as proper care planning and case management, good clinical care and positive outcomes, and effective documentation (billing and clinical) do not go away with PDPM and in fact, will be more critical as we implement PDPM.

> **"The biggest opportunity in PDPM is in providing respiratory therapy. SNFs will see a triple benefit: better reimbursement, better care, and better efficiencies."**
>
> *—Kris Mastrangelo, president and CEO of Harmony Healthcare International*

KM | The biggest challenge of PDPM will be coding accurately. PDPM brings a new level of complexity to reimbursement, and accuracy in coding will span many areas.

One example is ICD-10 and diagnosis coding. It is imperative to identify and properly document the ICD-10 codes that best reflect the patient's reason for Skilled Medicare Coverage upon admission to the SNF. When the SNF submits the ICD-10, there are three possible outcomes that providers should be aware of:

- Return to provider (RTP): RTP is not a good situation because the SNF will receive no-payment until more clarification about the selected ICD-10 is submitted to the MAC and an alternative ICD-10 code is selected. There are 23,000 ICD-10 codes that will result in an RTP.
- Resolved in hospital: An ICD-10 code that is not applicable to the SNF stay because

the condition occurred while the patient was hospitalized without further treatment post discharge

- Reason for skilled care: The ICD-10 code that reflects the condition that qualifies the patient for accessing the SNF Medicare Part A Benefit. These skilled services are attributed to a treatment or condition that arose secondary to hospitalization.

TS | I think one of the biggest compliance challenges is for providers who use an outside vendor for therapy. They will need to review their therapy contract because under the current RUG-IV system, therapy almost entirely drives reimbursement. This will not be the case under PDPM because therapy is just one of five case-mix indexed components. In the current RUG-IV system, many, if not most, therapy contracts base payment of therapy provided on a per minute basis. Under PDPM, a minute-based contract puts most of the financial risk on the provider. Because therapy no longer drives reimbursement, providers will need to look at other rate structures, such as a percentage of the therapy rate component or a percentage of the provider's total PDPM payment. These rate structures take into account the fact that therapy reimbursement declines over a patient's stay. Additionally, if the therapy company files the claims for therapy, SNF providers should ensure that they are indemnified in the event that the Medicare Administrative Contractor denies the claim. The SNF should have a means for recouping that money from the therapy vendor.

Another compliance challenge is that CMS has specifically stated they will look at underutilization of therapy because it is no longer the driving force for reimbursement. This makes some sense as providers are still required to provide care to patients who need therapy regardless of how they are paid. My guess is that once PDPM is in place for a year or two, SNFs will see an increase in audits looking at therapy utilization. Because all documentation (e.g., nursing) is more important under PDPM, deficient documentation could pose an audit risk to providers.

Q | What is the biggest reimbursement, compliance, or quality-related opportunity that exists in PDPM that SNF providers may not be aware of?

DC | One of the major reasons CMS used to justify the payment model change is that PDPM is based on resident clinical characteristics rather than primarily on how much therapy a person received. Therefore, the resulting payments will be better aligned to resident needs. In other words, PDPM payments will likely be higher than those in RUG-IV for residents with complex conditions, multiple co-morbidities, and resource-intensive service needs.

Providers already treating these types of residents are likely to see a positive revenue impact under PDPM. Additionally, providers that may have been reluctant to admit residents with more complex needs under RUG-IV may see an opportunity for expanding their case-mix with the more equitable PDPM payment design. The caveat, however, is that the opportunity will only be realized in both scenarios if the provider has effective care delivery, communication, and documentation systems in place and is able to code the MDS accurately and in a timely manner.

JW | There is an opportunity to really optimize reimbursement during the September to October transition. PDPM has declining rates after day 20 of the resident stay for PT and OT, and NTA payments decline from 300% of the rate to 100% on Day 4. These declines will not be applied to Medicare Part-A residents in the building on September 30 and October 1, so facilities will get paid at 100% for OT/PT and get the first three

days at 300% of NTA payments, regardless of the amount of time already in the facility.

CF | I believe that providers who have been diligently preparing for October 1st are quite aware of the opportunities that exist under the new system. The move from a therapy-driven payment model to a more clinically complex model opens doors for providers to work with their referral sources to provide a greater expanse of clinical care options. The rise of Medicare Advantage plans, while not directly associated with PDPM, is an area that SNF's will need to address as it can represent a potential opportunity moving forward. Medicare Advantage plans continue to gain popularity among older adults and because of this, SNF providers should seek to work with more of these plans. These plans tend to differ from traditional Medicare in that they often seek value-based reimbursement.

KM | The biggest opportunity in PDPM is in providing respiratory therapy. SNFs will see a triple benefit: better reimbursement, better care, and better efficiencies.

On average, the SNF PDPM Medicare Part A rate increase can be upwards of $100 per patient per day (PPD) if respiratory therapy is provided. See example on pp. 17–18.

TS | I think one of the biggest opportunities is in providers who can manage their admissions process in such a way that it will use the patient's records from the hospital to capture diagnoses, which is much more important under PDPM. Additionally, the MDS is much more of a driver for reimbursement under PDPM. The information on the MDS determines the case-mix components for each patient. Under the old RUG-IV system, therapy drove reimbursement, so providers did not pay as much attention to the other aspects of the MDS. Providers who can master completing an MDS that captures the total patient condition will likely be successful under PDPM, and that starts with gathering information about the resident during admission.

Q | Any other words of advice for readers as they enter the new payment model?

DC | We can't emphasize enough that providers must understand the importance of appropriate and accurate ICD-10 diagnosis coding on the MDS and claim under PDPM. CMS has identified a limited set of allowable ICD-10 codes that can

be coded into MDS Item I0020B to represent the PDPM primary reason for the SNF stay, as well as even more limited sets of codes to represent SLP or NTA active co-morbidities in MDS Item I8000 as well as the HIV/AIDS B20 ICD-10 code used on the claim. This will mean that the provider should have processes in place to obtain information from the admitting hospital and the resident's physician(s) that will support the ICD-10 code(s) submitted by the SNF.

> **"With a 2.2% unemployment rate in healthcare, recruiting is hard, so making current staff perform consistently is important to quality. Standardization provides the framework for all nurses to perform like your best nurse."**
>
> *—Jayne Warwick, director of market insights, PointClickCare*

JW | Make sure you have standardized what you can (i.e., care content, care delivery, reimbursement checks). Other payors will move over to PDPM in the future, and standardizing processes now will make those transitions easier. Standardization improves the quality of care delivered and improves morale because staff know what happens next in a standardized process. It takes away guess work, and they feel more secure in doing the right thing as prescribed. Standardization also floats people problems to the surface. If everyone is supposed to be doing the same thing the same way, then you can easily identify when certain caregivers do not achieve outcomes. Standardization allows SNFs to intervene quicker and provide the right training to bring the quality of care back to your standards. With a 2.2% unemployment rate in healthcare, recruiting is hard, so making current staff perform consistently is important to quality. Standardization provides the framework for all nurses to perform like your best nurse.

CF | Perhaps it's the eternal optimist in me, but I am confident that the majority of SNF operators have prepared for this new payment model. I like the fact that PDPM returns the industry back to the basics of providing good, solid nursing care to a wide range of patients and rewards providers for doing so. But, the pessimist in me, reminds me that the government intends for PDPM to be budget neutral, so there will be providers that experience revenue gains while conversely, others will experience reductions.

KM | Just breathe. Stay calm, stay focused and do not lose sight of the job—providing individualized quality care.

OBRA '87 regulations require facilities to provide services to meet "the highest practicable physical, medical and psychological well-being" of every resident. The medical regimen must be consistent with the interdisciplinary care plan and resident's assessment as performed according to the uniform instrument known as the MDS. Any decline in the resident's physical, mental or psychological well-being must be demonstrably unavoidable. (483.25).

TS | I have the following five tips for SNFs:

- Review your therapy contracts
- Get a handle on ICD-10 as it drives the admitting diagnosis
- Make sure you are capturing the entire patient condition on the MDS
- Make sure your documentation can justify the reimbursement you receive under PDPM as this will be a target for audits
- Incorporate PDPM training into their compliance and ethics programs **AJ**

PDPM respiratory therapy payment example

Providing respiratory therapy can have a significant impact on reimbursement. Consider the following example that compares payment for patient not receiving respiratory therapy to a patient receiving respiratory therapy in Essex County, Massachusetts.

Case-mix index

Patient not receiving respiratory therapy vs. **Patient receiving respiratory therapy**

PDPM category	PDPM component
PT&OT	TI
SLP	SA
NTA	ND
Nursing	CA1

PDPM category	PDPM component
PT&OT	TI
SLP	SA
NTA	ND
Nursing	CA1

Projected payment comparison

Day	Revenue: No respiratory therapy	Revenue: Respiratory therapy	Difference	Average Rate: No respiratory therapy	Average Rate: Respiratory therapy	Difference
1	$674.21	$777.85	**$103.64**	$674.21	$777.85	**$103.64**
2	$1,348.41	$1,555.69	**$207.28**	$674.21	$777.85	**$103.64**
3	$2,022.62	$2,333.54	**$310.92**	$674.21	$777.85	**$103.64**
4	$2,487.74	$2,902.29	**$414.55**	$621.94	$725.57	**$103.63**
5	$2,952.86	$3,471.05	**$518.19**	$590.57	$694.21	**$103.64**
6	$3,417.98	$4,039.81	**$621.83**	$569.66	$673.30	**$103.64**
7	$3,883.10	$4,608.57	**$725.47**	$554.73	$658.37	**$103.64**
8	$4,348.22	$5,177.32	**$829.10**	$543.53	$647.17	**$103.64**
9	$4,813.34	$5,746.08	**$932.74**	$534.82	$638.45	**$103.63**
10	$5,278.46	$6,314.84	**$1,036.38**	$527.85	$631.48	**$103.63**
11	$5,743.58	$6,883.60	**$1,140.02**	$522.14	$625.78	**$103.64**
12	$6,208.70	$7,452.35	**$1,243.65**	$517.39	$621.03	**$103.64**
13	$6,673.82	$8,021.11	**$1,347.29**	$513.37	$617.01	**$103.64**
14	$7,138.93	$8,589.87	**$1,450.94**	$509.92	$613.56	**$103.64**

Day	Revenue: No respiratory therapy	Revenue: Respiratory therapy	Difference	Average Rate: No respiratory therapy	Average Rate: Respiratory therapy	Difference
15	$7,604.05	$9,158.63	$1,554.58	$506.94	$610.58	$103.64
16	$8,069.17	$9,727.38	$1,658.21	$504.32	$607.96	$103.64
17	$8,534.29	$10,296.14	$1,761.85	$502.02	$605.66	$103.64
18	$8,999.41	$10,864.90	$1,865.49	$499.97	$603.61	$103.64
19	$9,464.53	$11,433.65	$1,969.12	$498.13	$601.77	$103.64
20	$9,929.65	$12,002.41	$2,072.76	$496.48	$600.12	$103.64
21	$10,391.88	$12,568.28	$2,176.40	$494.85	$598.49	$103.64
22	$10,854.10	$13,134.14	$2,280.04	$493.37	$597.01	$103.64
23	$11,316.33	$13,700.00	$2,383.67	$492.01	$595.65	$103.64
24	$11,778.55	$14,265.87	$2,487.32	$490.77	$594.41	$103.64
25	$12,240.78	$14,831.73	$2,590.95	$489.63	$593.27	$103.64
26	$12,703.00	$15,397.59	$2,694.59	$488.58	$592.22	$103.64
27	$13,165.23	$15,963.46	$2,798.23	$487.60	$591.24	$103.64
28	$13,624.56	$16,526.43	$2,901.87	$486.59	$590.23	$103.64
29	$14,083.89	$17,089.40	$3,005.51	$485.65	$589.29	$103.64
30	$14,543.23	$17,652.37	$3,109.14	$484.77	$588.41	$103.64
31	$15,002.56	$18,215.34	$3,212.78	$483.85	$587.59	$103.74
32	$15,461.89	$18,778.31	$3,316.42	$483.18	$586.82	$103.64
33	$15,921.22	$19,341.28	$3,420.06	$482.46	$586.10	$103.64
34	$16,380.55	$19,904.25	$3,523.70	$481.78	$585.42	$103.64
35	$16,836.99	$20,464.33	$3,627.34	$481.06	$584.70	$103.64

Source: Kris Mastrangelo, president and CEO of Harmony Healthcare International (HHI)

Limit financial risk by enlisting billers to forecast profitability prior to admission

Now that the Patient-Driven Payment Model (PDPM) is officially live, SNF's bottom lines are more vulnerable than ever before. The complexities of PDPM create substantial financial risks for SNFs, and it will take months of monitoring profitability to fully understand the financial implications of the new payment model.

Determining and tracking the profitability of each potential new patient will be key to protecting the SNF's bottom line in PDPM. Revenue and cost estimates can help administrators make the most financially advantageous admitting decisions for the SNFs.

As SNFs evaluate their standards of operations, maximize earnings by enlisting billing specialists to conduct a profitability check for potential new residents during the pre-admissions process.

"Billers can do that homework as part of prescreening so that you will know prior taking a patient whether the expenses will far outweigh revenue," says **Stefanie Corbett, DHA,** post-acute regulatory specialist for HCPro.

The forecast gives administrators valuable information that will help them understand the financial implications of each new patient admitted. Distinguishing between potential high- and low- revenue patients will allow administrators to make more informed and quality decisions that will protect SNFs profitability in PDPM.

Why pre-admissions profitability checks matter in PDPM

In the first several months of PDPM, SNFs will seek to understand how different clinical characteristics across their Medicare Part A censuses affect revenue.

In the RUG-IV system, SNFs frequently lose money daily on patients with certain conditions or needs. To make up for that loss in revenue, they take on

patients requiring a high level of therapy. For example, if a SNF admits a patient that falls into a low Medicare nursing rate category, they can prioritize the admission of a patient who will require the maximum amount of therapy. In RUG-IV, everyone knows that 720 therapy minutes is the magic number to receive the highest reimbursement, says **Reta Underwood, RAC-CT, C-NM, QCP,** Medicare specialist and president of Consultants for Long Term Care.

In PDPM, administrators will also want to balance high-paying and low-paying patients but finding that sweet spot will take trial and error. SNFs must learn which clinical characteristics will drive revenue in order to make up for profit deficits caused by low-reimbursement residents.

"In the RUG-IV system, if you get patient with a fractured hip you know, they're going to need therapy, you know you're in the ultra-high rehab category, and you know what your payment is. It's not that simple in PDPM because there are so many clinical characteristics that can drive payment," Underwood says.

Finding the optimal patient mix is further complicated by the fact that PDPM incentivizes SNFs to care for clinically complex patients. To maintain profitability, SNFs may need to take on patients who require IVs, tubes, and ventilators or who present with conditions, such as HIV/AIDS, depression, and multiple sclerosis, Underwood says.

In doing so, SNFs will have to proactively assess the costs associated with caring for higher acuity patients. High-cost drugs and services can easily exceed the reimbursement the facility will receive.

"If facilities are not careful to project and manage costs, then they may very well find themselves upside down as far as profitability," Corbett says.

Screening for profitability during in-take can prevent SNFs from going into the red. By reviewing the expense and revenue projections, administrators can make data-driven decisions to either admit the patient despite the financial risks or turn down the admission due to the high costs.

Understanding profitability for potential new patients can also inform admissions strategies. Use the profit projects to prioritize patients waiting to be admitted. For example, if you have three referrals awaiting admissions, billers can complete a quick revenue projection so that you can prioritize the highest earning patient, Underwood says.

Additionally, facilities can minimize financial risk by looking at the projections in context of the facility's current revenue projections across all patients.

"You can say to admissions, we can afford to take one or two patients with these needs, but if you want to admit any more than that at one time, we'll have to really look at the patient and facility dynamics because it might not be a financially fit decision," Corbett says.

> **"If facilities are not careful to project and manage costs, then they may very well find themselves upside down as far as profitability."**
>
> *—Stefanie Corbett, DHA, regulatory specialist*

Billers are key to identifying and protecting against financial risks

Billers have a unique set of skills and knowledge that makes them qualified to forecast revenue and expenses of each resident prior to admitting a patient, says Corbett.

Billers sit at a cross-section of all functions that impact the facility's cashflow and have detailed knowledge of how money flows in and out of the

facility's accounts. They manage accounts receivable and accounts payable, processing bills that generate cashflow and paying invoices to outside vendors. Collections and claim reconciliation also fall to billers, so they understand challenges with collecting and reconciling invoices from patients, payers, and vendors, Corbett says.

Because billers are already involved in these processes, they understand what factors facilitate and impede payments to the facility. They can easily identify potential patients that may expose the facility to financial liabilities during their stay, Corbett says.

This knowledge makes them the best resource in the facility to project revenue and costs and create a profitability forecast for each potential new admit.

Integrate revenue forecasting into the pre-admission process

"In RUG-IV, the business office knows that 720 therapy minutes equates to X dollars,

Billers: Use profitability checks as an opportunity for career growth

Billers should always be on the lookout for opportunities to advance their career. Reimbursement is about to get a lot more complicated in PDPM, and you have a lot of intel on how money flows in and out of their facilities.

Apply this knowledge to the admissions process by forecasting profitability for each new admit. Doing so will broaden the scope of your skills and bring additional value to the organization, says Stefanie Corbett, DHA, post-acute regulator specialist for HCPro.

In order to be successful in this new task, Corbett recommends taking the following steps:

- **Get to know the admissions process.** The admission process takes on an entirely new level of importance in PDPM and will be a high-focus area for SNFs as they modify operations to maximize revenue in PDPM.

  "If you really want to grow, become more involved in the front end of the business and understand the downstream effects admitting decisions can have on the billing and collecting process," Corbett says. There is so much opportunity for billers to work hand-in-hand with admissions staff to identify potential red flags that can hit the SNFs bottom line.

- **Understand the factors that influence PDPM reimbursement.** Therapy is not the revenue driver anymore. By understanding how all of the reimbursement dots connect in PDPM will allow the biller to help the SNF adapt to the new payment model. To best leverage your billing knowledge, you must also understand how CMS calculates PDPM payment rates. Use the PDPM calculation worksheets provided by CMS to learn what patient characteristics drive reimbursement. Meet with the MDS coordinator to learn how the provision of services relates to the MDS and preparation of the claim.

- **Become familiar with ICD-10 codes.** Although you do not need to know the ins and outs of how to code using ICD-10, learn how clinical documentation impacts those codes and reimbursement.

  With this newly gained knowledge, billing specialists can inform processes and strategies that can lead to cost savings or mitigate financial risks and elevate their status within the organization.

and 520 minutes will give them Y dollars. Billers do not have those benchmarks in PDPM. The profitability check is a quick way to get a rough idea of anticipated revenue," Underwoood says.

It is important to note that the pre-admissions screening does not result in a precise per diem projection. Because reimbursement is tied to the patient's clinical characteristics, billers cannot determine an exact daily payment until the clinical team completes their initial assessments and determines the primary diagnosis for SNF admission. However, admission and business office staff cannot wait that two or three days for those assessments to take place before making an admitting decision.

The profitability check gives billers enough information to inform admitting decisions and to flag:

- High-acuity patients for further financial analysis after admission, especially if they require high-cost treatment, equipment, or drugs
- Low-earning patients for the clinical team to further evaluate after admission to determine if there are additional conditions not included in the hospital records

The PDPM estimated reimbursement worksheet on pp. 25–26 walks billers uses a point-system to categorize residents as high-, medium, or low- potential reimbursement opportunities. The tool provides an average per diem payment rate based on a blended national rate averages for urban and rural facilities, Underwood says.

To complete the worksheet, billing specialists should:

- Review the medical records and orders provided by the referral source
- Estimate the therapy and nursing needs of the resident as described in each section
- Indicate the points based on the evaluation of therapy and nursing needs and identification of comorbidities
- Sum the points from each section and note the corresponding reimbursement

Accuracy hinges on receiving as much information as possible from the referral source. The pre-admissions team should also ask for the hospital's abstracted chart for the patient. This is the final coded medical record, and it gives you all the ICD-10 codes for the conditions that the hospital treated for that patient. Savvy billers will be able to review this document and identify comorbidities that influence the non-therapy ancillary (NTA) case-mix category the patient will be placed in, says Underwood.

"NTAs are a major driver for reimbursement in PDPM. Ideally, you will capture those either during the pre-admission screening or shortly after the admission. SNFs will receive a variable NTA payment, paid at 300% the first 3 days of the stay and 100% after day 4," Underwood says.

Print out CMS's list of the 50 NTAs and check every new patient's records for those conditions in order to get an accurate revenue calculation.

Reviewing the following items will help billers make more exact predictions:

- Hospital record face sheet
- Physician orders and discharge order for SNF placement
- Physician visits, including history and physical and progress notes
- Other provider consultation reports
- Physician discharge summary
- Nurse notes
- Medication administration records
- Treatment administrative records
- Surgery reports
- Laboratory and diagnostic results
- Therapy documents
- Intake, output, and vital sign records

If after admission, billers need to perform a more robust and accurate cost/revenue forecast, they should confer with the IDT to attain the clinical information necessary, including the primary diagnosis, which is the anchor of PDPM payment.

"Then you're locked into the calculation because the PDPM algorithm starts with the ICD-10 code you enter into I0020B of the MDS," Underwood says.

Plug the information into CMS Grouper Tool to determine the payment rate for that patient, Underwood says.

To further enhance the accuracy of your revenue predictions, biller should have a working knowledge of how CMS calculates payment rates. Although time consuming, use the PDPM calculation worksheets provided by CMS to calculate the rate for a variety of patients. This will help billers understand which clinical conditions and sections of the MDS drive payment, says **Bonnie Foster, RN, BSN, MEd,** president of Foster Consulting Inc.

Limit exposure to financial risk by flagging and managing patients with high-cost services and drugs

While reviewing a patient's pre-admission documentation for revenue opportunities, billers should also assess the expenses the facility will incur if they admit a patient.

"Because billers are the consolidated billing experts, they are the best resource in the facility to project costs and determine if they will exceed the revenue," Corbett says.

As SNFs admit more acute patients in order to attain higher reimbursement in PDPM, they will also incur higher costs. Effectively managing those costs can significantly impact the SNFs' profit margins.

Covering the cost of expensive drugs, such as chemotherapy, can cause SNF's to go into the red. Billers can also protect margins by screening potential new admissions and flagging high cost drugs prior to admitting the patient. Consolidated billing rules around high-cost drugs are complicated, but skilled billers know how to navigate the rules to determine whether the SNF will have to pay for the drugs during the patient's stay. Similarly, billers can identify patients who will require specialized equipment and supplies that the facility may not currently have on site and research the costs of acquiring the equipment. They can also asses the costs of owning versus renting the equipment and make a recommendation to administrators to make the most financially beneficial decision, Corbett says.

When facilities admit patients requiring high-cost drugs, services, or equipment, billers should share the expense projections with the administrator, director of nursing, or director of rehabilitation services. The clinical team can review the plan of care and drugs and determine if there is a less-expensive alternative that can reduce the costs.

In some facilities, it may not be possible for a biller to perform a profitability check for each potential admit. However,

they can still help protect the SNF's bottom line by providing admissions staff with lists of costly medications, equipment, and supplies to cross-reference during the pre-admission screening process. If any items on those lists appear in the patient's pre-admissions packet, they should bring those files to billers to perform a revenue and cost projection to present to the administrator.

"Administrators will be able to make more informed and quality decisions about the patients they're admitting because they will know exactly how those admitting decisions will impact their bottom line," Corbett says.

Enhance cashflow by preventing collections issues before they happen

Admissions staff are great marketers and sellers and excel at bringing residents into the SNF. They may have a list of financial or insurance red flags to scan for during in-take, but billers are best suited to identify potential insurance coverage red flags that have downstream effects on billing and collections and expose SNFs to financial risks.

Depending on the facility, billers are well-positioned to perform primary insurance verifications, or to support admissions by verifying secondary insurer coverage and confirming pre-authorizations and pre-certifications required by managed care insurers, Corbett says.

Billers have a vested interest in identifying potential non-coverage issues during admission because after the patient is admitted, the biller is left to face the challenge of billing and collecting from those patients—not admissions.

"If you own the insurance verification process from day one, then you are the subject matter expert on the resident's insurance. As a biller, I would want to know from the start if a patient does not have the appropriate insurance and benefits to cover the cost of their care. Otherwise, the patient is admitted, and I have the challenge of billing and collecting on that account," Corbett says.

Flagging patients who do not have sufficient coverage allows billers to mitigate collections risks by collaborating with admissions, social work, and discharge personnel from the start of a resident's stay. These staff can proactively work with patients to determine how they will pay for care once their Medicare Part A benefits exhaust or they no longer meet the criteria for a skilled level of care, says Foster.

"It can take a long time for residents to work with insurers or Medicaid. In some states, it takes six to nine months before you get approved for Medicaid. That means it might be a year before the SNF sees payment, so the earlier you can identify potential coverage gaps and have those conversations with patients and their families, the less time and trouble billers will have getting that claim paid," Foster says.

Additionally, collections is an ongoing function, billers often know better than anyone in the facility which insurers are tough to work with and the reasons why certain they deny or recoup payment, Foster says.

Leverage this information to support patients and facilitate payment by accepting insurance from more companies.

"One thing I hear all the time is that providers are not taking certain insurance because they do not pay. The biller is savvy as to what insurance companies turn down. Usually, they tell me it's due to a lack of documentation describing the patient's conditions and care," Foster says.

During interdisciplinary team (IDT) Medicare utilization review meetings, billers can inform the clinical team that the insurer usually denies payment due to documentation. The team can then ensure they document the information required for accurate payment. **AJ**

Sample PDPM estimated reimbursement worksheet

The purpose of this worksheet is to provide billing specialists a quick idea of the revenue a potential patient may generate. Billers should complete the worksheet pre-admission based on the information provided by the referral source. Because the SNFs clinical team has not reviewed the documentation or assessed the patient, the worksheet gives a very general revenue estimation billers and admissions teams can use to prioritize admissions, flag patients for further cost/earnings analysis, or flag patients for the clinical team to evaluate as their costs may outweigh the revenue.

To determine a more precise payment rate, use CMS's Grouper Tool available in the *downloads section here*.

PDPM Reimbursement Worksheet

MEDICAL CATEGORY (Up to 4 points)

Driver	Number of points	Points
Recent surgery	Yes = 1 No = 0	[Enter point amount in this column]
Physical therapy or occupational therapy needed	Yes = 1 No = 0	
Section GG PT/OT Functional score* (Scale 1-24)	0-9 = 1 10-24 = 2	
	Subtotal: Medical category	[Add all points for this component]

*To determine Section GG Functional Status: Review the documentation provided for admission to estimate the patient's functional level for the four activities of daily living components: toileting, eating, oral hygiene, walking and transfer status, including bed mobility. For the purposes of estimating revenue, determine whether the patient is highly independent or not. Payment changes drastically only when the patient scores in the highest or lowest category. Refer to CMS's *Fact Sheet: PDPM Functional and Cognitive Scoring for more information*.

SPEECH-LANGUAGE PATHOLOGY ISSUES (Up to 4 points)

Driver	Number of points	Points
Recent cerebrovascular accident (CVA) or other acute neurological condition	Yes = 1 No = 0	
Mechanical diet	Yes = 1 No = 0	
Swallowing problem	Yes = 1 No = 0	
Cognitive impairment	Yes = 1 No = 0	
	Subtotal: Nutritional issues	

NURSING SERVICES (Up to 6 points)

Driver	Number of points	Points
Nursing category	Extensive = 3 Special care high or low = 2 Clinically complex = 0	
Depression present	Yes = 1 No = 0	
Section GG Nursing Functional score* (Scale 1-16)	1-14 = 2 11-16 = 1	
	Subtotal: Nursing services	

*See CMS's *Fact Sheet: PDPM Functional and Cognitive Scoring for more information on calculating the nursing functional score.*

COMORBIDITIES (Up to 4 points)

Driver	Number of points	Points
NTA comorbidity score is 12+ points*	Yes = 1 No = 0	
NTA comorbidity score	5 points or higher = 2 4 points or less = 1	
HIV present or total parenteral nutrition (TPN) or IV required	Yes = 1 No = 0	
	Subtotal: Comorbidities	

*Refer to the CMS's *Conditions and Extensive Services Used for NTA Classification* to determine the points.

PDPM REIMBURSEMENT PROJECTION	
Total number of points across all components	[Add point subtotals from each component]

REIMBURSEMENT LEVEL (circle one)

Total points	Reimbursement category	Estimated average daily payment*
18-24 points	High PDPM reimbursement	$983.37
9-13 points	Medium PDPM reimbursement	$481.03
0-8 points	Low PDPM reimbursement	$397.96

*These averages are based on national average payment rates. Urban and rural rates across geographies are blended.

Source: Reta A. Underwood, RAC-CT, C-NM, QCP, Medicare specialist and president, Consultants for Long Term Care, Inc.

Proactively manage relationships with outside patients and external service providers to avoid costly consolidated billing mistakes

The Consolidated Billing Made Simple series delves into the ins and outs of consolidated billing. This series will untangle CMS consolidated billing regulations and give billers a solid understanding of the rules and tips for applying them effectively.

Navigating the intricacies of consolidated billing rules and compliantly submitting claims for Medicare Part A-covered residents is a core skill for any billing specialist. Once you've mastered the ins and outs of inclusions, exclusions, and the myriad of exceptions to seemingly straightforward rules, many billers are ready to go beyond compliance and use their consolidated billing expertise to safeguard the SNF's profit margins.

Communication gaps between SNFs and third-party vendors that provide equipment, services, or care to patients are one of the biggest consolidated billing challenges SNFs face, says **Olga Gross-Balzano, CPA, PMP**, a manager at BerryDunn (ME).

A lack of communication regarding patients' Medicare Part-A covered status and care decisions can significantly compromise an SNF's profitability. CMS puts the responsibility of coordinating residents' care squarely on the SNF, whether provided directly by the SNF or an outside vendor. Consolidated billing rules enforce this responsibility by also making SNFs financially liable for most (but not all) items or services furnished by outside providers—even if the

SNF is not aware of the services. Consolidated billing rules stipulate that SNFs must use their Medicare per diem payment to reimburse outside suppliers for the items and services rendered, Gross-Balzano says.

Because SNFs must pay medical service providers and other vendors from the Medicare Part A per diem rate, SNFs are likely to be more involved in managing the patient's care. SNFs can also incorporate the services provided outside the SNF into the resident's care and discharge plans.

SNFs often make erroneous or unnecessary payments to outside entities because they are unaware of patients' appointments with outside vendors, do not proactively communicate the patients' Part-A covered status with outside providers, especially physician offices, and lack effective processes for verifying the charges on invoices sent by vendors.

Billers must establish robust communication processes and be aware of their SNFs' payment arrangements with business partners to:

- Ensure that they have all the information required to determine whether they should include or exclude an item or service from the consolidated bill
- Fulfil their responsibility to inform outside entities of a patient's Part-A covered status
- Reduce the time spent reconciling bills and correcting errors on invoices received by outside entities
- Avoid costly items or services provided during appointments with physicians in the community or at specialty centers (e.g., wound care clinics, dialysis centers, or cancer treatment centers)

Protect the facility's revenue and enhance compliance with these best practices for managing patients' physician appointments, proactively communicating with outside providers about service delivery, and verifying invoices from outside suppliers.

> **"Communication gaps between SNFs and third-party vendors that provide equipment, services, or care to patients are one of the biggest consolidated billing challenges SNFs face."**
>
> *—Olga Gross-Balzano, CPA, PMP, a manager at BerryDunn (ME)*

Included vs. Excluded

The first step in avoiding costly consolidated billing mistakes is to understand the terms "included" and "excluded." This article will use the terms in the following manner:

- "Included" refers to the covered Prospective Payment System (PPS) items and services that are subject to or included in the consolidated bill. The SNF is responsible for billing Medicare for these services and medications. They must pay the outside vendor from the PPS per diem rate.
- "Excluded" refers to items or services that providers should exclude from the consolidated bill (CB). The outside vendor should bill these directly to Medicare Part B.

Get ahead of patient appointments

Managing appointments with outside providers is one of the most difficult consolidated billing issues SNFs experience.

CMS implemented consolidated billing partially to make one entity—the

SNF—accountable for the overall care residents receive. With the exception of a few services, SNFs must pay outside medical service providers for the majority of services provided during patients' Part A stay, which can substantially increase the costs associated with caring for that patient. (See sidebar below for the list of services excluded from consolidated billing.)

Consider the following example: Mrs. Ruiz is admitted to the SNF for a Part-A covered stay for a knee replacement. During her stay, she goes to an appointment for a mammogram that she scheduled six months prior. Because she went to that appointment while on a Part-A covered stay, the SNF must pay for the routine mammogram (radiology and facility fees), as well as transportation if the resident requires it, Gross-Balzano explains.

Having a solid process for learning about the appointments and assessing the consolidated billing implications can lead to substantial savings, but, frequently, SNFs do not perform enough investigative work to find out what appointments their patients have, says Gross-Balzano.

If the clinical team confirms that the appointment is not an urgent medical necessity, the SNF might request that the patient postpone his or her appointment until after he or she leaves the SNF. By doing so, the SNF encourages patients to focus on rehabilitation goals and

Services excluded from consolidated billing

For Medicare beneficiaries in a covered Part A stay, separately payable services include:

- Physician's professional services
- Certain dialysis-related services, including covered ambulance transportation to obtain the dialysis services
- Ambulance services that transport the beneficiary:
  - To the SNF initially
  - From the SNF at the end of the stay (other than transfers to another SNF)
  - Offsite temporarily in order to receive dialysis, or to receive certain types of intensive or emergency outpatient hospital services
- Erythropoietin for certain dialysis patients
- Certain chemotherapy drugs
- Certain chemotherapy administration services
- Radioisotope services
- Customized prosthetic devices

Additionally, SNFs should stop submitting a consolidated bill for services provided to a beneficiary during a Part A stay at the facility if the beneficiary does any of the following:

- Becomes an inpatient at a hospital, a CAH, or another SNF
- Receives services from a home health agency under a plan of care
- Receives outpatient services from a hospital or CAH
- Is formally discharged from the SNF without being readmitted by midnight of the same day

If any of these events occur during a beneficiary's Part A stay at the SNF, the SNF will no longer be held liable for billing or payment related to the beneficiary's care.

Source: CMS

avoids paying for those services out of the Medicare daily rate. To ease the burden on patients, offer to reschedule the appointments for them. Although this is extra work for SNF personnel, the few minutes it takes to contact the physician's office can save the SNF hundreds, sometimes thousands of dollars, says **Jennifer Matoushek, MBA/HCM, CPC**, senior consultant with LW Consulting, Inc.

Proactive communication with beneficiaries, pre-admissions staff and clinical teams is critical to reducing the payments SNFs must make for patient care provided outside the facility. Consider the following strategies for managing patients' appointments with outside providers:

- **Carefully review hospital referral information for required post-discharge follow up** (i.e., wound care clinic appointments or transportation to a remote doctor's office) and co-morbidities maintenance. Cconsider experimental cancer treatment medications and other costly medications that may not be on an "excluded" list.
- **Invite family members to admission conference or welcome meeting.** Most SNFs include a question about regular and ongoing appointments during intake, but it's prudent to confirm the information and ask the question again during care planning meetings. Admission is a stressful time for residents, who may not remember that they have scheduled appointments. Include family members in these meetings as they often play a role in coordinating the patient's care with other providers in the community, Gross-Balzano says.

- **Make upcoming appointments a standing agenda item during daily meetings.** Use morning or Medicare utilization review meetings as an opportunity to ask interdisciplinary team (IDT) members about upcoming appointments for those patients on the Medicare Part A census.

"Many clinical or support teams are aware of who has plans to leave the facility because they have to schedule therapies, support services, or medication administration around them. Or, they schedule transport or CNAs to accompany the resident to the appointment," Gross-Balzano says.

Or, if staff enter appointments into a log, the business office should check the log daily and flag any appointments that may result in services included in consolidated billing, so that an advance notice could be given to service providers.

You can also use this meeting to learn about and confirm leaves of absences. This is especially important if the resident does not return to the facility by midnight. Any services performed outside the SNF during that day are not the SNF's responsibility, says Matoushek.

It is important to note that in many cases, Part-A covered patients must see external specialists, receive treatments, or undergo procedures. Billers still want to know about these appointments ahead of time so that they can confirm and pay for the service after they receive the invoice from the medical services provider.

costs of care provided outside the facility.

Proactively communicating with physician offices is especially critical in containing costs associated with additional tests or care outside physicians or physician extenders, such as physician assistants or nurse practitioners, may provide and order that may be subject to consolidated billing, says Gross-Balzano.

> **"I've seen some facilities where the billers do not have any knowledge of the terms of the contracts. That's not how an SNF billing office should be run. Your business office should have an up-to-date copy of those contracts to refer to, especially when they have to do some reconciliation."**
>
> *—Jennifer Matoushek, MBA/HCM, CPC, senior consultant with LW Consulting, Inc.*

Billers can also factor those costs into profitability projections for the patient. (See "Limit financial risk" on pg. 14 for more information about the importance of profitability projections in PDPM).

Notify external providers of patients' Part-A covered status

The SNF is responsible for communicating to other providers that the patient is in the SNF under a Part-A-covered stay. Notifying external service providers that patients are on a Part-A stay helps SNFs manage

Consider the following example: Mr. Eaton goes to his orthopedic surgeon's office for a post knee-replacement follow up. While there, Mr. Eaton tells the physician assistant (PA) that because his knee feels better, he would like the PA to look at his shoulder, which has bothered him for years. The PA orders radiology services to assess Mr. Eaton's shoulder condition. Radiology is in the same building, and they are able to see Mr. Eaton right away. In this case, the SNF is responsible for the radiology services bill.

Prior to the patient's appointment, billers should send beneficiary-specific "under arrangement" agreements to the physician's office, suggests Gross-Balzano. (*View CMS's sample notification*)

The notification letter should:

- State that the SNF is responsible for coordinating the care of the patient and specify the service or procedures that the physician is authorized to perform during the office visit.
- Request that physicians and physician extenders gain SNF approval prior to providing additional medical services or tests and before referring residents to a healthcare entity outside the outpatient hospital setting for certain emergency care or high-level diagnostic services, Matoushek says.

When the physician's office calls for approval, the SNF's clinical team can determine whether the additional medical services are immediately necessary or can wait until after the patient is discharged from the facility, and the SNF is no longer responsible for reimbursing the external physician, Matoushek explains.

Outline the consolidated billing regulations and

specify the types of services and tests the physician office should invoice the SNF for and which it should bill directly to Medicare Part B. Also be clear about the implications the setting has on billing and payment.

The letter should also outline specific payment terms. In the instructions for how the physicians' office should bill the SNF, require providers to use the UB92 form and include the HCPCS and CPT codes for the services and items provided. This allows billers to more easily look up procedures and tests on the Help File and confirm whether they are included or excluded from consolidated billing. It also allows them to determine that only the non-professional, technical components are included on the invoice, Gross-Balzano says.

The notification should also set parameters for the timeframe in which service providers should invoice the SNF. Medicare requires services to be billed within a year of provision of services, so specify that the provider should bill the SNF within the year. If the provider or vendor sends a bill after a year has passed, the SNF should reject it for untimely filing, Gross-Balzano says.

Know the ins and outs of general payment agreements with outside vendors

CMS requires that any service subject to SNF consolidated billing must be either furnished directly by the SNFs or under arrangement, meaning that the SNF has an agreement with the provider of the services. In addition to beneficiary-specific payment agreements, SNFs should have robust general agreements in place with external service providers governing overall (i.e., not beneficiary-specific) terms for payment and billing. (See the sidebar below for the general guidelines CMS outlines for arrangements between SNFs and third-party providers and suppliers.)

SNFs should enter into these agreements with outside entities prior to their first provision of services or equipment to residents during a Part A stay.

Payment agreements outline several parameters related to consolidated billing that can

Under agreement responsibilities

Any services subject to SNF CB must either be furnished directly by the SNF with its own resources or furnished under arrangement. "Provided under arrangements" means that the SNF has an agreement with the provider of the services.

CMS will not get involved with the contracts between SNFs and other providers but does offer the following guidelines of responsibility for each party.

SNF responsibilities:

- Must bill Medicare on the Part A claim for items included in the consolidated bill
- Must pay the supplier for those services
- Must make a good-faith effort to inform suppliers of a beneficiary's Part A status
- May not bill the family privately for the items

Vendor responsibilities:

- Suppliers should make an effort to determine whether patients are in a Part A SNF stay
- Suppliers must bill SNFs on a timely basis
- Suppliers cannot bill either Medicare Part B or the family privately for services that should be included on the Part A SNF claim

Source: Medicare Guide for SNF Billing and Reimbursement, Second Edition.

prevent denials, miscommunication, and financial risks for the SNF, says Matoushek.

Billing specialists typically do not participate in the negotiation of arrangements with vendors and medical services providers, but billers should be aware of and understand all contracts the facility has with third parties. The agreements have vital information billers need in order to verify and process invoices from outside suppliers and care providers, such as:

- The process for submitting the invoice
- Payment rates
- Turnaround times between billing and payment

"I've seen some facilities where the billers do not have any knowledge of the terms of the contracts. That's not how an SNF billing office should be run. Your business office should have an up-to-date copy of those contracts to refer to, especially when they have to do some reconciliation," Matoushek says.

Business office managers should work with the chief financial officer (CFO) to ensure billing staff have updated versions of the agreements, especially the negotiated rates for services provided. This allows them to review the invoices for accuracy and reconcile any charges the SNF may not be responsible for, Matoushek says.

"Business office managers should work with the chief financial officer (CFO) to ensure billing staff have updated versions of the agreements, especially the negotiated rates for services provided."

Verify invoice accuracy

Hopefully, your efforts to strengthen processes for learning about patient appointments and notifying external business partners of patients' Part-A covered status will curtail invoicing errors, but billers must have a robust process in place for reviewing the accuracy of invoices received by outside entities.

It is common for SNFs to receive invoices from physician offices or providers that:

- Include incorrect rates for services, items, or care provided
- Are for residents either not in the SNF or in the SNF but not on a Part-A covered stay
- Charge for services excluded from SNF consolidated billing that they should instead bill Medicare Part B for directly

Carefully review every charge on every invoice to ensure that they are not paying for a service the SNF is not responsible for or paying the incorrect amount, says Matoushek.

Include the following steps in your invoice verification process:

- **Confirm basic information.** Check that the invoice relates to a resident in the SNF who was in a Medicare Part A covered stay. Ensure that the patient's name is correct and that the dates of services match the SNF's log, Gross-Balzano says.
- **Determine whether services provided are included or excluded from SNF consolidated billing.** Your payment agreements with vendors should specify that the vendor include the relevant HCPCS and CPT codes. Cross-reference the codes on the claim with the CMS "Help File" or "Update File", which lists the HCPCS codes excluded from CB. Simply search the file for the HCPCS codes listed on the invoice. If the HCPCS code is in the file, the biller

should contact the provider and ask them to remove the charge. If the code does not appear in the file, the SNF should include it on the consolidated bill.

"CMS updates these files quarterly. Make sure you download the most recent version from the CMS website so that you do not pay for an item excluded from consolidated billing," Gross-Balzano says.

- **Confirm the setting where the service was provided.** The setting in which residents receives care also dictates whether the SNF is responsible for paying for the services. Billers must be clear whether an outpatient facility providing a service is part of a hospital. This can be tricky because many entities are located close to a hospital and may have a similar name, so billers exclude them from the consolidated bill. However, if the medical services provider is not a part of the hospital, the SNF should include it in the consolidated bill. If you are unfamiliar with a physician office or specialty center, call the business office and confirm whether the bill came from the hospital's provider number.
- **Screen for modifier 26.** Modifier indicates the professional components of a service, which is excluded from consolidated billing. Physicians should bill those components directly to Medicare because it covers the costs associated with interpreting a test, such as an X-Ray.

  However, SNFs are responsible for paying for the technical component of the test and should therefore include anything with a -TC modifier in the consolidated bill. The technical component is the cost of performing the test, Matoushek says.

  If the invoice does not include -26 or -TC modifiers, billers should call the physician or hospital billing office and ask for the HCPCS codes for the technical and professional components.
- **Verify the invoice reflects the adjustment for the SNF's consolidated billing administrative fee.** When negotiating the rates SNFs will pay outside providers and vendors, many SNFs are not aware that they can charge a fee for processing payments for services included in consolidated billing.

  "CMS allows SNFs to take a reasonable adjustment for billing and making payments. You can charge a flat fee or a percentage of the bill," Gross-Balzano says.

  If outlined in your payment agreement, the vendor should subtract the fee amount from the total cost of the invoice.

When you discover errors, billers must confirm that the charge is incorrect by referring to consolidated billing rules and the payment agreement with the vendor. Once you are sure that there is an error call the provider, explain the issue, referring to CMS rules and the payment agreement, and ask for them to send a new invoice reflecting the correct charges or amounts, Matoushek says.

Working with external service providers is much easier when you have an established, positive, working relationship.

"I recommend all billers to make contacts at each third-party vendor and regularly check in with them. Resolving billing issues is a lot more pleasant when you have a relationship with the person on the other end of the line," Matoushek says. **AJ**