THE CHARTS GROUP

MANAGING THE MEDICARE RESIDENT

A Practical Approach to Facility Survival

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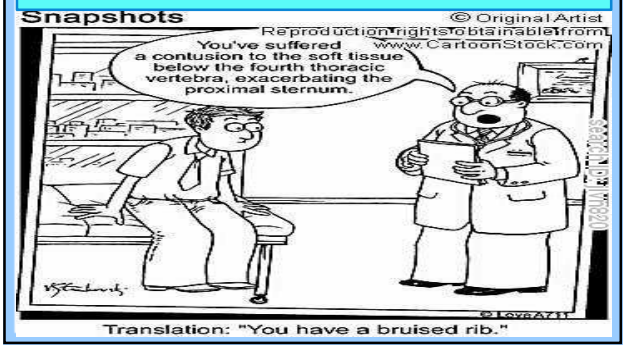
CURRENT CHALLENGES IN SNF CLINICAL REIMBURSEMENT

ICD-10 DIAGNOSIS CODING & YOUR FISCAL SURVIVAL *(This explains it ALL!)*

NOTE:

INTERDISCIPLINARY CLINICAL CARE (based on PATIENT CHARACTERISTICS & CO-MORBIDITIES, PROPER DOCUMENTATION & CODING: THE KEY TO SUCCESS



ICD-10 DIAGNOSIS CODING

NOT SKILLED – PLEASE DO NOT BILL FOR MEDICARE PAYMENT

"If you are not at the table, you are in the MENU." –
Michael Enzi

IF YOU DO THE RIGHT THING, EVERYTHING ELSE FOLLOWS. BE Positive and STAY Positive!

TEAM WORK IS A MUST

OUR GOAL

"You took such good care of me, I decided to sell my house and move into one of your rooms. Which one is available?"

THE ALTERNATIVE?

You may be diagnosed with the following ICD-10 Codes:

- ❑ Z56.6 – Work-Related Mental Stress
- ❑ Z56.2 – Threat of a Job Loss & will Exhibit the ff:
  - R45.82 – Worries
  - R45.81 – Low Self-Esteem
  - R51 – Headache
  - F50.89 – Loss of appetite, non-organic origin
- ❑ Z59.6 – Inadequate Financial Income
- ❑ F43.9 – Reaction to Severe Stress
- ❑ Z65.3 – Problems related to other legal circumstances

STRATEGIES FOR SUCCESS

- ❑VERIFICATION OF COVERAGE: TECHNICAL AND CLINICAL
- ❑MDS 3.0 & ICD-10-CM DIAGNOSIS CODING
- ❑SUBMISSION OF CLEAN CLAIMS: UB-04 CODING

VERIFYING COVERAGE

FOOD FOR THOUGHT: "Could you ever go to any Health Care Provider for Treatment & Care AND expect them to provide you with services IF you do NOT provide them with verification of your "Payer Source"?

TRADITIONAL MEDICARE (FEE-FOR-SERVICE); MEDICARE ADVANTAGE; MSP; VA; TRICARE

VERIFYING MEDICARE COVERAGE

- ❑Provider is required to keep evidence of verification – to show that facility has fulfilled its "Due Diligence" in verifying eligibility. This will also be helpful in appealing under "limitations of liability" - if coverage issues arise.
- ❑Under the Provider Agreement, Facility is REQUIRED to check for **MSP (Medicare Secondary Payer Source)**
- ❑**WHEN TO CHECK THE CWF/HETS:**
  1. **Prior to Admission**
  2. **Monthly BEFORE Billing**
  3. **Resident comes in from the hospital**

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INSURANCE VERIFICATION

MEDICARE ADVANTAGE PLANS:

- ❑ Maybe HMO, PPO, SNP, MSA, PFFS – ***Need to know "What Plan/Policy" the member has.***
- ❑ Verification of Coverage does NOT guarantee PAYMENT
- ❑ Prior Authorization does NOT guarantee PAYMENT

Root-Cause Analysis on why claims are denied or recovered: Missing or NOT Communicating Information regarding Specifics of Insurance Plan from Admissions

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MANAGED CARE CONTRACTS

KNOW THE CONTRACT TERMS:

- ❑**CONTRACT ELEMENTS**
  - o**Payment Options: "How will I get paid?"**
    - ❖Rate Levels
    - ❖RUG based
    - ❖Percent of Charges
    - ❖Case rates
    - ❖Capitation
- ❑**Medical Necessity:** The key issue is "Who decides medical necessity – the Provider or the MA?"
- ❑**Carve-Outs or Exclusions:** Can be NEGOTIATED but will usually need separate "Prior Authorizations" and make sure that you bill them separately.

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MEDICARE SECONDARY PAYER

Situations where Medicare is the Secondary Payer:

- ❑Automobile accident case
- ❑No-Fault accident case
- ❑Worker's compensation case
- ❑Beneficiary is covered under a Group Health Plan

* When in doubt, contact Coordination of Benefits

SUPPLEMENTAL INSURANCE - TRICARE

- TRICARE is a health care program for active-duty and retired uniformed services members and their families that includes:
  - TRICARE Prime
  - TRICARE Extra
  - TRICARE Standard
  - TRICARE FOR LIFE (TFL)

TRICARE

- **TRICARE FOR LIFE (TFL) – TFL provides expanded medical coverage to Medicare-eligible uniformed retirees 65 or older, to their eligible family members and survivors, and to certain former spouses. You must have Medicare Part A and Medicare Part B to get TFL benefits.**
- ***Patient can get 300 more days after Medicare Benefits Exhaust (Day #100) if SKILLED CARE continues.***

Assessing/Anticipating Clinical Needs

- Review Hospital Records
- Identify the presence of Valid Diagnoses to ensure appropriateness of SNF Placement
- Determine the need for Daily Skilled Services
- Complete the "PDPM Ballpark Projections Questionnaire" (See attached Hand-out)
- Use NTA Checklist to identify Conditions and Treatments
- Review Medications – Price Quote

Assessing/Anticipating Clinical Needs

- ❑Determine if any special equipment(s) or devices required
- ❑Any indication of need for further treatment/diagnostics?
  - Excluded services through CB
- ❑Project 5-day RUG Levels for each of the 5 PDPM Case Mix Components

Admitting the Resident

- ❑Communicate admission and special needs to appropriate staff
- ❑Communicate with family Medicare coverage requirements.
- ❑If covered for rehab, strongly enforce participation to continue coverage
- ❑If any doubt related to Medicare eligibility; treat as Medicare until questions resolved.
- ❑Determine Secondary Payor & Discharge Plan

SNF STAY: SUPPORTING DOCUMENTATION & INTERVIEWS ARE CRITICAL TO PROPERLY CODE THE 5-DAY MDS

- ❑Establish ARD for 5-Day MDS.
- ❑Interdisciplinary Collaboration to obtain proper documentation for Accurate Diagnosis Codes. QUERY the Physician as needed.
- ❑Collaboration between Rehab and Nursing to establish resident's "Usual/Baseline Performance" – supported by documentation
- ❑Ensure Daily Skilled Documentation to support continued Medicare A Coverage

Include in Daily Morning Meetings

- ❑Communication of any changes in Part A days available or co-insurance dates
- ❑Opportunity to discuss new admissions
  - oEstablish initial treatment plan
  - oSet goals
  - oOrganize communication with resident and family
  - oGuarantee that facility will NOT bill Default *"ZZZZZ" (for sleeping behind the wheel) – SET ARD FOR 5-DAY MDS PROMPTLY!*

UTILIZATION REVIEW MEETING

- ❑Conduct meeting at least weekly
- ❑All necessary disciplines should attend the meeting: MDS Coordinator, Rehab, Billing, Admissions, SS, Nursing, Administrator
- ❑Utilize a comprehensive form that contains pertinent information relevant to resident's coverage.
- ❑GOAL: To ensure that reimbursement is maximized and potential provider liability is avoided or minimized.

Guidelines for Utilization Review Meeting

Goal: IDT will manage the beneficiary's treatment plan & coordinate discharge plan.

- ❑Treatment planning
- ❑Clinical review of current needs/progress
- ❑Update diagnoses
- ❑Track Certification/Re-Certifications
- ❑Update Care Plan
- ❑Discharge Planning
- ❑Track Denial Notices

Guidelines for Utilization Review Meeting

- ❑ Review and organize skilled documentation from:
  - Nursing
  - Therapy
  - Social Services
  - Dietary
  - Care Planning
- ❑ Documentation planning
  - Coordinate IDT information so that it supports the need for both Skilled Nursing and Rehab Services if provided.

Documentation

- ❑ Review of skilled services- explain why services are needed (pertinent for both Nursing and Rehab)
- ❑ Summarize resident's response to treatment
- ❑ Include review of any changes in condition
- ❑ Identify barriers, issues preventing progress
- ❑ Update Care Plan as indicated
- ❑ Update Goals/Plans for skilled services as indicated

CASE MIX

THE ESSENCE OF CASE MIX:

You get paid for the amount of services and resources utilized to care for the resident.

KEY: EDUCATE NURSING STAFF ON CAPTURING SERVICES THROUGH DOCUMENTATION

- If it's not written, it was not done.
- Focus on the payment drivers.
- Justify staff's existence & justify the resident's stay in a SNF.

CONSOLIDATED BILLING

- ❑ CONSOLIDATED BILLING SERVICES
- ❑ Educate nurses on Consolidated Billing Exclusions
- ❑ Ensure that the Billing Office is aware of the Major Category Exclusions and how to use the "Medicare-Fee-Schedule Look-up"

MDS 3.0 & ICD-10-CM DIAGNOSIS CODING

"We need to focus & understand this. This will be our "niche" to success."

DOCUMENTATION TO SUPPORT CODING AND CLAIM

- ❑ **Medical Records Must support codes**
  - o Review all available records to determine appropriate assignment of ICD-10-CM Codes.
    - ➢ Hospital H&P and Records
    - ➢ Discharge Summary
    - ➢ Physician/NP Progress Notes
    - ➢ Consultation Notes
    - ➢ Physician/NP Orders

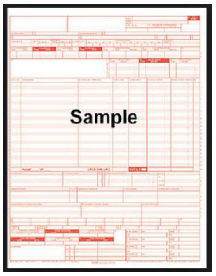
DOCUMENTATION TO SUPPORT CODING AND CLAIM

- **Medical Records Must support codes**
  - Justifying medically necessary services depends on specificity of diagnosis coding
  - Coding MUST be supported in the medical record
  - Under Audit, use of a "Default" or "Unspecified" code is acceptable ONLY if there is no additional documentation in the record that supports a more specific code which should have been used.
  - With that, MD's will need to provide more specificity when known

SUBMISSION OF CLEAN CLAIMS

UB-04 CODING

UB-04: FORM (Front)



UB-04: (Back) ATTESTATION

- *"The Submitter of this Form Understands That Misrepresentation or Falsification of Essential Information as Requested by this Form, May Serve as the Basis for Civil Monetary Penalties & Assessments and May Upon Conviction Include Fines and/or Imprisonment Under Federal and/or State Law(s)."*

TRIPLE CHECK PROCESS

- ❑UB-04 = MDS = MEDICAL RECORDS
- ❑Review all information that are going into the UB-04 prior to Billing

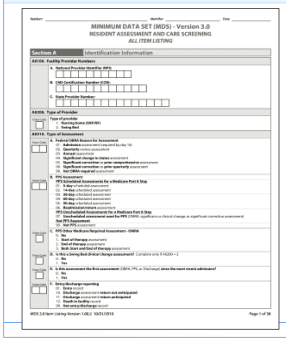
"The Proof is in ~~the Pudding~~ CODING" (supported by Documentation)

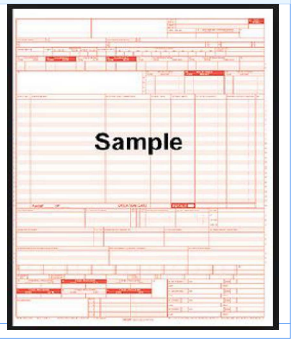
- ❑The **Claim Form (UB04)** communicates the type of care you are billing Medicare for.
- ❑The **MDS** and the **Medical Record Documentation** must support the claim.

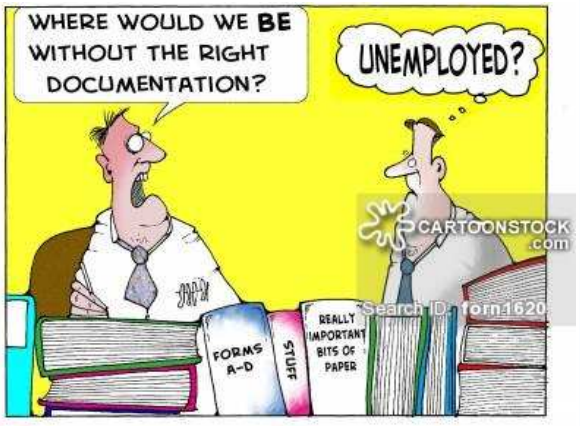
DEFINITION OF TRIPLE CHECK

- ❑**ICD-10-CM CODING:** Will be Key to Success
  - oRequire the skills of "Clinically astute" professionals who appreciate & understand "Transitions of Care"

MOST IMPORTANT DOCUMENTS FOR PAYMENT: MDS & UB-04


MINIMUM DATA SET (MDS) - Version 3.0
RESIDENT ASSESSMENT AND CARE SCREENING
ALL ITEM LISTING





THE END

"After careful consideration of all 437 charts, graphs, and metrics, I've decided to throw up my hands, hit the liquor store, and get snockered. Who's with me?!"

F10.10 – ALCOHOL ABUSE, Uncomplicated

RESOURCES

- www.cms.gov
- www.ahca.org
- www.hcanj.org
- www.aanac.org
- www.oig.hhs.gov
- www.novitas-solutions.com
- www.ngsmedicare.com
- www.noridian.com
- www.wps.com
- **Medicare Benefits Policy Manual Chapter 8**
- **Medicare Claims Processing Manual Chapter 6**
- **Medicare Program Integrity Manual Chapter 3**
- **Medicare Program Integrity Manual Chapter 6**