BerryDunn

Medicare reimbursement checklist

Skilled Nursing Facility (SNF)Medicare A reimbursement rates

The Centers for Medicare and Medicaid Services (CMS) updates SNF reimbursement rates and Value-Based Purchasing Program (VBP) Incentive Payment Multipliers (IPM) annually. This update is effective October 1, 2023. Providers must update their billing system setup (both charges and contractual allowance adjustments) to help ensure the correct rates are billed and Medicare A payments are reconciled.

This checklist is designed to help you achieve uninterrupted cash flow, prevent costly write-offs, maximize reimbursement opportunities, and strengthen regulatory compliance. We have included links to help your team gain a deeper understanding of Medicare reimbursement complexities.

The SNF Patient Driven Payment Model (PDPM) update for FFY24 includes:

- A 4.0% net payment rate increase for SNFs
- Updates to the ICD-10 code mapping used under the PDPM
- Consolidated billing exclusions for marriage and family therapists and mental health counselors stemming from the Consolidated Appropriations Act of 2023

Your SNF revenue cycle team (including admissions, nursing, and business office staff) should be very familiar with the PDPM basics and understand how SNF reimbursement is calculated to help ensure payment drivers are clearly documented in the patient's record and included in the Minimum Data Set (MDS) assessment and billing rates are correctly set in the accounting and billing software to produce accurate claims. In addition, SNF consolidated billing requirements should be considered in SNF patient stay management to balance patient recovery needs and the facility's bottom line.

For more information on the rule, you can access:

- The Final Rule, CMS-1779-F at cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/list-federal-regulations/cms-1779-f
- The CMS-1779-F fact sheet at cms.gov/newsroom/fact-sheets/fiscal-year-fy-2024-skilled-nursing-facility-perspective-payment-system-final-rule-cms-1779-f?mibextid=Zxz2cZ
- The ICD-10 and other coding revisions at cms.gov/training-education/medicare-learning-network/newsletter/2023-09-28-mlnc#_Toc146695258
- The SNF consolidated billing at cms.gov/medicare/coding-billing/skilled-nursing-facility-snf-consolidated-billing

Checklist

SNF PDPM FFY24 updates	Why it matters	Resources
1. Update your facility's Medicare billing rate for FFY24	Remember the final PDPM rates should reflect variable per diem adjustment factors for physical therapy (PT), occupational therapy (OT), and non-therapy ancillary (NTA) components, based on the length of a patient's stay.	Access our Prospective Payment System (PPS) rate calculator at berrydunn.com/pps
2. Update Medicare contractual allowances and patient copays for FFY24 *Sequestration is currently 2%.* *The Medicare A copay, effective on October 1, 2023 (days 21-100), is $200 per day.* *IPM for VBP is facility-specific.*	Updates of Medicare co-pay amounts, sequestration-related reduction of payment, and VBP adjustment are needed to generate a correct Medicare claim and patient bill and to reconcile reimbursement received from CMS.	
3. Carefully review your November accounts receivable (A/R) reports	As your facility receives and posts payments for October 2023 claims, carefully review your accounts receivable report to help ensure your rates, contractual adjustments, sequestration, and IPM/VBP adjustments are set up correctly and A/R balances are correct. Balances in increments of $200 will most likely indicate an incorrect number of patient co-insurance days, while smaller balances will most likely indicate incorrect contractual adjustments related to VBP or PDPM rates.	For more information on how to approach the analysis of your facility's A/R Reports, please visit our website. Read our A/R segmentation article at berrydunn.com/segment
4. Develop a plan to identify and resolve rejected or denied claims quickly *Review and update your written checklist to help billing staff identify and resolve rejected or denied claims promptly.*	Facilities may experience a much higher volume of claims requiring prompt attention due to Medicare Beneficiary Identifier (MBI) and ICD-10 coding changes. Encourage your billers to generate pull communications (using available reporting tools on insurance portals) to review claim status and resolve any unpaid or suspended claims promptly. This is usually a quicker process than waiting for a push communication (remittance advice) to identify unpaid claims. Reworking rejected claims may help your cash flow.	Read our collections article at berrydunn.com/ar

Other Medicare reimbursement optimization tips

	Why it matters	Resources
1. Revive your triple check meetings *Medicare triple check is one of the most effective quality assurance tools for SNFs. The purpose of this meeting is to encourage communication and effective documentation and help prevent false claims.*	With the changes in MDS schedules and updates of the ICD-10 coding effective October 1, 2023, triple check is a necessary compliance step in patient classification assessment and claims review prior to submission to help ensure a consistent, well-supported, accurate claim. While the MDS coordinator, biller, therapy, and nursing department representatives are the key participants in the meeting, it may be helpful to include medical records, nursing administration, and facility administration departments.	Access the SNF billing reference at cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/EnrollmentResources/provider-resources/snf-billing-reference
2. Review all patient records for the updated MBI *MBI is required for all SNF Medicare A and B claims for dates of service starting January 1, 2020. Due to a breach in 2023, about 40,000 Medicare beneficiaries will get a new MBI.*	To help prevent claim denials and interruptions in cash flow, make sure to ask the beneficiaries for their new Medicare cards and have a process for regularly validating Medicare eligibility.	Access the MBIs overview at cms.gov/training-education/partner-outreach-resources/new-medicare-card/medical-beneficiary-identifiers-mbis Access details about the breach at cms.gov/training-education/partner-outreach-resources/new-medicare-card/providers-office-managers
3. Medicare Utilization Review (UR) meetings and special areas reimbursement *For many facilities, the SNF VBP program and related IPM (increase or reduction of the reimbursement rate) have led to increased costs resulting from efforts to improve clinical outcomes and increases in physician or medical director involvement in UR management.*	Medicare UR is a meeting to coordinate patient care needs and successful discharge planning. This meeting is usually attended by the medical director or their designee (PA, NP). CMS reimburses facilities through the cost report for expenses related to the medical director's participation in UR. As facilities are incentivized to lower preventable hospital readmissions, we recommend maintaining meeting attendance notes to help support reimbursement requests.	Access our UR checklist at berrydunn.com/ur-checklist Access the provider reimbursement manual at cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929
4. Review compliance with Medicare bad debt requirements (special reimbursement areas) *Even with the most robust Medicare collections system, sometimes patients are unable to pay Medicare A copays for their SNF stays days 21-100. Some state Medicaid programs do not make payments toward Qualified Medicare Beneficiary (QMB) copays.*	CMS reimburses SNFs 65% (less sequestration) of the eligible Medicare bad debt written off during the cost report (fiscal) year, regardless of the dates of services. We recommend reviewing write-offs for inclusion on the Medicare cost report and maintaining required support.	Access our Medicare bad debt checklist at berrydunn.com/bad-debt

5. Update your schedules to submit mandatory Medicare reports

CMS requires SNF providers to submit additional reports, including:

1. Quarterly Medicare credit balance reports

2. No-pay (information only) claims for the beneficiaries who drop to a nonskilled level of care and remain in a Medicare-certified area of the facility; "shadow" (information only) claims for Medicare Advantage beneficiaries.

We recommend educating your organization's revenue cycle team on Medicare reporting requirements. Management should regularly review compliance as a part of the quality assurance efforts.

Access the Medicare credit balance reporting requirements at cms.gov/medicare/cms-forms/cms-forms/downloads/cms838.pdf

6. Understand your corporate compliance requirements

As defined in the 42 CFR §483.85, an SNF's compliance and ethics program, at a minimum, must have eight required components. Organizations operating five or more SNFs have additional mandatory requirements, such as designating a compliance officer and mandatory annual training.

Compliance with these rules is required to avoid civil money penalties and regulatory compliance survey F895, F867, and F946 findings.

Access the SNF rules of participation with Medicare at berrydunn.com/rules

Access the revised long-term care surveyor guidance at cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/revised-long-term-care-surveyor-guidance

Listen to our compliance and ethics program podcast at berrydunn.com/compliance-program

7. Assess your responsibilities based on the 5-Claim Probe and Educate Review

The 5-Claim Probe and Educate Review program, effective on June 5, 2023, is designed to help SNFs better understand billing under the PDPM. SNFs that have errors identified from the review will be offered education to help avoid future claim denials and adjustments.

While this program is focused on education, providers need to understand how the Medicare claims review will impact their operations.

Read the 5-Claim Probe and Educate Review article at berrydunn.com/5-claim

Access the 5-Claim Probe and Educate Review initiative overview at cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medical-review-and-education/skilled-nursing-facility-5-claim-probe-and-educate-review

8. Review your Program for Evaluating Payment Patterns Electronic Report (PEPPER) annually *PEPPER summarizes provider-specific Medicare data statistics for services vulnerable to improper payments.*	This report is critical for any provider type and should be a part of your organization's compliance program, as it will help identify outliers for these risk areas. While PEPPER was developed as a compliance tool, an analysis of the data in the report can identify opportunities for revenue cycle optimization.	BerryDunn's PEPPER checklist offers insights and tips on how to work through the report and leverage information to better position your facility for optimal reimbursement and stronger compliance. Access the checklist at berrydunn.com/pepper-checklist
9. Review the Changes to Civil Money Penalties (CMP): Waiver of Hearing, Reduction of Penalty Amount (§ 488.436) *CMS is streamlining an administrative procedure by adopting a constructive waiver process that will consider a facility to have waived its hearing when CMS does not receive a request for a hearing within the requisite time frame. There is a 35% penalty reduction; however, CMS is committing to review the appropriateness of this policy and the reduction amount in the future.*	While a CMP 35% reduction may be welcome news for some SNFs, organizations need to carefully consider the implications of accepting CMP and waiving an appeal hearing. More importantly, lack of timely attention to the resolution of underlying non-compliance may result in an ongoing assessment of CMP and other non-compliance consequences.	Access the Medicare program overview at federalregister.gov/public-inspection/2023-16249/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities

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