

PDPM is here. Now what? Find out with our checklist.

Changes in the Skilled Nursing Facility (SNF) Medicare reimbursement environment do not stop at the payment model upgrade.

WHY THIS MATTERS

At times providers are so focused on managing and mitigating risk of the biggest change in reimbursement in decades that many other important aspects of financial planning shift to the “back burner” and do not get enough attention.

We created this checklist to assist you in achieving uninterrupted cash flow, preventing costly write offs, and maximizing reimbursement opportunities. In our easy-to-use checklist, we have included links to help your facility’s team gain a deeper understanding of Medicare reimbursement complexities.

Test your readiness here.

- Familiarize your staff with the Final Rule for FFY 2020 SNF Prospective Payment System (PPS) and consolidated billing.**
The Final Rule, published in the Federal Register August 7, 2019, provides updates beyond PPS payment rates and the Value-Based Purchasing Program (SNF VBP). Revisions to the definition of group therapy, assessment schedules, requirements for the SNF Quality Reporting Program (SNF QRP) and other items are covered and are essential for your team to be familiar with.

Learn more:

- BerryDunn’s [summary of the Final Rule](#)
- [Full document](#) from the Federal Register

- Update your facility’s Medicare billing rates.**
Remember the final 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.

Learn more: CMS [variable per diem fact sheet](#)

Review and update your facility's Medicare Value-Based Purchasing Adjustment.

During the CMS SNF VBP Program Performance Score Report Teleconference on Tuesday, August 27, 2019, CMS notified providers of a potential error in calculating their FY2020 value-based purchasing adjustment. CMS estimated **14% of providers' reports had errors** in calculation of their readmission rate. Revised files are now available through the CASPER reporting system.

CMS reported 72% of SNFs had Incentive Payment Modifier (IPM) <1, earning a net negative incentive adjustment (rate reduction). The VBP IPM applies to all SNF inpatient claims covered by Medicare as of October 1, 2019.

VBP adjustment application notes:

- If a provider report shows "dashes" instead of numbers, the provider is a low utilization provider with 25 or less Medicare discharges in a year, and the IPM is 1 (exempt from VBP adjustment). VBP adjustment (IPM) is not-patient-specific, and does not apply to individual MDS/assessments;
- VBP adjustment (IPM) only applies to SNF Medicare A (inpatient) claims;

IPM applies to the federal per diem rate similarly to sequestration, as an adjustment to the overall Medicare payment to providers (not a part of claim submission).

Learn more: CMS [PDPM FAQ summary](#)

Understand how the PDPM payment is calculated for HIV/AIDS patients.

The PDPM includes specific provisions to help ensure that it accounts for the increased costs associated with caring for SNF patients with HIV/AIDS.

Learn more: CMS [SNF patients with HIV fact sheet](#)

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 changing payment drivers and a new added complexity of ICD-10 codes ranking to support patient classification, triple check is a necessary compliance step in assessment and claims review prior to submission. In addition to the MDS coordinator, biller, therapy and nursing department representatives, we recommend engaging medical records, nursing administration and facility administration.

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- **Consider attending utilization review meetings.**
Medicare utilization review is a meeting where your facility's team coordinates patient care needs and plans for successful discharge. This meeting should be attended by clinical, nursing administration, therapy, social work and administration departments to help ensure patient needs are met, and the facility captures all reimbursement opportunities. Medicare reimburses facilities (through the cost report) for expenses related to the medical director's participation in utilization review. As facilities are incentivized to lower preventable hospital readmissions (see VBP adjustments section above), we recommend inviting your facility's medical director to participate in this meeting.
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- **Update your reference file for Consolidated Billing (CB) exclusions.**
SNFs can avoid high-cost consolidated billing claims by screening patients' needs prior to admission, better coordinating care with attending physicians and families, and ensuring community service providers are aware of a patients' Medicare A SNF stay status and your facility's billing requirements. At BerryDunn, we strongly recommend a refresher training on consolidated billing impact to your facility's reimbursement cycle to your administrative team at least annually.

Learn more:

- Program basics
CMS [Consolidated Billing background](#)
 - Sample notices, claim processing instructions "Under Arrangement" forms
[Best practices guidelines](#)
 - Up-to-date listing of [CB excluded HCPCS codes](#)
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- **Review all patient records for the new Medicare Beneficiary Identifier (MBI).**
The transition period, when either the Health Insurance Claim Number (HICN) or the MBI could be used to file a Medicare claim, ends on December 31, 2019. Claims submitted to Medicare Administrative Contractors (MAC) on or after January 1, 2020, **will be rejected** if the MBI is not provided.

Learn more: CMS [MBI overview](#)

- **Develop a plan to identify and resolve rejected and denied claims fast.**
Have a written checklist to help your staff identify and resolve rejected or denied claims promptly. Facilities may experience a much higher volume of claims requiring prompt attention due to 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.

Learn more: BerryDunn's [six steps to gain speed on collections](#)



Review compliance with Medicare bad debt requirements.

On April 4 of this year, CMS reminded providers claiming Medicare bad debt that they should meet 42 CFR 413.89 and all requirements from Chapter 3 of the [Provider Reimbursement Manual](#). For all cost reporting periods beginning on or after October 1, 2019, Skilled Nursing Facilities must comply with these longstanding Medicare bad debt requirements in order to receive reimbursement. In addition to required claim-level supporting documentation, your facility should correctly classify unpaid deductible and coinsurance amounts for Medicare-Medicaid crossover claims in accounting records.

Providers are reminded to not write off such claims to a contractual allowance account, and to charge uncollected cross-over co-insurance to an expense account for uncollectible accounts (bad debt).



Update your schedules to submit mandatory reports.

Providers are required to file:

- Quarterly Medicare credit balance reports;
- Submit no-pay (information only) claims for the beneficiaries who drop to a nonskilled level of care and remains in a Medicare-certified area of the facility;
- Submit “shadow” (information-only) claims for Medicare Advantage beneficiaries.

CMS [form and provider instructions for credit balance reporting](#)

Learn more: Medicare Learning Network [SNF billing reference](#) (pages 13 and 17)



Carefully review your October and November accounts receivable reports.

As your facility receives and posts payments for October claims, carefully review your accounts receivable report to ensure your rates, contractual adjustments, sequestration and IPM/VBP adjustments are posting correctly.

Learn more: BerryDunn’s [tips on how to segment accounts receivable reports](#) and use them to understand where you are

HOW WE CAN HELP

Find this and other revenue cycle resources at berrydunn.com/senior-living. Contact the senior living team if you are looking for guidance with your Medicare billing checkup:

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