Payment bans: Managing the procedure

No facility wants to experience a payment ban, which halts Medicare Part A payments for new admissions and is typically caused by an immediate jeopardy F-tag citation.

Handled improperly, a payment ban can be a reimbursement and public image nightmare for a SNF. Consequently, should a facility find itself facing a possible ban on payment, it's vital to be prepared to handle the necessary procedures and the required responsibilities.

The better a SNF is equipped to handle the challenges that result from a payment ban, the easier it can navigate any complications and the quicker the facility can work through the ban to return to normal reimbursement standing with Medicare Part A.

A ban will not be lifted by CMS until the SNF can prove that it is up to code. That could take as little as a day or two, or as long as a few months, says **Theresa Lang,** vice president of clinical services at Specialized Medical Services, Inc., in Milwaukee.

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A quick turnaround

If a facility is cited for a quality-of-care or a quality-of-life issue during a state survey, the threat of a payment ban may be imminent.

The state agency will send a letter to the SNF notifying the facility that a ban on payment will go into effect on a certain day, often 30 days from the citation.

The facility then must submit a plan of correction (an explanation of what actions will be taken to correct the problem), which must include a date certain—the date that the SNF says it will be in compliance by, Lang says.

> **"When you should be working on fixing the quality-of-care issue that you have … now you've created a billing and an administrative paper nightmare that could take you months to get out of."**
>
> *—Theresa Lang*

Next in the process is a return visit by the survey agency, which will resurvey the facility to make sure there are no new issues and to verify that the problem that caused the citation has been fixed.

"As long as the survey agency gets out prior to that ban on payment date, there usually aren't any problems because the facility knows they had a resurvey and they are back in compliance by the date," Lang says.

In these situations, the ban will not have an effect on the SNF's Part A reimbursement. However, the process doesn't always go so smoothly.

The process predicament

A facility must respond to the initial letter right away in order for a quick turnaround to take place. More importantly, the SNF has to follow through. "If your plan of correction looks great on paper, but you're not

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Payment bans

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institutionalizing it or putting it in place in the facility, that's when a payment ban typically happens," says **Karen Connor**, president and CEO of Connor LTC Consulting in Haverhill, MA.

Outside complications can also lead to the ban taking effect. Communication between the survey agency, the fiscal intermediary (FI) or Medicare administrative contractor (MAC), and CMS is not always immediate.

The survey agency sends a copy of the initial letter to CMS, who forwards it on to the facility's FI or MAC, Lang says. Upon receiving the notification, the FI or MAC automatically adds the ban into the Medicare system as of the date the letter stated the ban would go into effect. This takes place even if the survey agency returned to the SNF, completed its resurvey, and determined that the facility was back in compliance, according to Lang.

A second letter sent out by the survey agency then acknowledges that the SNF is in compliance and the ban on payments can be removed. But delays in communication can leave a facility in a bind even after a satisfactory resurvey has taken place.

"In between there, you have people who are having payments withheld by Medicare because of that gap in time," Lang says.

SNFs can also find themselves in a process predicament if the survey agency doesn't return for the resurvey until after the predetermined payment ban date. In those situations, the SNF should give written notice to all residents admitted after the ban was initiated that the facility was in a ban on payment, Lang says.

Notifying residents and no-pay billing

The written notice that facilities must provide to new admissions is a patient liability notice, which explains to the potential resident that the SNF is in a Medicare Part A payment ban. The notice should describe what a payment ban entails.

The patient liability notice is intended to inform any new residents of the SNF's current standing with Medicare; however, the liability notice also serves a financial purpose.

"If a beneficiary who pays privately for coinsurance signs the patient liability form, then the facility is able to collect the copayment amount from that resident," says Connor.

If a facility thinks it will be off the ban within a few days to a week, it may choose not to use the patient liability notice because it is willing to take the risk of not getting payment on the new admissions that have occurred, she adds.

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Regardless of the length of the ban, SNFs must complete no-pay bills for everyone that's admitted during the ban on payment.

"You have to show Medicare they were in your facility, but you're not going to get paid for it because you're on a payment ban," Lang says. "Once the ban is lifted, then all of those residents will start all over with a new admission date, and the billing process starts all over again—new Medicare five-day, 14-day, 30-day assessments."

Facilities are not permitted to bill Part B for ancillaries as a substitute for billing Part A during a ban, which Connor says she has seen take place due to confusion over particular services.

If the resident is admitted as skilled under Part A, facilities cannot bill any services to Part B unless those services actually fall under the Part B criteria.

It is important to note that SNFs can continue to bill (and get paid for) Part A residents admitted prior to the ban. However, a resident who leaves during the ban, goes to the hospital, and returns to the SNF with a new set of benefits is technically a new admission according to Medicare, Lang says. "If the facility has not been doing its no-pay and its benefit exhaust claims, Medicare didn't know they were in the facility before [the ban went into effect]," she says. "It's one more reason these no-pay and benefit exhaust bills are so critical." ■

Managing the procedure: Helpful hints

It's true that handling a payment ban can be very stressful, difficult, and time-consuming. But facilities can take the following steps to best manage the procedure while simultaneously improving internal practices:

- **Make it a group effort.** If a SNF is going to get through a payment ban as painlessly as possible, everyone needs to be invested in the effort, and communication needs to be open. Upon getting an immediate jeopardy F-tag, communication between the billing office, the clinical staff, and the administration must be top-notch, says **Theresa Lang,** vice president of clinical services at Specialized Medical Services, Inc., in Milwaukee. "What happens a lot of times is that the administrators are not sharing the payment ban information with the staff, and the staff don't know about it until the billers start to bill and they get the error codes back saying they're in a payment ban," Lang says. "I understand why sometimes administrators don't want everybody to know—they don't want the whole community to know; they don't want the newspaper to pick up on it. But in the process, if the billing office, the MDS staff, and the administrator aren't all aware of what's going on, it just creates chaos. When you should be working on fixing the quality-of-care issue that you have and the resident safety issue that you have or whatever, instead, now you've created a billing and an administrative paper nightmare that could take you months to get out of."
- **React quickly and be thorough.** As soon as a deficiency is pointed out by the survey agency, a facility should focus on getting up to code as soon as possible. The quicker a SNF is back in compliance and a plan of correction is submitted to the survey agency, the greater the chance of an immediate resurvey, which could result in a quick turnaround and an avoidance of the payment ban altogether. But quickness alone won't do it. "Whatever you put in your plan of correction, make sure you do what you say you're going to do," Lang says.
- **Reach out.** Being able to efficiently manage the payment ban procedure is contingent on when the ban will be lifted, which is a why a staff member should start networking with Medicare as soon as possible to determine when the ban will be over. The sooner a SNF has that information, the better off it will be, says **Karen Connor,** president and CEO of Connor LTC Consulting in Haverhill, MA.
- **Delay bill submission.** If a SNF finds itself still waiting for a resurvey after the day the ban on payment is scheduled to start, the facility may want to delay any billing between when the payment ban began and when the resurvey occurred. "Hold it and delay it until there can be a processing time period to get all of the edits lifted," Lang says. It's also a good idea to submit one claim at a time, she adds. If an entire batch of claims is denied, it only adds to the SNF's troubles.

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The Part D process: Where billers fit in

Filing Medicare Part D claims may not be the primary responsibility of the billing office, but that doesn't mean SNF billers can afford to be out of touch with the regulations and processes of Part D. In fact, facilities can benefit financially, and in terms of resident care, from billers who possess a thorough understanding of Part D.

Part A includes medication coverage. But for those residents who are not in a Part A stay, Part D benefits are relied on heavily.

"Part D is the payer for medications for most nursing home residents, so it's a big deal," says **Joseph Gruber, RPh, CGP, FASCP,** vice president and clinical products specialist at Mirixa, a medication therapy management provider headquartered in Reston, VA. "It's not just a billing issue, it's a facility issue."

Because of its widespread use and the variety of plans available, Part D is an instrumental aspect of day-to-day life in a SNF. As a result, it affects all staff members. In gaining familiarity and comfort with Part D, a staff member can contribute to the overall well-being and possible improvement of a facility.

For billers, the difference between understanding and not understanding Part D can have a substantial monetary effect on the SNF.

"The biller may not have a technical billing issue, but if they get into a situation where they haven't thought through the medication cost issues properly, then obviously it's a financial issue," Gruber says.

Making an effort to get to know available Part D plans, maintaining a proactive approach, and staying on top of residents' coverage allows billers to help the facility avoid unnecessary losses.

They can also alert residents of changes to their drug coverage status and could even save residents money by suggesting more affordable options, as long as they are in compliance with the Medicare Prescription Drug, Improvement and Modernization Act of 2003, which restricts providers from steering residents toward plans that serve the financial interests of the facility.

Beginner basics

The first task billers can undertake to jump-start their comprehension is completing some basic research to gain a foundation-level understanding of Part D. Billers should seek answers to the following questions:

- What is the purpose of Part D?
- How does Part D work in terms of process?
- Who is eligible for Part D coverage?
- Who offers Part D coverage?
- What types of Part D plans are available to SNF residents?
- How can I tell whether a resident is on a Part D plan?

In order for a biller to eventually develop a thorough understanding of Part D's place in SNFs, being able to answer these questions is a critical first step. This will make it easier for billers to differentiate between the various Part D plans available to residents.

"Every plan is different, and everyone is on a case-by-case basis too," says **Josh Banach, CPA,** senior healthcare associate at FR&R Healthcare Consulting, Inc., in Deerfield, IL.

Those plans vary in terms of size and scope. Some are available nationally, whereas others are strictly regional. It's important for billers to be familiar with the preponderance of plans in their area because it gives them the chance to open the lines of communication with the pharmacies, says Gruber.

"Facility billers need to be buddies with the pharmacy billers. They all have to be talking back and forth," he says.

Know the benefits, know the coverage

If a resident enters a SNF under a Part A stay, the resident's medication coverage lasts only as long as his or her Part A benefits. Once those benefits expire with the resident still in the facility, it's likely that he or she will seek drug coverage through Part D.

"So as the calendar clicks down, we know that person is going to go from A to D," Gruber says. "So when

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is that happening? Have they signed up for a plan? What plan are they going to choose?"

It's worthwhile for billers to keep track of this information, Gruber says. They could establish an informal policy in their SNF where four weeks before a resident's Part A benefits are exhausted, the facility needs to begin taking action to help the resident find a new plan, he says. "At that point, within the guidelines that CMS allows, the pharmacy and the nursing facility can work with that resident or the resident's responsible party," Gruber explains.

Facilities will want to point out what medications the resident is taking, what plans are available through Part D, and what plans the pharmacy accepts.

Facilities and/or pharmacies can assist the resident in reviewing the formulary for each plan to see how it aligns with the medications the individual needs. It may not be exact, but a plan can usually be found that best matches the formulary.

"The guidance can be given, but it's a little bit of a sticky area," Gruber adds. "CMS, in wanting to advocate for beneficiaries and not have them inappropriately directed to specific plans that perhaps are financially beneficial to the nursing home chain or a pharmacy chain, has put some pretty strict guidelines in place about to what extent the pharmacy and the nursing home facility can offer assistance."

The information about plans offered by the pharmacy and/or the facility has to be fair and balanced, says Gruber. "You can't just walk in and say, 'Hi, we're XYZ nursing home. We deal with XYZ pharmacy, and they take these two Part D plans. Pick one.' "

Constant communication

Like so many other aspects of providing care in a SNF, when it comes to efficiently managing residents' medication coverage, communication is critical.

This is especially true with residents whose benefits shift from Part A to Part D. The billing office, the clinical staff, and the pharmacy all need to be on the same page with each resident.

When a facility notifies the pharmacy that a resident's coverage status has changed to a Part D plan, the pharmacy will switch its billing codes to correspond with the change, Gruber says.

If the clinical staff at the SNF isn't notified of the resident's adjustment in medication coverage, a previously Part A–covered medication may not be on the Part D plan's formulary. Then the issue centers on who will pay for that medication. In the end, Gruber says, the responsibility rests with the facility.

"With the *Conditions of Participation* for CMS, they can't deny medications to their patients," he says. "They have to, some way or another, get it cleared up."

Most pharmacies now make a point to state in their contract that if there are discrepancies when it comes to payment, the SNF is ultimately responsible, Gruber adds.

By sharing necessary information throughout departments, the facility as a whole will be in tune with residents' coverage issues. As a result, facilities will be able to avoid those discrepancies altogether and instead focus their Part D efforts on what matters most: the residents.

Resident rights

It is important for billers—in fact, all staff members—to remember that residents have the final say in regards to which Part D plan they select.

"The main right that the residents maintain with Part D is that they have the right to ultimately choose which Part D plan they go with. No one can choose it for them," says Banach. "Anyone in the facility can help them and show them what their options are and lay everything out for them, but they have to make the ultimate decision."

And that decision isn't limited to a set period of time or schedule, Banach adds.

"Any private residents in a nursing home, they can switch at any time," he says. "If they can find a better plan, they can save themselves some money."

Billers, if they are familiar enough with the available Part D plans in their area and the resident's medication needs, may be able to point out a plan that can save the

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Part D

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resident money through the monthly premium, which can be taken out of the resident's fixed income, Banach says.

Dual-eligibles—beneficiaries that qualify for both Medicare and Medicaid coverage—make up the bulk of Part D residents in SNFs and have no copay and no enrollment period, Gruber says. They too can change Part D plans, for which they're eligible, at a moment's notice without any restrictions.

However, Banach points out that a plan that's good for one person is not necessarily good for another person. Subsequently, any discussions between a facility and a resident about changing plans should be based on the resident's specific needs.

Selecting a plan isn't difficult, Banach says. With an accurate list of the resident's prescriptions and dosages, a staff member can use the Medicare Part D Web site to compare up to three plans at a time to find a best-fit option for the resident.

Although assisting residents with this process may not be a common activity for billers, it's a great way to maintain an understanding of Part D.

"If you're a biller in a nursing facility, you're part of the financial structure of the facility," Gruber says. "And if the largest portion of who pays your drug bill in the facility is Part D, I'd think you'd want to have a working knowledge." ■

2010 Medicare Part D national stand-alone prescription drug plans

Data as of September 3, 2009.
Employer sponsored plans (800 series) are excluded.
National is defined as plans offered in all 50 states plus Washington, D.C.

Parent Company	Contract Marketing Name(s)	Contract(s)	Number of "Benchmark" Regions (eligible for autoenrollment)
Aetna Inc.	Aetna Medicare	S5810	20
CIGNA	CIGNA Medicare Rx	S5617	23
Coventry Health Care Inc.	Coventry AdvantraRx, First Health Part D	S0197, S5569, S5670, S5674, S5768	21
CVS Caremark Corporation	SilverScript Insurance Company, RxAmerica	S5601, S5644	15
Health Net, Inc.	Health Net	S5678	17
HealthSpring, Inc.	HealthSpring Prescription Drug Plan	S5932	24
Humana Inc.	Humana Insurance Company, Humana Insurance Company of New York	S5884, S5552	3
Medco Health Solutions, Inc.	Medco Medicare Prescription Plan	S5660, S5983	18
Torchmark Corporation	First United American Life Insurance Company, United American Insurance Company	S5580, S5755	2
UnitedHealth Group, Inc.	UnitedHealthcare, United HealthCare Insurance Company	S5805, S5820, S5917, S5921	27
Universal American Corporation	Universal American	S5597, S5803, S5825	30
Wellpoint, Inc.	Blue MedicareRx, UniCare	S5596, S5960	12

Source: CMS.

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ICD-10 conversion presents opportunities, challenges

Editor's note: The following article and sidebar originally appeared in the January **Medical Records Briefing.**

You may think you have plenty of time to get ready for the conversion from ICD-9-CM to ICD-10-CM/PCS. After all, you don't have to begin using the new codes until October 1, 2013, and that's still four years away. No need to worry about that now, right? Wrong.

"For payers and vendors, and even for big providers who have in-house systems and applications they want to keep, it's past time to get going," says **Rhonda Butler, CCS, CCS-P,** clinical research analyst at 3M in Wallingford, CT. Butler and **Sue Bowman, RHIA, CCS,** director of coding policy and compliance at the American Health Information Management Association (AHIMA) in Chicago, discussed the challenges involved in converting from ICD-9-CM to ICD-10-CM/PCS during the October 3, 2009, AHIMA national convention in Grapevine, TX.

Substantial conceptual and structural differences exist between the two code systems. In fact, the differences are so significant that Butler compared the two coding systems to two different languages. But not everyone realizes how great the changes are.

"It's a tough job to convince the industry that this is a big deal," Butler says.

Health information management staff members can help get their facilities on board by educating those who don't understand the complexities of the switch but need to know how the new systems work.

Conversion choices

Once your facility begins planning for the switch, you need to determine which homegrown systems you have and decide how you are going to convert ICD-9-CM codes to ICD-10-CM/PCS codes in those systems.

One option is to convert ICD-9-CM–based applications at your facility to native ICD-10-CM/PCS applications. Most applications are composed of logical relationships between the lists of codes. This method of conversion involves finding the ICD-9-CM lists embedded in an application and replacing them with equivalent ICD-10-CM/PCS lists. If your facility can do this from a technology standpoint, this is the best way to go, Butler says.

The second option is to develop applied ICD-10-CM/PCS to ICD-9-CM mapping that allows ICD-10-CM/PCS codes you submit to be processed using ICD-9-CM–based applications. In this scenario, the application selects the best choice of an ICD-10-CM/PCS code for the ICD-9-CM code through the use of general equivalence mapping (GEM).

Reimbursement maps allow legacy systems still using ICD-9-CM codes to process claims submitted with ICD-10-CM/PCS codes without converting the legacy system over.

ICD-10-CM/PCS reimbursement maps are available on the CMS Web site. However, CMS is not using the reimbursement map. Rather, the agency is converting its applications to process ICD-10-CM/PCS codes directly.

General equivalence mapping

GEMs are a general-purpose translation aid because it is not possible to have a one-to-one crosswalk from one code system to the other. Instead, GEMs provide a starting point for conversion of ICD-9-CM applications to native ICD-10-CM/PCS applications. But remember that GEMs are just the beginning.

"It's impossible to produce a one-size-fits-all map because the two code sets are very different," Bowman says.

For the GEMs, codes are divided between diagnosis and procedure codes. Two GEMs exist for each type of code. One starts with the ICD-9-CM code and maps to the ICD-10-CM/PCS code, whereas the second GEM starts with the ICD-10-CM/PCS code and maps to ICD-9-CM.

CMS maintains the two GEMs for procedure codes, and the Centers for Disease Control and Prevention (CDC) maintains the diagnosis code GEMs. The GEMs

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ICD-10 conversion

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were created to ensure that consistency in national data is maintained after the transition to ICD-10. These GEMs are in the public domain, and anyone can use them.

CMS and the CDC will maintain the GEMs for at least three years after ICD-10-CM/PCS implementation.

GEMs are helpful tools, but they should not be used in place of ICD-10-CM/PCS. “Mapping is not coding,” Bowman says. “Mapping links concepts in the two systems. Coding assigns the most appropriate code based on the available medical record documentation.”

When you input a code into a GEM, you can end up with multiple possible codes. On the other hand, multiple codes can map back to one alternative.

GEMs can be used to convert multiple databases from ICD-9-CM to ICD-10-CM/PCS, including:

- Payment systems
- Payment and coverage edits
- Risk-adjustment logic
- Quality measures
- Disease management programs
- Financial modeling

Application conversion

GEMs are a sort of all-purpose dictionary—code meaning to code meaning. As such, they can be useful in facilitating conversion of any size or type of application from ICD-9-CM to ICD-10-CM/PCS—the logic of the application is unchanged, and you can take advantage of your knowledge of ICD-9-CM.

When converting your applications, you must decide whether to use replication or optimization. They have different goals and different results. Replication tries to create an ICD-10-CM/PCS–based application that produces essentially the same result as the current ICD-9-CM–based application. You must review the translation because the process is not automatic due to code differences.

Optimization is a way to use the increased detail available in ICD-10-CM/PCS. With optimization, you take an ICD-10-CM/PCS–based copy of your application and look at the meaning of the list of codes. Code editors require optimization because they must be based on the ICD-10-CM/PCS codes.

Data trending challenges

GEMs can be useful in many ways, but they won’t solve all of your data trending problems because the differences in the code sets go beyond changes in code titles or levels of specificity, Bowman says. Other differences include:

- Terminology
- Definitions
- Meaning of a code
- Changes in instruction for code assignment

You must reconcile those differences, and the method of reconciliation will vary. To ensure that you are coding correctly, you need to understand the differences as much as possible, says Bowman.

Some terms may have a different meaning between ICD-9-CM and CD-10-CM/PCS. For example, ICD-9-CM frequently uses the word “or,” which presents a big problem when trying to map codes to ICD-10-CM/PCS, says Bowman. ICD-10-CM/PCS is more detailed; its code descriptions generally do not include the word “or.”

Take advantage of the situation

Facilities face more challenges with this transition than they did with the previous transition from ICD-8 to ICD-9-CM.

However, it’s not all doom and gloom. Bowman says facilities can reduce or eliminate potential problems during the initial transition period with proper advance preparation.

Bowman points out that although there are challenges associated with the transition to ICD-10-CM/PCS, this transition will also provide many opportunities, including:

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- Better data, which will lead to more accurate payment, improved patient safety, and better patient outcomes
- Fewer compliance risks
- Improved clinical documentation and coding accuracy
- Increased administrative efficiencies and reduced administrative costs ■

Four reasons to use general equivalence mapping

General equivalence mapping (GEM) helps bridge the language gap between ICD-9-CM and ICD-10. This is really a translation tool to use while you convert ICD-9-CM–based applications to native ICD-10 applications.

So why should you consider using GEMs?

The following are some reasons **Rhonda Butler, CCS, CCS-P,** clinical research analyst at 3M in Wallingford, CT, believes GEMs are a valuable tool:

➤ **They organize all translation alternatives.** GEMs provide all of the reasonable translation alternatives for the complete meaning of the code you are looking up, and GEMs have different content depending on where you start. For example, not all ICD-9-CM codes are used in the ICD-10 to ICD-9-CM GEM.

➤ **They navigate multiple translation alternatives.** One source system code could produce multiple translation alternatives, all of which are equally plausible. The coder can't always tell which one is the best choice without having the chart in front of him or her.

For example, ICD-9-CM code 94223 (Burn [acid] [cathode ray] [caustic] [chemical] [electric heating appliance] [electricity] [fire] [flame] [hot liquid or object] [irradiation] [lime] [radiation] [steam] [thermal] [x-ray]; blisters, epidermal loss [second degree]; abdominal wall, flank, groin) translates into the following ICD-10 codes:

- T2122xA (Burn of second degree of abdominal wall, initial encounter)
- T2122xD (Burn of second degree of abdominal wall, subsequent encounter)
- T2162xA (Corrosion of second degree of abdominal wall, initial encounter)
- T2162xD (Corrosion of second degree of abdominal wall, subsequent encounter)

The ICD-10 codes specifically include burns (thermal) from electrical heating appliances, electricity, flame, friction, hot air and hot gases, hot objects, lightning, radiation, chemical burns (corrosions, external and internal), and scalds.

In this example, the coder would need to know the cause of the burn to ensure correct coding.

➤ **They identify untranslatable ICD-10 codes.** Some people mistakenly believe ICD-10 is merely an expansion of ICD-9-CM, says Butler. ICD-10 captures types of information not translatable to ICD-9-CM. For example, no equivalent ICD-9-CM code exists for the following ICD-10 codes:

- T500x6A (Underdosing of mineralocorticoids and their antagonists, initial encounter)
- T500x6D (Underdosing of mineralocorticoids and their antagonists, subsequent encounter)
- T500x6S (Underdosing of mineralocorticoids and their antagonists, sequela)

➤ **They manage complex translation.** Some concepts expressed by one ICD-10 code need more than one ICD-9-CM code for a complete translation. The reverse is also true.

Combination codes exist in both code systems, but not always in the same cluster of codes.

For example, ICD-10 code 0273346 (Dilation of coronary artery, four or more sites, bifurcation, with drug-eluting intraluminal device, percutaneous approach) would need the following ICD-9-CM codes:

- 00.66 (PTCA or coronary atherectomy)
- 00.41 (Procedure on two vessels)
- 00.46 (Insertion of two vascular stents)
- 36.06 (Insertion of non-drug-eluting coronary artery stents)

For more information about the GEMs, visit the CMS Web site at *www.cms.hhs.gov* and the Centers for Disease Control and Prevention Web site at *www.cdc.gov.*

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LTC billing IQ

Think you're a long-term care (LTC) billing pro? Test your knowledge of SNF billing by answering the following questions, which are based on the facts and information found in this issue's articles.

1. A Medicare Part A payment ban will not be lifted by CMS until the affected facility can prove _______.
   a. that a resurvey was completed
   b. that it is in compliance with all CMS regulations
   c. that it wrote a letter of apology to new residents
   d. all of the above

2. The cause of most payment bans is _____.
   a. fraud
   b. HIPAA infractions
   c. a quality-of-care or quality-of-life citation
   d. none of the above

3. The plan of correction, which a SNF needs to submit after being notified of a pending ban on payment, must include _________.
   a. the number of residents in the facility
   b. an explanation of what actions will be taken to correct any problems
   c. a date certain
   d. both b & c

4. During a payment ban, facilities are supposed to provide potential new admissions with a patient liability notice.
   a. True
   b. False

5. SNFs do not need to complete no-pay bills for everyone admitted during a payment ban because technically those residents will not be considered "admitted" until the ban on payment has been lifted.
   a. True
   b. False

6. Medicare Part A SNF stays include medication coverage.
   a. True
   b. False

7. CMS issued regulations detailing to what extent a facility/pharmacy can assist a resident in selecting a Medicare Part D plan so that beneficiaries _______.
   a. do most of the work on their own that's required when selecting a plan
   b. are encouraged to seek help from friends and family members
   c. are not directed to only the plans that would financially benefit the facility/pharmacy
   d. none of the above

8. SNF residents are allowed to switch their Part D plans ________.
   a. during the first week in every month
   b. during the month of their birthday
   c. at any time
   d. at any time, but only once per year

9. If your facility is technologically capable, the best option for converting ICD-9-CM codes to ICD-10-CM/PCS codes is by converting ICD-9-CM–based applications at your facility to native ICD-10-CM/PCS applications.
   a. True
   b. False

10. General equivalence mapping is best and most accurately defined as a crosswalk from one code system to another.
   a. True
   b. False

Are you stumped? Wondering if you got the answer? Find the correct answers on p. 12. ■

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BALTC Q&A

Editor's note: This month's "Q&A" was written by ***Lee A. Heinbaugh,*** *president of The Heinbaugh Group, a long-term care consulting company in Lakewood, OH. To submit a question for upcoming issues, e-mail Associate Editor Justin Veiga at* jveiga@hcpro.com.

Q I work for a nursing facility and I am looking for advice to ensure that our records are accurate for billing purposes at the start of each new year. Do you have any suggestions?

A The most common change that occurs first at the start of a new year is Medicare benefit coverage. Most recently I have seen an increase in nursing home residents electing Medicare Part C Advantage plans, more commonly known as Medicare Managed Care plans. Don't be confused by the terminology; just be sure that you have verified who the primary payer is when it comes to Medicare benefits. Billing the wrong payer will delay cash flow.

The easiest way to avoid this issue is to verify the payer using the Medicare online Health Insurance Query Access (HIQA) system, or you may use another system that utilizes this same information. Either way, verifying this information before you bill will be beneficial. Often, the resident or authorized representative does not personally make the change. The change may be because the resident is in a retirement program that has made the decision on behalf of its retirees. The resident or family may not even be aware of the change. I realize that notifications are sent to the retirees, but that doesn't mean they understand what the notification regarding the change means to providers such as your nursing home.

Your facility should be proactive with these types of changes. As I suggested, using the Medicare online HIQA records is the first step, but communication with the financially responsible party is also important. You might want to include a letter with your next invoice mailing to let the individuals know that you are looking for any changes that may have occurred to your residents' insurance coverage and that you would like copies of the new cards. Even without a change in insurance coverage, the billing number and mailing address for claims can change. As I always say, getting copies of the insurance cards is essential to the proper billing and collection process for any business that bills insurance companies for payment of their services.

Understanding nursing home coverage of the new insurance is crucial. I have seen an increase in residents with insurance policies that begin coverage after Medicare benefits have been exhausted. Some require that the resident remain at a skilled level of care. Other policies simply require the resident to reside in a nursing home regardless of the level of care. Investigating and understanding the various insurance coverage issues should be done for every resident.

Verifying benefits and ensuring that the financial file has copies of insurance cards is the only way to ensure that billing is being done properly. If the claim is processed

> *continued on p. 12*

MDS 3.0 is coming!

Let HCPro help you prepare with consulting and custom education programs. Our experts have years of experience in the long-term care industry and are on the cutting edge of MDS 3.0 training. An HCPro consultant can perform a detailed analysis of your facility's operations to help you best prepare for MDS 3.0's impact.

Bring an HCPro long-term care consultant to your facility for help in any of the following areas:

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For more information or a facility-specific needs analysis, contact Client Relations Manager Elizabeth Petersen at epetersen@hcpro.com or 781/639-1872, Ext. 3432.

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BALTC Q&A

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correctly the first time, it should not require any effort in the future from a collections perspective.

Q When we receive payment from coinsurance or managed care insurance companies, they often do not pay the entire amount. What do you suggest in this situation?

A I spend a lot of time reviewing accounts receivable and assisting nursing homes in collections, and I have found this to be a huge issue. I think part of the reason is that one person is doing the billing and another person is posting the deposits. Often, the amount not paid by the insurance company is not being communicated to the person responsible for the accounts receivable collections.

I recommend that when the check is being posted, the person doing the posting should make a copy of the payment paperwork showing the amount of deductible and/or copayment being deducted from the net amount paid and forward that information to the person responsible for the collections of accounts receivable. This way, the amount can be reviewed and the necessary adjustments can be made to the account.

Also, if you are moving this amount to the private-pay account, you now have a copy of the supporting documentation to send with the next private-pay invoice. This will ensure that the accounts remain accurate on a daily basis.

By taking time regularly to compare payments to the amount expected in the accounts receivable and completing the appropriate adjustments, you will find it easier to manage your accounts. ■

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LTC billing IQ answer key

1. **b.** that it is in compliance with all CMS regulations
2. **c.** a quality-of-care or quality-of-life citation
3. **d.** both b & c
4. **a.** True
5. **b.** False
6. **a.** True
7. **c.** are not directed to only the plans that would financially benefit the facility/pharmacy
8. **c.** at any time
9. **a.** True
10. **b.** False

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