

# Billing Alert for Long-Term Care

Volume 17  
Issue No. 1

JANUARY 2015

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## New legislation to promote standardization across PAC heralds major provider IMPACT

The IMPACT Act carries standardized quality measures and assessment criteria for postacute care providers that could set the stage for sweeping payment reform

On October 6, President Obama signed into law an historic bill intended to foster connectivity and collaboration across postacute care (PAC) settings. But although the legislation has been lauded by lawmakers, industry stakeholders, and the public, some providers are wary about the potential burden of the significant changes it bodes for the coming years.

The Improving Medicare Post-Acute Care Transformation (IMPACT) Act (H.R.4994) is intended to standardize key data across four PAC provider types: SNFs, home health agencies, inpatient rehabilitation facilities (IRF), and long-term acute care hospitals. According to **Cynthia Morton, MPA**, executive vice president of the National Association for the Support of Long Term Care (NASL), a trade association for PAC ancillary service providers based in Washington, D.C., the primary impetus for the bill was the dearth of legislation surrounding an industry that’s steadily gaining precedence as it faces a group of older Americans who are living longer with

more complex conditions and seeking PAC services like never before. Of all the Medicare beneficiaries who are discharged from the hospital, 40% transition to at least one PAC setting, and 20% of those who make the transfer are rehospitalized, Morton says.

Fittingly, legislators hope the addition of more comparable data across PAC settings will facilitate improvements to quality of care and discharge planning for this vulnerable patient population, as well as help shape future payment systems based on these criteria—an aim that’s weighing heavily on many providers.

“The idea of making a more standardized patient assessment and being able to gather better data I think is appealing to most people who are working in postacute care,” says **Paul Pitts, JD**, partner at Reed Smith, LLP, a global law firm headquartered in Pittsburgh, Pennsylvania, and lead author of a recent analysis of the act. “[But] I think there’s some anxiety in terms of, how will this in the long term impact payment policy?”

In addition to the intention to usher in large-scale payment reform, the collaborative process used to create the bill—and the ease with which it was passed by a notoriously at-odds Congress—sets the IMPACT Act apart from typical legislation, according to experts.

“This was entirely different,” says Morton. “[The drafting process] truly involved stakeholders, and Congress doesn’t normally write bills like that.”

The act was drafted by a bipartisan, bicameral group of legislators based on feedback from a June 2013 survey that asked any self-identified stakeholders to peg their top areas of concern in the PAC realm. From there, the authors of the act held meetings with 45 industry groups in a two-week time frame, Morton recalls, which further influenced the direction of the bill.

### Legislation rundown

According to Pitts’ analysis, the provisions of the act will be introduced in four stages:

- **Data collection, reporting, and analysis**, which

will require PAC providers to implement revised assessment, quality, and resource usage measures to begin submitting “standardized and interoperable” data on their Medicare patients for review by the Secretary of Health and Human Services and CMS. SNFs will be expected to submit the assessment portion of this data—which includes information on the functional, cognitive, and mental statuses of a given patient, as well as his or her medical conditions and any special services he or she requires—no later than October 1, 2018. Reporting on quality and resource usage will begin earlier—as soon as October 1, 2016, for many of these measures.

- **Feedback reporting**, during which the Secretary will supply PAC providers with confidential feedback reports detailing their performance on studied metrics, likely on a quarterly and annual basis. The Secretary will start issuing these reports one year after the dates that PAC providers begin reporting quality and resource use measures.

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- **Public reporting**, during which the Secretary will release performance data to the public. To facilitate this process, the Secretary will develop procedures that allow PAC providers to review and submit corrections to data on their organizations before it's released to the public beginning two years after the dates that PAC providers start reporting quality and resource use measures.
- **Congressional reporting**, during which the Secretary and the Medicare Payment Advisory Commission (MedPAC) will submit recommendations to Congress about future payment plans for PAC providers, as well as analyses of the plans' prospective effect on both the studied metrics and the financial state of the industry. Specifically, MedPAC will be expected to submit two reports that weigh the validity of a PAC prospective payment system that considers criteria such as individual patient characteristics, clinical appropriateness of care delivered, and patient outcomes. The first report will also provide recommendations about which fee-for-service regulations should be altered in current payment systems. After MedPAC's initial report, the Secretary must report to Congress its recommendations for alternative payment models. Additionally, the Secretary will be expected to submit a report evaluating the effects of socioeconomic status and associated risk factors (e.g., race, health literacy, English proficiency) on quality measures and resource use within five years of the IMPACT Act's enactment.

In addition to these provisions, legislators amended the original draft of the bill with three provisions for hospice, which isn't otherwise listed among the act's targeted provider types. The most notable addition in this realm requires CMS to survey hospices for recertification at least once every three years for the next 10 years—a significant improvement over the stretches of time that can exist between these surveys today, according to industry trade groups. An August 2013 report from the Office of Inspector General found that 17% of state-surveyed hospices did not receive a survey within the preceding six years.

### New assessment data

Of the four stages of the act, the first, which kindles the introduction of new measures and methods for

assessing patients, will have the most direct and immediate impact on providers, experts say.

“The big change for [SNF] providers is going to be utilizing the new assessment tools that will be incorporated into the MDS when CMS specifies them,” says **David Gifford, MD**, senior vice president of quality and regulatory affairs at the American Health Care Association in Washington, D.C.

Currently, the PAC providers affected by the IMPACT Act each use a distinct patient assessment tool (e.g., SNFs use the MDS, while IRFs use the Patient Assessment Instrument) with disparate criteria. But legislators want to standardize key assessment areas to facilitate comparison across PAC settings, a goal which could have significant implications for providers down the road, says Morton. For example, hospital discharge planners will eventually be able to use publicized performance and quality data, such as how well a PAC provider has historically treated a specific medical condition, to help a patient determine which setting is right for his or her needs. CMS also plans to use cross-setting information to gear future payment systems toward rewarding quality of care rather than quantity of services rendered, she adds.

CMS has been developing a tool to foster such standardization since the 2005 enactment of the Deficit Reduction Act triggered the agency to develop a Medicare Payment Reform Demonstration (PRD) that examined the consistency of payment incentives across the various providers that treat Medicare populations. According to the agency's website, the Continuity Assessment Record and Evaluation (CARE) Item Set, progeny of the PRD, is “designed to standardize assessment of patients' medical, functional, cognitive, and social support status across acute and post-acute settings.”

The IMPACT Act allows CMS to leverage what it learned in developing this tool in PAC settings. However, this does not mean that the standardized item set will replace the various assessment tools long used in the different PAC settings—a requirement that would place undue burden on providers, Morton says. Instead, certain items from each PAC assessment will be swapped out for questions from the CARE set for “apples-to-apples” comparisons (e.g., of how patients' capacity to eat differs and progresses from setting to setting).

“That’s where everything’s going,” Morton explains.

Although Morton says this question-level revision will be much less taxing than the introduction of an entirely new assessment used uniformly across PAC settings, she warns that providers will face a learning curve.

“It’s still going to be a change,” she says, explaining that if CMS replaces 20 questions on the MDS, providers will have to familiarize staff with the 20 new items taking their slots. “Even though [the CARE items are] replacing old [questions], they’re still new, and they still have to be wired to the RUGs because the MDS informs the RUG system ... so there is burden.”

She adds that NASL has brought concerns about this burden to Congress, and although members were receptive to the group’s questions, she says potential problem areas remain and urges providers to be attuned to future challenges the act might forecast for their practices.

Pitts echoes Morton’s advice to providers, stressing that they should raise concerns to CMS as soon as possible (e.g., through town halls, open door forums, and mailbox submissions) to increase their chances of shaping, rather than reacting to, proposed rulemaking.

### Revamped quality measures

Along with new methods of reporting, the IMPACT Act heralds the introduction of new and updated quality measures during the first phase of implementation—another area that could put an additional strain on providers’ current operations. The new legislation will require PAC providers to report the following measures:

- Functional status, cognitive function, and changes in function
- Skin integrity and changes in skin integrity
- Major falls
- Medication reconciliation
- Communication and transfer of a patient’s health information and care preferences to the individual and his or her prospective caretakers when the individual transitions from (1) an acute care to a PAC setting or his or her home without further care, or (2) a PAC setting to a different PAC or acute care setting, or to his or her home without further care

SNFs will be required to begin reporting on the first three quality measures by October 1, 2016, and the final two measures by October 1, 2018.

In addition, providers must report three measures regarding patients’ resource use: total estimated Medicare spending per beneficiary, discharge to community, and potentially preventable hospital readmission rates. For SNFs, these expectations will take effect October 1, 2016.

Morton thinks the quality areas the act promotes are important to helping consumers decide which setting is best for their loved ones. Because the eventual public reporting of these measures will have significant bearing on consumers’ choice in setting, Gifford hopes CMS will risk-adjust them in a way that captures how services delivered by providers influence patients’ conditions.

“We want to make sure the measures really reflect the care that’s been provided in the SNF setting, and that it actually helps people make informed choices,” Gifford says. The act directs the Secretary to adjust quality and resource usage measures to account for clinical risk factors that may contribute to poor outcomes (e.g., age, comorbidities, severity of illness).

Although the act promises an intensified focus on quality—and new public implications forthwith—Morton clarifies that some of these measures, such as functional status and skin integrity, are nothing new for providers. Instead, the real challenge in these areas will come from trying to comply with more rigorous, uniform standards.

“Functional change, medical condition, cognitive function—a lot of facilities are already measuring [these] internally, but the big change will be that we’re going to do it according to CMS’ set quality measures ... and there’ll be growing pains with that,” she explains.

In addition, if providers fail to comply with the reporting requirements for assessment, quality, and resource use by their respective deadlines, they will experience a 2% reduction in their market basket for the fiscal year. However, although Morton says this offers further incentive for providers to ramp up their reporting processes, she hopes that SNFs’ familiarity with reporting data through the MDS will help them to avoid incurring reductions—the threat of which they should be used to by now, adds Pitts, who calls financial penalties “the way of the world ... these days.”

### Start prepping

To prepare for the new expectations ahead, particularly in the quality and resource use realms, Gifford suggests evaluating the strength of current processes

and starting to bolster weak aspects as soon as possible.

“We don’t know exactly all the specifications CMS is going to provide in the future for these measures, but you know they’re going to be focusing on [these topics], so if you can get yourself looking good on those topics now, you’ll look good on whatever comes down the road,” he explains, adding that acting now is especially important because it’s hard to predict when CMS will begin incorporating content from the act into proposed rules and making changes takes time. And while Pitts thinks providers might have some leeway in fielding new expectations because planned start dates are still several years away, Morton thinks SNF providers could start seeing inklings of act provisions as early as the next proposed rule, which will come out in April 2015, because CMS has such an intensive process planned for creating and vetting new requirements, including considering input from providers and gaining the endorsement of the National Quality Forum.

Because of the potential nearness of this impact, Morton, like Gifford, recommends providers start taking stock of their internal processes surrounding MDS accuracy and adherence to quality measures. She urges providers to follow important developments surrounding the IMPACT Act—including studying the specifics of the CARE tool—to begin readying staff to adapt to the changes ahead.

“[Providers] should start [opening] their minds that we’re going to have real quality measures coming into place in the next two years,” she says. “They need to ... have their internal teams ready to accept that.”

Pitts also backs provider awareness of the IMPACT Act as it unfolds, stressing the importance of engagement as regulators begin to grapple with the difficult task of transforming the written stipulations of the act into concrete plans for achieving the legislation’s ultimate goal: payment reform.

“Postacute care providers were interested in [the act], and it was generally supported, which is why it flew through Congress ... [but] their interest might not be quite as aligned when it comes to reforming how CMS pays for services across the continuum of post-acute care,” he explains.

Indeed, Morton emphasizes that the act is not the last word on reforms in the PAC realm, but rather, an important step in an ongoing process of gathering the evidence needed to implement a payment system that promotes high-quality, patient-centered care.

“We are setting up the foundation for collecting quality measures that can ... inform pay for performance down the road,” she explains. “The law itself is a process, it’s not a result, so it’s setting the foundation for analysis that the government and MedPAC and Congress will need, and the industry too will need, to determine the next payment model.” ■

## HIPAA: Top tips for getting what you need to know, without giving away what you shouldn’t

by Debra Mozo, FR®R Healthcare Consulting, Inc.

Those of us who work in the healthcare industry are pretty familiar with HIPAA; however, on occasion there is still confusion about what can and cannot be shared with others. Therefore, let’s discuss some top tips for getting what you need to know, without giving away what you shouldn’t.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was established in an effort to protect the privacy of individually identifiable health information. Although it’s been around

for many years, many of us are still confused by all the rules and regulations. HIPAA is composed of the Privacy Rule and the Security Rule. The basic purpose of HIPAA is to limit the situations in which an individual’s protected health information (PHI) could be used or released by a covered entity, such as medical offices, nursing facilities, or health plans. The Privacy Rule protects all health information that can identify a patient, including the patient’s past, present, or future physical or mental health or condition, while the Security Rule applies only to health

information stored or transmitted in an electronic format.

Some may think HIPAA only applies to written and electronic communications; however, the rules of HIPAA also relate to any oral communication. It is easy to remember that electronic healthcare claims, payment and remittance advices, or written referral certifications or authorizations are all covered transactions under HIPAA. But don't forget: When you are speaking to a family member or friend, to a case manager, or to an insurance company regarding patient PHI, these interactions also fall under the rules of HIPAA. HIPAA interactions arise so many times during the workday that it's essential to think about ways to safeguard against possible violations. Therefore, let's cover a few potential problem areas and tips to help you throughout your day.

As you carry on your daily responsibilities, it's important to remember that one of the main safeguards in the Privacy Rule involves the minimum necessary standard. Any conversation about patients—their care, their diagnosis, or any other aspect of why they are in the nursing facility—is protected under the minimum necessary standard, meaning disclosure of information must be limited to only the minimum amount of PHI needed to complete the task. According to the U.S. Department of Health and Human Services, the minimum necessary standard is a “reasonableness standard that calls for an approach consistent with the best practices and guidelines already used by many providers today to limit the unnecessary sharing of medical information.”<sup>1</sup>

Another way to think about approaching the minimum necessary standard guideline is by using the “need to know test.” This involves asking yourself a series of questions and assessing the information when working with PHI. For example:

- Who needs to know?
- What needs to be known?
- What pieces of information are considered PHI?
- What is the minimum information I can share while ensuring the work is completed?

<sup>1</sup>U.S. Department of Health and Human Services. *Health Information Privacy*. [http://www.hhs.gov/ocr/privacy/hipaa/faq/minimum\\_necessary/207.html](http://www.hhs.gov/ocr/privacy/hipaa/faq/minimum_necessary/207.html) 14 03 2006. Electronic Media. 22 09 2014.

Now of course, as with most rules, there are certain exceptions when it comes to disclosure of PHI. One of the exceptions allows disclosure for treatment, payment, or healthcare operations (TPO). Case in point, if a patient is being transferred from a skilled nursing facility to a hospital and the skilled nursing facility provides the hospital with the patient's name, date of birth, insurance identifier, and recent nursing notes, the disclosure is allowed under the exception because the PHI is being provided for the purpose of treatment by another healthcare provider.

So, you might be asking, how do you do your job and not have your hands tied because of HIPAA? In most cases, if you are a business office or billing staff member, you will always be involved with HIPAA because you have direct access to patients' PHI. It's important to remember during your day-to-day operations that you should make use of the minimum necessary standard, possibly by utilizing the “need to know test,” and also bear in mind that disclosure of PHI is allowable if it's for the purpose of TPO.

One area of HIPAA that poses a challenge for covered entities is oral communication. In many cases, conversations must take place inside the workplace for

### Helpful tips and suggestions

1. Apply the “need to know test”
2. Try to lower your voice when discussing patients' PHI
3. Move PHI-related discussions with residents to a quiet corner or private office
4. Ask for authorization documents when receiving unknown requests for patients' PHI
5. Retrieve copier, fax, or printed documents containing PHI promptly
6. Place private records in a folder or envelope when leaving them on your desk or inbox
7. Lock your computer files when walking away from your workstation
8. Secure electronic files by using unique passwords

people's jobs to be done effectively; such conversations include discussions with case managers, coordination of care with other team members, or verification of benefits for treatment. However, what about conversations outside the workplace?

If you are having an informal, work-related discussion about patients while in the lunchroom or when meeting with someone for dinner, this would be considered prohibited under the rules of HIPAA, because the conversation is taking place where there is no likelihood of privacy. Additionally, discussing patients in an elevator when others are present or using the phone in one patient's residence to talk about another patient are also examples of oral communications prohibited under the rules of HIPAA. While the rules do not require elimination of all risks, they do require reasonable safeguards to be taken to prevent incidental disclosures.

For conversations that must occur in the workplace, consider taking a proactive approach to limiting the information that can be overheard by an outside person. For instance, if you are speaking on the phone with an insurance company, try to lower your voice or close the office door when discussing patients' PHI. If you are assisting a resident in a public area, such as the dining room or lobby, suggest that the conversation be moved to a quieter corner or private office. The rules of HIPAA do not forbid all oral communications,

just those that violate the patient's privacy. Therefore, it's important to take reasonable measures to minimize the chance that someone would be incidentally exposed to a patient's PHI.

Another area that can pose a significant challenge with regard to oral communication is verifying who you are talking to, whether it's in person or on the phone. For example, a visitor to your facility requests information about your patient, Mr. Miller, and claims to be Mr. Miller's son John—however, no one at the facility has ever met John or knows what he looks like. How can you confirm this person is who he says he is? Has Mr. Miller approved his son to be involved in his care? The regulations require covered entities to have documentation or statements, either orally or in writing, from a person asking for PHI when it is not known if that person has the right to receive a patient's PHI. It's important to check the patient's file to see if there are records that verify who is authorized to receive the patient's health information.

Alternatively, in the office and around your workstation, how are you ensuring patients' files are kept private? Are patient files left out in the open for others to easily view? Or, if you are transporting files outside of the office area, are paper records being transferred in a locked case and electronic records secured with encryption? These are some questions to consider when working with PHI; it is important to follow

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your organization's policies and ensure that you are taking appropriate measures to safeguard patient information. Think about the space you work in; are there printers, copiers, and fax machines where documents may be found with PHI? If so, make it a common practice to pick up these documents promptly. In addition, a best practice is to put private records inside a folder or envelope when leaving them on your desk or inbox. If you are working with files on a computer, make it a habit to close the files when you walk away from your desk.

Lastly, a new potential problem arises from electronic security and measures to protect patient information against data breaches. As more and more companies are moving toward a paperless culture, it's imperative to be aware of how your electronic files are being secured. For example, can medical records be accessed without a password? Is another user able to log into your workstation? Do you lock your workstation when leaving?

First and foremost, when working with PHI electronically, it's crucial the files are secured. This is best accomplished through the use of encryption or unique passwords. Some helpful hints when creating passwords are:

- Use at least 6–7 alphanumeric characters
- Include a mixture of upper and lowercase letters

- Always use a combination of letters and numbers, but never real words or any obvious string of numbers, such as 123456
- Select special characters, such as @ or #, to include in your password

Furthermore, check to see the type of access outside vendors, consultants, and auditors have to files. Do they have full access or read-only access? They should not have access to anything they don't need to complete their responsibilities.

To sum everything up, you want to be aware of HIPAA requirements at all times. Keep in mind where you are discussing PHI and whether you are keeping your conversations as private as possible. On calls, verify whom you are speaking with and confirm that the person has authorization to receive PHI. In addition, make certain that all files containing PHI are secured and kept private. Finally, check to make certain your passwords are unique and contain the features mentioned above. Do a risk analysis of your office and look through your workstations for possible HIPAA violations. If you see any, reach out to your privacy and/or security officer to address them. By taking these small steps, you are doing your best to minimize exposure of patients' PHI and maintain HIPAA compliance. 📧

## Q&A: Long-term care ICD-10 coding specifics

*Editor's note: This month's "Q&A" was modified from the HCPro book ICD-10 Essentials for Long-Term Care, written by **Karen L. Fabrizio, RHIA, CPRA**. ICD-10 Essentials for Long-Term Care provides you with a three-step plan that takes you from understanding the differences between ICD-9 and ICD-10 to full-scale ICD-10 readiness at your facility. For more information or to order, call customer service at 800-650-6787 or visit [www.hcmarketplace.com](http://www.hcmarketplace.com). To submit a question for upcoming issues, email Managing Editor Olivia MacDonald at [omacdonald@hcpro.com](mailto:omacdonald@hcpro.com).*

**A** Because this is a new venture for everyone, the steering committee should receive education right away on the ICD-10 code structure as well as the differences between ICD-9 and ICD-10. This will serve as a basis for understanding the challenges of the transition and future decision-making concerning education and any capital expenditures.

The change to ICD-10 is not a simple substitution of one code set for another but rather a new learned classification system that will have a learning curve for both clinicians and administrative staff.

The three major considerations to the ICD-10 transition project are:

- Quality of information and data

**Q** What should we be considering right now for the October 2015 implementation date for ICD-10?

- Cost of conversion
- Time and education

Your facility may want to consider developing subgroups to focus on these elements. If a Gantt chart is used to track the identified steps, the use of color will help differentiate the tasks assigned to each subgroup.

Quality of information is the fundamental component of the project because it affects patient safety, communication, and reimbursement. This subcommittee should be in charge of testing the 5010 conversion, testing the data, and auditing the documentation for sufficient detail. Also consider contingency plans in the event of critical systems failure during the ICD-10 transition.

Cost allocation is essential in the planning process so that the expenditures can be submitted and entered into the correct budget year. Because this is a two- to three-year project, costs can be spread across 24–36 months. The budget subcommittee will estimate the costs for education, additional staffing, new equipment, and IT or HIM consultants. Plan, prepare, and budget for outside education, coding certification, and staff turnover.

Another subcommittee should focus on education. This group would assess the different needs for education: who, how, what, and when. Because education is a key component of the conversion to ICD-10, look at the resources available to the organization such as in-house experts, local experts, or national resources such as webinars, training seminars, or written resources.

**Q What are some standard questions or issues that we should be considering while beginning to implement ICD-10 coding?**

**A** It is important that each individual understands the importance of using a complete and correct ICD-10-CM code and ensures data is captured from the correct source.

A few examples of questions that should be considered include:

- Does the attending physician identify diagnosis as a narrative statement or does the electronic medical record (EMR) require an ICD-10-CM code?
- Do therapists identify the diagnosis as a narrative

statement or does the EMR require an ICD-10-CM code?

- Is the therapy diagnosis added to the resident's diagnosis list?
- Does the interface import all diagnoses or just the top five into the billing system?
- At what point is the interface completed?

The policy manual and standard operating procedures will also need to be assessed for any changes under ICD-10. Each core team member is responsible for seeing that departmental policies are in place and support law, regulation, and practice. Interdepartmental collaboration is recommended as processes flow to other areas.

Determining who will have responsibility for specific tasks should be done as early as possible so they may participate in the scheduling of tasks and identify needed financial resources. Establishing “buy-in” from all parties involved will be essential for a smooth transition. Benefits from the preparation and planning process can be realized right away, such as the improvement in detailed documentation and the education of staff.

When the transition is completed, evaluate the implementation, resolve issues quickly, continue to test when resolving issues, and evaluate and re-evaluate to be sure things are working properly. The same core team, subteam members, and processes that were used pre-implementation will still be essential. Assess the reimbursement impact and your outcomes for future improvement. Evaluate what worked well and what did not, and celebrate all the things that worked well with staff. Positive feedback is always welcome and keeps communication open. In areas that had problems, you should provide feedback and any additional education and training.

**Q How will ICD-10 affect the reimbursement claim?**

**A** The claim must include diagnostic codes related to the Part A benefit and the services provided during the identified dates of service. The code related to the reason for admission and coverage by Part A should be identified as the primary diagnosis.

Additional diagnoses justifying feeding tube and wound care supplies should be included. If a resident receives restorative occupational, physical, and speech-language therapy, a treatment diagnosis should be added.

As a resident's coverage ends, he or she may continue to need care by the facility at a custodial level. There are two sets of charges that can occur. The first is the room and board charge for the resident's care. The facility will need to determine if the resident carries an insurance policy that will cover custodial care, if the resident has qualified for Medicaid benefits, or if the care will be paid for via private funds.

The second set of charges is ancillary charges, such as laboratory and radiological tests, or charges for physician visits. If the resident has benefits under Medicare Part B, these charges should be billed to the Part B provider first. Medicare Part B requires a diagnosis code to justify the services provided and has a very stringent set of edits to validate the charges. For example, Medicare Part B will not pay for a PT/INR test with a diagnosis of diabetes mellitus. It is in the facility's best interest to ensure that the coding staff are involved in the diagnosis code assignment for these services to eliminate costly delays in payment.

**Q Do you foresee ethical challenges increasing with the use of ICD-10?**

**A** As coding becomes more closely tied to reimbursement, coders will face ethical challenges.

The American Health Information Management Association (AHIMA) has adopted Standards of Ethical Coding for its members. This document serves as a guide for professionals in all areas of coding practice. The premise is that coders will adhere to the ICD-10-CM Official Guidelines for Coding and Reporting and will not record codes that are not clear, concise, or supported by evidence in the medical record.

To manage coding effectively, coding staff need to review and understand the service areas of coding risk.

The areas of coding risk include the following:

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- The False Claims Act
- The Office of Inspector General (OIG) fraud and abuse
- Recovery Auditors
- General healthcare fraud
- Corporate compliance 

## Consolidated billing Q&A with Janet Potter

*Editor's note: This Q&A first appeared in the HCPro webcast "SNF Consolidated Billing: Who Really Has to Pay All These Invoices?" on August 17, 2014. Click here to order the webcast.*

**Q When a person goes to an office visit, why isn't it Part B? Are the x-rays and lab charged to the SNF?**

**A** Yes. The office visit, the physician portion of it, the physician visit, the evaluation and management code, and any professional code is Part B and would be billed directly to Part B. But the x-rays and the lab, the technical components, if it is for a Part A resident, are going to be the responsibility of the SNF under Part A. Now this does not apply if they're not a Part A resident. If they're just a long-term resident in your facility and then they go out, the whole thing is

billed to Part B. So remember, it's only our Part A residents who are on a Part A Medicare inpatient SNF stay.

**Q Since hospitals use a different fee schedule, is the SNF responsible to pay that fee for services provided by hospital, or does the SNF always pay the physician fee?**

**A** The SNF pays whatever they can negotiate with the hospital, and in some cases it might even be the usual and customary amount. So it's whatever you can negotiate. Maybe have your administrator or your CFO or somebody involved in the negotiation with the hospital to come up with what you're going to pay.

**Q What if the HCPCS code is not found on the CMS physician fee schedule lookup website or Help File? An example is 80154.**

**A** I think that might be a lab code. Nonphysician services aren't included on the fee schedule, for example, a lab code. There is a separate lab fee schedule. If you go to your MAC website, you can see lab payment amounts and you can look it up there. There are some items, such as blood products, that are paid under what's called [OPPS], and you're just not going to find that out there, and you're going to have to just work with your hospital to come up with a rate to pay.

**Q** **If Medicare takes their money back due to an audit, are we still liable for consolidated billing during that period?**

**A** I think you would be responsible for the consolidated billing items because you would be probably appealing that denial. And if it's the hospital having their money taken back, then the SNF is still supposed to be able to bill Medicare and not have an automatic denial. I think either way, the answer is yes. You are responsible for that. I think we'd have to look into the real details of it before I tell you to just send off the check, but my gut feeling is you'll be responsible for those amounts.

**Q** **What does the column titled "CONV Fact" on the physician fee lookup mean?**

**A** That is a conversion factor, and that is just the number used in calculating the rates and it's not something you'll ever have to use. So just ignore that one.

**Q** **Is dental care while under skilled care included or excluded in consolidated billing?**

**A** Dental care is not covered under Medicare. You could look up each service if it gets into surgeries. It's possible something would be excluded. General dental care, though, would not be a Medicare service, so it would not be included as a responsibility of the SNF.

**Q** **How does the SNF determine the types of chemotherapy treatments they will be responsible for or not be responsible for? Is there a list of specific HCPCS?**

**A** Yes, in the SNF Help File there is a list of which chemotherapy codes are currently excluded or not. So you can look that up from there and see.

**Q** **In Major Category I, are all procedures done at the hospital excluded?**

**A** Yes, if the services are excluded under category 1, then all items/services done in the hospital connected with that service will be excluded.

**Q** **Should we ask vendors for their reject from Medicare when they ask for consolidated billing payment? Would this also be a guide as to pay or not to pay?**

**A** I think it's a good idea to ask for the denial. I don't know that it would really be a guide. I think you'd still want to look it up because if they have billed something incorrectly that could have been paid. But I think that would be a really good tool to have. You are still going to need to look up on your own each individual service.

**Q** **Who is responsible when a Part A resident goes to a wound clinic based in the hospital itself? The hospital is trying to bill the SNF.**

**A** We need to find out for sure what the provider type is. If it is a freestanding wound clinic—it's not going to be excluded because it's not billing under the hospital provider number. I suspect that's the case here. They just have the wound care clinic within the hospital. Find out what provider number they're billing under. If it's under the hospital number, they should be able to bill it, but I suspect that's going to be a separate provider number and it would fall to the SNF.

**Q** **Is a PET scan included or excluded in consolidated billing?**

**A** The PET scans are included. Again, get the HCPCS code. Don't just do this from memory. Look it up and see, but that's one of the areas that I frequently get asked, too. They just have not added it to consolidated billing as an exclusion, and the SNF ends up having to pay for it. 📄

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