The Medicare Billing Manual for Long-Term Care

Frosini Rubertino, RN, C-NE, CDONA/LTC, CPRA

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About the Author

Frosini Rubertino, RN, C-NE, CDONA/LTC, CPRA

Frosini Rubertino, RN, C-NE, CDONA/LTC, CPRA, is a registered nurse with over 30 years of experience in the healthcare industry. Rubertino is the founder and executive director of TrainingInMotion.org, a long-term care training organization, and a member of the Arkansas Healthcare Association's Education Committee. She received her executive management certificate from the Weatherhead School of Management at Case Western Reserve University and her continuous process improvement training in the dynamic healthcare environment of Cleveland. She brings her experience in risk management, regulatory compliance, and clinical systems management to her role as a regulatory specialist and educator for multiple organizations across the country conducting workshops and audits. She is also the author of *Carmelina: Essential Nursing Systems for Long Term Care*.

1 Overview and History of the Medicare Program

History of Medicare

The year was 1945, and only seven months into his presidency, Harry S. Truman proposed a comprehensive prepaid national health insurance plan for all senior citizens ages 65 years and older. It was not until 20 years later, in 1965, that the Social Security Amendment Title 18 and 19 for Medicare was signed into law by President Lyndon B. Johnson at the Truman Library in Independence, Mo.

At this historic event, President Truman and his wife, Bess, were the first to be enrolled in the Medicare program and received the first two Medicare cards. The Part A deductible was $40 per year; the Part B premium was a mere $3 per month. More than 19 million individuals were enrolled during the first year of the Medicare program. There are currently more than 40 million Medicare beneficiaries in the United States, and this number is climbing as the baby boomers approach their senior years.

Timeline

The changing landscape of long-term care is not new. There have been ongoing changes for skilled nursing facilities (SNF) and beneficiaries for many years. Here is a brief history.

1972: Medicare coverage for individuals with disabilities and end-stage renal disease is signed into law by President Nixon.

1985: The Institute of Medicine releases a study identifying the need for reform in nursing homes in areas of quality of care, quality of life, and resident rights.

1987: The Omnibus Budget Reconciliation Act substantially changes the focus of regulation, establishing new standards for quality of life and quality of care while revising the enforcement and inspection process.

1998: The Balanced Budget Act of 1997 takes effect and the new prospective payment system (PPS) replaces the cost-based system for SNFs using resource utilization groups (RUG) for Part A reimbursement.

2001: The Healthcare Financing Administration, a division of the Department of Health and Human Services (HHS), renames itself the Centers for Medicare & Medicaid Services (CMS).

2002: CMS launches the Nursing Home Quality Initiative, which includes public reporting of quality measures.

2003: The Medicare Prescription Drug, Improvement and Modernization Act introduces a new outpatient prescription drug benefit to begin in 2006 and directs HHS to conduct a three-year Recovery Audit Contractor (RAC) demonstration program.

2008: CMS releases the RAC demonstration project report, identifying $371.5 million in improper Medicare payments, with 96% representing overpayments.

CMS also announces its enhanced efforts to fight Medicare fraud and abuse by consolidating its fraud efforts with Program Safeguard Contractors, Zone Program Integrity Contractors, and Medicare Drug Integrity Contractors in addition to launching the national RAC program.

The Quality Indicator Survey process, focusing on person-centered care, begins to roll out nationwide, replacing the traditional survey process.

CMS begins to replace fiscal intermediaries and carriers with Medicare administrative contractors to process Medicare claims.

2010: CMS uses statistics from staff time and resources studies to redetermine the distribution of RUG payments for SNF services under Part A.

A new Minimum Data Set (MDS) assessment tool, the MDS 3.0, is introduced which focuses on person-centered care.

The Patient Protection and Affordable Care Act (healthcare reform law) gives HHS and its Office of Inspector General the authority to impose compliance programs to prevent and detect violations. SNFs are expected to have effective compliance programs in place by 2013, and the secretary of HHS is expected to submit a report to Congress evaluating these compliance programs.

Provider expectations mandated by CMS continue to evolve and challenge providers to regularly reexamine their systems for quality care delivery and regulatory compliance while maintaining fiscal viability. The key to success is to first understand the Medicare components that affect the SNF industry, and then to ensure solid systems to remain compliant with care and billing expectations.

Medicare: A Breakdown

So let's begin. There are four categories of the Medicare program, as described in the following brief summaries:

Part A

While Part A is considered inpatient hospital insurance, it also includes coverage for inpatient SNFs, inpatient rehabilitation facilities, critical access hospitals, hospice services, and some home healthcare services. If the beneficiary has paid Medicare taxes while working, there is no premium for Part A coverage. For SNFs, reimbursement for Part A services are paid under the SNF PPS, which means that all services and items that are provided during the stay are paid in one lump sum per day according to the RUG. The RUG grouper is assigned according to the amount and type of services provided and the activities of daily living score.

Part B

Referred to as medical insurance or supplemental medical insurance, Part B covers outpatient hospital services, physician services, diagnostic and lab services, some home health services for skilled nursing or therapy care, medically necessary supplies, and some preventive services. There is a monthly premium for this optional coverage. Reimbursement for therapy services is capped at a set amount determined by CMS.

Part C

Also called Medicare Advantage Plans such as PPOs and HMOs, these plans are sometimes considered to be Medicare replacement plans since they take the place of the traditional national Medicare plan and are available through private insurance companies that must be approved by and be under contract with Medicare. Part C plans usually include Part A, Part B, and some prescription drug coverage.

Part D

Part D plans are prescription drug plans. There are many Part D plans operated by private insurance companies approved by and under contract with Medicare. Drug formularies vary from company to company.

Eligibility for Part A and Part B

Medicare Part A is automatically available to individuals ages 65 years or older and takes effect the first day of the month in which the beneficiary turns 65. If the beneficiary paid 40 quarters (10 years) into the Medicare program, then the benefit is available at no cost. If he or she paid 31–39 quarters, the benefit is available at a reduced premium. Individuals younger than 65 with certain disabilities or end-stage renal disease may voluntarily enroll but are subject to paying a monthly premium. A beneficiary is responsible for a deductible per day from day 21 to 100 of SNF services furnished during an illness episode. The deductible and coinsurance amount for Part A is set by HHS and adjusted January 1 of every year to reflect the case mix changes.

Medicare Part B is voluntary. All enrollees are subject to a premium based on income and an annual deductible.

The Future

The message is clear. We live in a globally aging society. The U.S. Census Bureau predicts that the number of Americans over the age of 65 will more than double by 2030 to 70.3 million from 34.8 million in 2000, which will then represent 20% of the population. The average life expectancy of those Americans who are 65 years old today is estimated to be 84 years for females and 81 for males, according to the National Center for Health Statistics Bureau. This longevity is largely due to the new generation of retirees—the baby boomers—being better educated about health maintenance.

Overcoming the obstacles of change, meeting higher expectations for quality of care, striving to provide an environment conducive to quality of life, and balancing fiscal responsibility will continue to be among the challenges facing providers for years to come.

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Conquer no-pay bills, exhaust billing, and proper reimbursement under RUG-IV

The Medicare Billing Manual for Long-Term Care provides easy-to-understand guidance to help long-term care facilities correctly file Medicare Part A and Part B claims. It breaks down the often misunderstood consolidated billing process, clarifies the appropriate use of beneficiary notices, and offers practical solutions for billing under RUG-IV.

This book will help you:

- Understand and comply with the billing changes under RUG-IV
- Correctly file monthly, no-pay, and benefits exhaust claims
- Complete the UB-04 accurately
- Apply expert insight and insider tips to your SNF consolidated billing
- Understand which ancillary services are covered under Part B
- Increase cash flow and financial viability with Part B billing
- Avoid auditor scrutiny by correctly submitting claims to Medicare on the first try

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75 Sylvan Street, Suite A-101
Danvers, MA 01923
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