LONG-TERM CARE BILLING A to Z

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Long-Term Care Billing A to Z is published by HCPro, a division of BLR.

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ISBN: 978-1-68308-141-8

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About the Authors

Charlotte L. Kohler, RN, CPA, CVA, CRCE-I, CPC, ACS, CHBC, lead author, is the president of Kohler HealthCare Consulting, Inc. She has more than 30 years of healthcare experience.

Kohler HealthCare Consulting’s major clients include most types of healthcare organizations and services. This includes nursing home (skilled and non-skilled), home health agencies, rehabilitation facilities and organizations, long-term hospitals, large academic centers, multisystem hospitals, insurance companies, medical practices, radiology, infusion/chemotherapy, psychiatric providers and hospitals, durable medical equipment suppliers/DME, wound care, lithotripsy, radiology, oncology, and radiation therapy supporting coding, compliance, and litigation. Kohler has a special interest in effective and compliant billing activities. In the areas of consulting and litigation support/expert services, Kohler specializes in compliance and regulatory issues, valuations, and outpatient and professional services reimbursement.

Daria Malan, RN, LNHA, MBA, RAC-CT® is a director at Kohler HealthCare Consulting. Without her depth of knowledge and extensive experience in many aspects of long-term care, this book would not have been possible. Malan has over 35 years of clinical, management, leadership, and administrative experience. She has an executive MBA from Loyola and is dually licensed in Maryland as a registered nurse and a long-term care nursing home administrator.

Malan’s effectiveness and background in long-term care nursing administration, rehabilitation, and overall healthcare management brings practicality to the book’s topics. She has held an integral role in overseeing nursing, therapy and other clinical interdisciplinary divisions in acute care, rehabilitation, chronic/LTACH, subacute, SNF/LTC, ambulatory, and home health settings. Malan has also been an organizational leader, working to meet requirements for COMAR, Medicare, OHCQ, Joint Commission, CARF, and other regulatory agencies. She has served as nursing home administrator and director of nursing, and holds a certification as a resident assessment coordinator for the MDS 3.0, the national standard for skilled nursing facility PPS and MDS education.

Timothy Sheridan is a senior manager at Kohler HealthCare Consulting and is a revenue cycle and healthcare business operations leader with 27 years of experience working in hospitals, large multi-specialty physician group practices, and provider-based clinics. In his previous role as assistant vice president (AVP) at an Ascension Hospital, Sheridan was responsible for management of the rev-
enue cycle activities for various aspects of the hospital, owned physician practices, and their nursing home. Sheridan has an extensive working knowledge of both the Medicare and Medicaid programs and has promoted best practices in the automation and workflow management used for claim submission.

**Special thanks to others at Kohler HealthCare Consulting in the creation of this manual:**
Linda Berry, Tammy Morris, Beth Laizer, and Janet Ellis.
Introduction

Long-Term Care Billing A to Z is a high-level reference manual written to assist long-term care (LTC) billing professionals meet the various requirements for Medicare and other payers’ billing. The greatest challenge faced by LTC billers is the situational complexity of the resident’s status along with the rules and timing surrounding Minimum Data Set (MDS) submission.

A LTC biller’s training needs are constant, since it can be difficult to stay on top of and comprehend the constantly changing reimbursement regulations. Much of a LTC biller’s knowledge is acquired by working alongside the MDS coordinator, on-the-job training, working through issues, and searching for resources to support the tasks. Establishing a resource to assist in this endeavor is the goal of Long-Term Care Billing A to Z. The alphabetical listing helps the reader go directly to the desired topic and gain information quickly. Because of the ever-changing nature of Medicare rules and regulations, citations are included to assist in quickly locating the source of the rule, regulation, or guidance.

Reimbursements for services received in a skilled nursing facility (SNF) are subject to increasing scrutiny. Federal and state governments are systematically reviewing claims submitted to their payers to verify that any payments made are only for services that are necessary and appropriate based on the documentation, and that they are accurately billed. The Office of Inspector General has expressed concern that nursing homes are overcharging Medicare by over $1.5 billion annually and have found that providers are over-coding the MDS and therefore submitting fraudulent bills. Submitting inaccurate bills to Medicare and other payers carries many potential consequences. These consequences can be long-term or short-term, and can affect the facility’s reputation, as well as residents, practitioners, and the staff responsible for billing.

Long-Term Care Billing A to Z will guide billing professionals to meet Medicare and other insurance billing requirements. The 73 chapters are brief, each addressing only one topic. References at the end of chapters provide URLs to ever-changing Medicare rules and regulations, current CMS Fact Sheets, and citations that will assist in quickly locating the source of the rule, regulation, or guidance from Medicare, as well as other payers.

Long-Term Care Billing A to Z will help professional billing staff understand the variety of requirements and complexities that can affect the accuracy of LTC bills to all payers. It also provides information that can help mitigate payer audits and repayments.
Advance Beneficiary Notice of Noncoverage (ABN), Notice of Medicare Noncoverage (NOMNC), and Detailed Explanation of Noncoverage (DENC)

Skilled Nursing Facility Advance Beneficiary Notice of Noncoverage (SNF ABN)

The SNF ABN is used to advise and inform the Medicare beneficiary they may be responsible for payment of services. This is based on expected or known denial activity by Medicare, based on the service not meeting medical necessity or the service not being reasonable and necessary. The patient must not be under duress when the ABN is signed.

The ABN serves multiple purposes:

- Provides Medicare beneficiaries the option to receive services and take financial responsibility for paying for the services/treatments if Medicare does not pay for the specific service.
- Validates when the Medicare beneficiary was informed prior to receiving services that Medicare may not pay.
- Offers protection to the Medicare beneficiary and gives them the right to appeal Medicare’s decision to not cover a service.
- Please note, an ABN is NOT required if services are not or were never covered as a Medicare benefit. Some examples of excluded items are hearing aids, eye exams, and dental services.
Basic requirements for SNF ABNs

A SNF ABN is a Centers for Medicare & Medicaid Services (CMS)—approved written liability notice that the SNF delivers to a Medicare beneficiary, or authorized representative, before extended care services or items are furnished, reduced, or terminated. This notice must be issued when the SNF, the Utilization Review (UR) entity, the Quality Improvement Organization (QIO), or the Medicare contractor believes that Medicare will not pay for, or will not continue to pay for, extended care services that the SNF furnishes and that a physician ordered on the basis of one of the following statutory exclusions:

- Not reasonable and necessary ("medical necessity") for the diagnosis or treatment of illness, injury, or improvement of functioning
- Custodial care, which is not a covered level of care

For Part A items and services, SNFs may use either the SNF ABN or one of the five SNF denial letters as the liability notice. SNF ABN forms, instructions, and denial letters may be downloaded from CMS at www.cms.gov/Medicare/Medicare-General-Information/BNI/FFSSNFABNandSNFDenialLetters.html.

For Part B items and services, SNFs must use the Advance Beneficiary Notice of Noncoverage, Form CMS-R-131. Information on this notice and guidelines for mandatory and voluntary use of the ABN are published in the Medicare Claims Processing Manual, Chapter 30, Section 50, and can be found at www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html.

HCPro offers a chart that includes SNF scenarios that require ABNs, both voluntary and required.

<table>
<thead>
<tr>
<th>Scenarios</th>
<th>Skilled Nursing Liability Notice (Denial/SNF ABN)</th>
<th>Expedited Determination Notice(s)**</th>
<th>ABN (CMSR-131)</th>
<th>SNF NEMB or other type of notice (Voluntary)</th>
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<tr>
<td>1 On Admission to SNF: Beneficiary had 3-day hospital stay. (Technical Denial)</td>
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<tr>
<td>2 On Admission to SNF: Beneficiary had 3-day hospital stay and has MD orders for care, but requires custodial care only.</td>
<td></td>
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<tr>
<td>3 On Admission to SNF: Beneficiary had 3-day hospital stay, but does not require daily skilled care.</td>
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FIGURE 1: BENEFICIARY NOTICE REQUIREMENTS
### FIGURE 1: BENEFICIARY NOTICE REQUIREMENTS (CONT.)

|   | Part A Stay will end because: 
<table>
<thead>
<tr>
<th></th>
<th>Provider determines that beneficiary no longer requires daily, skilled services. Beneficiary will not be receiving therapy or other part B services, <strong>resident will remain in facility (custodial).</strong></th>
</tr>
</thead>
</table>
| 5 | Part A Stay will end because: 
|   | Provider determines that beneficiary no longer requires daily, skilled services. Beneficiary will not be receiving therapy or other part B services, **resident will be discharged from the SNF.** |
| 6 | Part A Stay ends because: 
|   | Resident had exhausted 100 days of SNF Part A coverage. (Technical Denial) |
| 7 | Part A Stay ends because: 
|   | Beneficiary is discharged to hospital, discharged AMA or elects Hospice services. |
| 10 | Part A Stay ends at your facility because: 
|   | Beneficiary is transferred to another SNF closer to his home, will continue to be covered under Part A. |
| 11 | Part B 
|   | Beneficiary is in continuing stay, not covered under Part A. Needs short-term PT, covered under Part B, to address significant decline in function. PT ends. **Therapy cap has not been met.** |
| 12 | Part B 
|   | Beneficiary is in continuing stay, not covered under Part A. Needs short-term PT, covered under Part B, to address significant decline in function. **PT ends. PT/SLP cap has been met.** |
| 13 | Part B 
|   | Beneficiary is in continuing stay, not covered under Part A. Needs short-term PT and OT services. OT services end, but PT continues.++ |
| 14 | Part B 
|   | Same as 12, PT services are terminated. **PT/SLP cap has not been met.** |
| 15 | Part B 
|   | Same as 12, PT services are terminated. **PT/SLP cap has been met.** |

 CMS requires, upon first therapy encounter, that the beneficiary be notified of their Part B therapy benefits and caps. Facilities may voluntarily use the CMS R-131 for this purpose or may design a notice of their choosing.  
++ Reduction in services example. Reduction of services pursuant to a Physician’s order do not require an ABN-R-131.  

**DISCLAIMER:** This table is FOR INFORMATIONAL PURPOSES ONLY. It does not constitute or substitute for legal advice, nor is it intended to be a comprehensive guide to all issues to be considered.  

**Source:**
Notice of Medicare Noncoverage (NOMNC) and Detailed Explanation of Noncoverage (DENC)

SNFs are required to provide a Notice of Medicare Noncoverage (NOMNC), form CMS-10123, to Medicare enrollees when their Medicare-covered service(s) are ending. The NOMNC informs enrollees on how to request an expedited determination from their QIO and gives enrollees the opportunity to request an expedited determination from a QIO. Providers must deliver a NOMNC to all beneficiaries eligible for the expedited determination process, even if they agree with the termination of services.

A Detailed Explanation of Noncoverage (DENC), form CMS-10124-DENC, is given only if a beneficiary requests an expedited determination. The DENC explains the specific reasons for the end of services. The expedited determination process is available to beneficiaries or their representative, whose Medicare covered services are being terminated. For SNFs, this includes services covered under a Part A stay, Part B services provided under consolidated billing (i.e., physical therapy, occupational therapy, and speech therapy), and beneficiaries receiving Part A and B services in swing beds.

NOMNC and DENC forms and instructions may be downloaded from the CMS website at www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html.


References:

CMS—Beneficiary Notices Initiative (BNI)-FFS SNF ABN and SNF Denial Letters

KY & OH Part A » News & Publications » News » Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) and Notice of Medicare Noncoverage (NOMNC)
Ancillary Services

The term “ancillary services” refers to services provided by a professional healthcare provider for patients/clients as an adjunct to basic medical or surgical services. Ancillary services are classified under three categories of service:

- Diagnostic
- Therapeutic
- Custodial

Diagnostic ancillary services include audiology, radiology, pulmonary testing services, and clinical lab services. Most often in a skilled nursing facility (SNF), they are ordered by the professional provider and are utilized to support the determination of the patient’s diagnosis or to manage a chronic condition. They can also be provided at a hospital, an ambulatory surgical center (ASC), or freestanding testing center often called an independent diagnostic testing facility (IDTF).

Therapeutic ancillary services include physical therapy, occupational therapy, speech therapy, radiation therapy, nutrition therapy, and weight management. Most therapeutic services are rehabilitative or restorative.

Custodial ancillary services may include hospice or specialized wound care via home health and are provided as indicated by the type of service.

When no Part A program payment is possible, some or all services may be medically necessary and can be covered as ancillary services under Part B. Some services, such as x-ray and lab, may be billed by the SNF or the rendering provider or supplier under an arrangement with the SNF. For a complete listing of services, see Medicare Claims Processing Manual, Chapter 7, “SNF Part B Billing,” available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c07.pdf. Refer to the “Consolidated Billing in a SNF” chapter for more information.

For these ancillary services, it is important for providers to understand constraints directed by the Stark Law regarding physician self-referrals. Stark Law prohibits a physician from making referrals for certain designated health services (DHS examples include lab, therapy, and durable medical equipment) payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership, investment, or compensation), unless an exception applies. Exceptions include financial relationships that do not pose a risk of program or patient abuse. All
providers or suppliers are encouraged to contact the Government Accountability Office at (202) 512-7114 for more information.


References:

Physician Self-Referral—Centers for Medicare & Medicaid Services
www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral

SocialSecurity.gov, Limitation on Certain Physician Referrals
www.socialsecurity.gov/OP_Home/ssact/title18/1877.htm
Medicare Benefit Policy Manual (Publication 100-02), Chapter 8

Long-term care billing departments are known by various names, but they all face the challenge of understanding and complying with Medicare’s many billing requirements for accurate reimbursement. *Long-Term Care Billing A to Z* is a comprehensive, user-friendly reference to long-term care billing requirements, with a focus on Medicare. This valuable resource will help billers understand how compliance, external audits, and rejected and returned claims affect the billing process.

**This book will help you:**
- Understand Medicare billing requirements
- Submit accurate bills to Medicare
- Mitigate government audits and repayments