Billing and Processing Issues

Identified Billing Errors - Provider Education Needs

Modifiers – New Additions and Appropriate Use

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Special Billing Situations:

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Identified Processing Problems

Identified Billing Problems

Medical review workgroup discussions identified frequent billing errors in SNF PPS claim submissions. These errors are common across the country and speak to the need for additional provider education.

Assessment Reference Date (ARD)

The ARD marks the end of the look back period. It must be set within the window of days allowed by the Medicare MDS assessment schedule. All medical data scored on the MDS is based on this date. An inaccurate date might results in an inaccurate RUG III score for Medicare billing. It is a requirement of the program that it be reported correctly on the claim. Failure to do so may result in claim denials (on prepay review) or the cancel of claim payment (on a post pay review.)

- ARD is reported in field 45 (service date) on the UB92
- ARD is = A3 (page 3) on the MDS
- ARDs set outside the timetable established by the assessment schedule requires billing the DEFAULT code (AAA00) for all days up to the ARD date
- The ARD of a regularly scheduled assessment does not effect a change in billing
- Billing codes change on the first day of the next payment block
- An “off cycle” assessment (significant change in status, significant correction to a full prior, OMRA) changes the billing effective with the ARD of that assessment:
- If the ARD falls within the window of the next regularly scheduled assessment, the billing changes with that ARD date and REPLACES the regularly scheduled assessment
- If the ARD falls within the grace day period, the billing changes with the 1st day of the regular payment block

Number of Days in the Payment Block

The SNF PPS schedule establishes the maximum number of days that can be billed per each assessment. The schedule has not changed since the program's inception. SNFs must bill all of the days of each billing block as long as the beneficiary continues to be medically and technically eligible.

- Check the assessment schedule and bill payment blocks accordingly
- **End billing** if the beneficiary discharges, dies, leaves the facility or is benefits exhaust
- **Stop billing** covered days within a payment block if skilled care comes to an end
- **Change HIPPS codes** within a payment block if a "significant change in status assessment" , correction to a full prior assessment or OMRA was done to reflect a **change in medical condition** (and continue to bill with the new code until the next assessment is due)
- Payment blocks should be reflected in demand bills following a "cut" from clinical coverage.
- Shared systems do not have any current edits to check for correct number of days billed per assessment
  - When identified in medical review, claims should be returned to provider for correction if claims have been submitted with an incorrect number of days billed per payment block
- CWF has been directed to write consistency edits to check the number of days billed per each type of Medicare assessment
  - CWF edits will require a check of claims history – because more than one claim may be submitted per billing block (monthly claim submission follows a calendar month, not a payment block

Modifier Selection

From the beginning of SNF PPS HCFA has provided a list of acceptable modifiers. This list contained 19 valid modifiers applicable for dates of service July 1, 1998 – September 30, 2000. Effective October 1, 2000 the modifier list has been expanded. Beginning with the payment block on or after October 1, 2000, the new modifiers should be used. There are no system edits to check for inappropriate modifier use.

- The Medicare contractor should return claims to provider for correction if they identify billing errors involving modifier selection.
- Contractors are not to deny claims for incorrect modifier selection during a grace period of 30 days beginning October 1, 2000.

New and Redefined Modifiers:

HIPPS MODIFIERS/ASSESSMENT TYPE INDICATORS

The HIPPS rate codes established by HCFA contains a 3 position alpha code to represent the RUG III medical classification of the SNF resident + a two-position modifier to indicate which assessment was completed. Together they consist of a 5 position HIPPS rate code for the purpose of billing Part A covered days to the fiscal intermediary.

Each of the 30 modifiers refers to a specific assessment as explained in the following table.

DESCRIPTION OF ASSESSMENT	MODIFIER CODE
Regular Assessments	
Admission/Medicare 5 Day Comprehensive	**11**
Medicare 5 Day (Full)	**01**
Medicare Readmission/Return	**05**
Medicare 14 Day (Full or Comprehensive)	**07**
14-day Medicare-required and Initial Admission	**17**
Medicare 30 Day (Full)	**02**
Medicare 60 Day (Full)	**03**
Medicare 90 Day (Full)	**04**
Quarterly Review-Medicare 90 Day (Full)	**54**
Other Medicare Required Assessment (OMRA)	**08**

DESCRIPTION OF ASSESSMENT **MODIFIER CODE**

Significant Correction Of Prior Full Assessment

Description	Code
Off-cycle Significant Correction of Full Prior	40
Significant Correction of Prior Full - 5 Day	41
Significant Correction of Prior Full - 14 Day	47
Significant Correction of Prior Full - 30 Day	42
Significant Correction of Prior Full - 60 Day	43
Significant Correction of Prior Full - 90 Day	44
Significant Correction of Prior REPLACING Readmission/Return	45

Significant Change in Status Assessment (SCSA) (Replacement)

Description	Code
Off-cycle Significant Change (outside window)	30
Significant Change in Status – Replacing 5 day	31
Significant Change in Status – Replacing 14 Day	37
Significant Change in Status – Replacing 30 Day	32
Significant Change in Status – Replacing 60 Day	33
Significant Change in Status – Replacing 90 Day	34
Significant Change – Replaces Readmission/Return	35

OMRA (Replacement)

Description	Code
OMRA – Replacing 5 day	18
OMRA – Replacing 14 day	78
OMRA – Replacing 30 day	28
OMRA – Replacing 60 day	38
OMRA – Replacing 90 day	48

DEFAULT CODE:

A modifier is required with the use of the default code (AAA) when days are billed on the UB92 to the Medicare Fiscal Intermediary for services which are determined to be “covered care”, but no assessment has been completed to classify the resident.

Most Common Mistakes Involving Modifier Choice:

- Using 08 for all OMRAs and 38 for all "Significant Change Assessments" rather that applying the proper modifier when the special assessment **replaces** a regularly scheduled assessment

- Choosing a modifier for a "Significant Change Assessment" when an OMRA was done

- Choosing a modifier for an OMRA when a "Significant Change Assessment" was done

  - Adding AA8a and AA8b together to determine the billing code for Medicare

  - Failing to start the Medicare schedule over again following a readmission or "cut" from skilled care; resulting in an incorrect modifier on the claim

  - Relying on software to assign modifier without checking with the clinical staff for verification of the specific assessment that was done

  - Failing to check the modifier chart to see if the clinical information matches the HCFA descriptor of the appropriate modifier

5-Day Presumption

The SNF PPS Final Rule allows for “presumption of coverage” on the initial 5-day assessment done for Medicare immediately following the beneficiary’s discharge from the hospital. If the beneficiary scores into the TOP 26 RUG III Groups, that beneficiary is “presumed covered” until the assessment reference date (ARD of that 5-day assessment.

If the beneficiary is **no longer skilled following this presumptive period**, code your initial claim as follows:

- Submit a covered claim for all days up to the ARD of the 5-day assessment (day 1-8)
  - If ARD is = to day 1, there is 1 covered day
  - If ARD is = to day 8, there are 8 covered days
- Enter occurrence code 22 (and date) = to the ARD of the 5 day assessment
  - If ARD is day 1, occurrence code 22 = day 1
  - If ARD is day 8, occurrence code 22 = day 8
- All days following the ARD “CUT” day would then be non-covered
  - Submit separately as a demand bill if beneficiary or his representative makes a request for intermediary review
  - Use the HIPPS code from the 5 day assessment for the balance of the billing block

If the beneficiary **continues to be receiving covered care following the ARD of the 5-day assessment, Medicare billing continues as long as skilled care continues.**

- Bill all 14 days of the 5-day assessment as covered days as long as the beneficiary remains technically and medically eligible
- Do the next scheduled assessment to determine continued Medicare clinical eligibility

Leave of Absence

Whenever a Medicare beneficiary is absent at midnight census taking time, the resident is said to be on a “leave of absence” (LOA). The effect on the Medicare assessment schedule and on Medicare billing makes no distinction between an absence for medical or social reasons. No Part A benefit day is taken when the beneficiary is absent at midnight.

Assessment Schedule:

- Continue the current assessment schedule (do not start a new 5-day assessment when the beneficiary returns)
- Skip over the LOA days on the assessment schedule as if they did not exist

Claim Coding:

- Report LOA days with span code 74
- Report non-covered days (field 6)
- Report revenue code 0180 on the claim
  - Units (field 45) are = to the number of days the beneficiary was gone at midnight
  - Do not record charges as non-covered
  - Put zero (0) in the charges field
- Bill existing HIPPS code for all days of the payment block, skipping over the LOA days as if they didn’t exist
- Report all ancillary charges rendered to the beneficiary in the facility before they leave on an LOA day
  - **These ancillary services cannot be separately billed to Part B**

Consolidated Billing:

- Does NOT apply to services rendered outside the facility on a LOA day for the Part A beneficiary

Medicare HMO Beneficiaries

If a beneficiary chooses a Medicare HMO as their form of Medicare, he cannot look to traditional “fee for service” Medicare to pay the claim if the HMO denies coverage. SNF PPS does NOT apply to beneficiaries enrolled in a RISK HMO.

Apply the following policies to HMO beneficiaries who are admitted to your SNF:

- If you are non-participating with the HMO, the beneficiary must be notified of this status because they are private pay in this circumstance
- Pre-approve the SNF stay with the HMO
- If the HMO denies coverage, appeal to the HMO, not to the “fee for service” fiscal intermediary
- Count the number of days paid by an HMO as Part A days used (this IS their 100 days of Medicare SNF benefits)
- Submit a claim to the “fee for service” intermediary to take benefit days from the Common Working File records
  - HMOs do not send claims to CWF for SNF stays
  - Failure to send a claim to the fiscal intermediary will inaccurately show days available
  - Submit covered claims, with a HIPPS code (use AAA00 if no assessment was done) and condition code 04

If the beneficiary drops their HMO participation, they have the **balance of their 100 SNF days** available to use

- Start the 5-day PPS schedule at that time
- Beginning in 2000, if the HMO approved the SNF admission without a qualifying stay, the “fee for service” intermediary must pay the balance of the benefit period if the clinical requirements are met and the reason for the beneficiary leaving the HMO is that the HMO terminated from Medicare.

Demand Bills

Correct coding of Part A PPS claims is required before the medical review process takes place. Currently, incorrectly coded claims are returned to provider. This gives the SNF the opportunity to resubmit a valid claim. In the future, there may be a policy change requiring that these claims be denied. When that change occurs, the SNF's only recourse would be to file an appeal.

- The assessment reference date (ARD) must be the same date that is recorded in section A3 of the MDS.

- The HIPPS code from the last valid assessment done for Medicare covered billing must be used on the demand bill. Bill that HIPPS code for the balance of the current payment block. Any additional days on the demand bill claim can be billed at DEFAULT code if NO other assessment was done for Medicare.

- Demand bills do not have to be 30 days in length, but EMS recommends this time frame because this is the maximum number of days allowed to have benefits reinstated if the beneficiary goes back to a skilled level of care. If the medical review examiner agrees with non-coverage for a 30 day period of time, the beneficiary is no longer technically eligible to use SNF Part A benefits until a new qualifying hospital stay occurs.

Coding Reminders:

- Submit with non-covered days and charges

- Use condition code 20

- Do NOT send medical records nor put medical information on remarks section of claim. The FI will request records according to their operating procedures.

Demand Bill Example:

A 30-day assessment was done on June 28, 2000 and was effective for 30 days of Medicare billing beginning August 1, 2000. The HIPPS code was RMB02.

All therapy services ended on August 5. No other clinical condition existed. The SNF issued a letter of non-coverage dated August 5, effective for beneficiary liability on August 6. The beneficiary requested a demand bill. The SNF billed a 30-day claim from August 6 – September 4, 2000. No further assessments were completed for Medicare.

Code the demand bill: 25 days at RMB02 (the balance of the 30 day payment block) and 5 days at AAA00 (Default code) because no further assessment was completed for Medicare. All days and charges are non-covered. Condition code 20 must be on the claim.

Remember: non-covered demand bills CANNOT cross fiscal year end or change in federal payment (April 1, 2000) or October 1 of each year beginning in 1999.

ADJUSTMENTS

Adjustments can be made to SNF PPS claims for a variety of reasons. The newest reason is to adjust a HIPPS code based on a correction to MDS data. Whenever the SNF corrects data on a previously submitted MDS that results in a different HIPPS code from the original claim, an adjustment may be sent to the intermediary.

- Adjustments must contain condition code 54
- Adjustment must contain a different HIPPS code than the original bill
- Adjustments cannot be made to dates of service prior to June 1, 2000
- Adjustments cannot be made to claims which have been through the medical review process or otherwise denied

Current Processing Issues

Medical Review:

Post and Pre-pay Downcoding.

Downcoding an existing HIPPS code presents processing problems in the FISS system. If the medical review department determines that a claim is payable, but not at the level billed, the examiner will follow the downcoding instructions per MR PM A-99-20 and A-00-08. These instructions permit the selection of an alternate RUG group based on the documentation of services and the "reasonable and necessary" status of those services.

- **Downcoding** results in a "**partial denial**" of payment, but not a denial of days. When finalizing the claim, the system will not accept the denial reason (example 56939)
  - All days are paid
  - No bene or provider liability
  - Provider receives lesser payment
- **Appeals** issues exist on downcoded RUGS groups – because no days are denied, what is the basis for an appeal for the sole purpose of restoring a prior payment rate

Ancillary Charges on Denied/Partially Denied Claims

When medical review decisions result in partial or full denials with multiple liability (beneficiary and provider), the entire non-covered charges show on the MSN as beneficiary liability.

- MSN shows beneficiary must pay all non-covered charges. HCFA is working on a remedy.