Recovery audit contractors: Ready or not, here they come

With the October announcement of the new recovery audit contractors (RAC), CMS marked the project’s transition to a permanent program and solidified industry-wide fears.

The congressionally mandated RAC program, which was implemented to identify and correct past improper Medicare payments, is not new. Initially, it began as a three-year demonstration in California, Florida, and New York in 2005, before expanding to Massachusetts, South Carolina, and Arizona in 2007. Congress believed the demonstration was successful and called for the RAC program to include all 50 states by January 2010.

The RAC demonstration ended in March and, according to a report released by CMS in June, The Medicare Recovery Audit Program: An Evaluation of the Three-Year Demonstration, a total of $980 million in overpayments to providers were corrected, $16.3 million of which were from SNFs.

The amount of overpayments providers were required to return to the Medicare Trust Fund incited panic among the healthcare industry. However, billers who learn from the mistakes of others and enact prevention techniques, such as internal reviews, correct coding training, and staff education, will better prepare their SNFs for the expanding RAC program.

A new type of program

Although a Medicare audit is never a welcome experience, a RAC audit tends to be more devastating than its predecessors.

One component contributing to the fierce nature of the RAC program is the speed of the audit process. When conducting audits, RACs employ two types of reviews: automated and complex.

An automated review is done when an improper payment can be identified without any human analysis of the medical records. Instead, a determination is made based on analysis of the monthly National Claims History file from CMS.

Automated reviews are often conducted when there is certainty that the service is not covered or incorrectly coded, such as duplicate claims or pricing mistakes, says Wayne van Halem, principal at WVH Consulting in Atlanta.

A complex review occurs when RACs suspect improper payment but must evaluate medical records to make a determination.

“It is apparent that RACs are able to review an enormous number of claims using the automated systems, putting a huge burden on nursing facilities to respond and/or appeal.”

—Glenda Hynes, RN

> continued on p. 2
"It is apparent that RACs are able to review an enormous number of claims using the automated systems, putting a huge burden on nursing facilities to respond and/or appeal," says Glenda Hynes, RN, director of clinical reimbursement at Landmark Health Solutions, a healthcare management and consulting firm in Haverhill, MA.

Another factor that drives the RAC program is the monetary gains of the contractors. RACs receive a contingency fee for each improper payment corrected, which gives them an incentive to find overpayments. Medicare contractors are not usually reimbursed in this manner, and providers have expressed concern regarding this new payment methodology.

What RACs mean for SNFs

SNFs rely heavily on Medicare funding, and the RAC program threatens this relationship. "Medicare payments have been an avenue for SNFs to improve their revenue streams to add programs, equipment, and initiate capital projects," Hynes says. RAC audits that find staggering amounts of what are deemed overpayments could mean financial ruin for a SNF that would have to repay the money.

Although SNFs may only account for about 2% of the demonstration-identified overpayments, the national program is expected to detect a larger amount. The demonstration focused mainly on inpatient hospitals, whereas the national RAC program will target all healthcare providers. SNFs must prepare for the increased scope of the RAC program and analyzing the demonstration results can help them.

According to The Medicare Recovery Audit Program: An Evaluation of the Three-Year Demonstration, the majority of overpayments collected during demonstration.

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNF</td>
<td>84.19%</td>
</tr>
<tr>
<td>Physician</td>
<td>6.07%</td>
</tr>
<tr>
<td>Inpatient hospital</td>
<td>4.25%</td>
</tr>
<tr>
<td>Outpatient hospital</td>
<td>2.50%</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>2.07%</td>
</tr>
<tr>
<td>Inpatient rehabilitation facility</td>
<td>0.72%</td>
</tr>
<tr>
<td>Ambulance/lab/other</td>
<td>0.51%</td>
</tr>
</tbody>
</table>

Source: The Medicare Recovery Audit Program: An Evaluation of the Three-Year Demonstration, CMS.
all overpayments identified were due to the following errors:

- Medically unnecessary (40%)
- Incorrect coding (35%)
- Insufficient documentation, usually occurring when providers neglect to submit records when requested by RACs (8%)
- Other, such as billing errors related to benefit periods or duplicate services (17%)

Although SNF overpayments were consistent with the overall results of the demonstration, claims which failed to meet the Medicare criteria for skilled therapy and billing for excessive or multiple units were a particular problem for SNFs.

Since the demonstration was considered successful in correcting improper payments, the national RAC program is likely to focus on the same problem areas, Hynes says. Therefore, in preparation for the program, SNFs should be sure to avoid mistakes proven to result in RAC audits.

**RAC improvements**

Fortunately, many changes have been made to the RAC program in response to criticisms of the demonstration. One of the more important modifications deals with the presence of medical professionals to assist with claims review. During the demonstration, RACs were not required to employ industry experts, such as medical directors or coding specialists, while making claim determinations. The national program requires RACs to use appropriate medical personnel, who must provide credentials upon request.

“If it is a coding issue, it is now required that the determinations are made by certified coders, which is a good thing for providers considering the area is one of defined expertise,” van Halem says.

In addition, RAC medical directors must discuss claim denials with providers if requested.

Another adjustment CMS made to the national program aims to reduce the fee-driven motivation that may lead RACs to inaccurately identify overpayments. The

> continued on p. 4

**SNF audit areas and top errors**

<table>
<thead>
<tr>
<th>Source: The Medicare Recovery Audit Program: An Evaluation of the Three-Year Demonstration, CMS.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Excessive/multiple units</td>
<td>38%</td>
</tr>
<tr>
<td>Failed to meet Medicare criteria for skilled therapy</td>
<td>40%</td>
</tr>
<tr>
<td>Other</td>
<td>22%</td>
</tr>
</tbody>
</table>

**New RACs and regions**

In October, CMS announced the four new recovery audit contractors (RAC) and the regions each will cover. They are:

- **CGI Technologies and Solutions, Inc., Fairfax, VA**—Region B: Michigan, Indiana, and Minnesota.
- **Connolly Consulting Associates, Inc., Wilton, CT**—Region C: South Carolina, Florida, Colorado, and New Mexico.
- **HealthDataInsights, Inc., Las Vegas**—Region D: Montana, Wyoming, North Dakota, South Dakota, Utah, and Arizona.
RAC  < continued from p. 3

demonstration only required RACs to return the contingency fee to providers if the overpayment determination was overturned on the first-level appeal. However, the national program calls for fees to be returned if the determination is overturned at any level of the appeals process.

Also, under the national program, RACs must disclose the areas they intend to focus on when looking for improper payments. Once determined, they will be listed on the CMS RAC Web site, www.cms.hhs.gov/RAC.

All of the improvements made to the RAC program should reduce its effect on providers and improve a SNF’s chance of surviving a RAC audit.

Preparing for RACs

Although the RAC program is expected to be less punitive than the demonstration, its potential for monetary damage remains alarming.

To successfully prepare your SNF for the RAC program, a multifaceted approach is needed, one which couples awareness of common mistakes with effective audit prevention methods.

Many of the RAC reviews will be based on data analysis, which will make it difficult for billers to determine whether their SNF will be a target, van Halem says. For example, it is likely that RACs will be looking at facilities that are billing more than their peers. However, concluding whether your facility is one of these targets will not be an easy task.

If a facility review team, including a biller, is able to determine whether the facility stands out from others or expects it to be a target, an internal review should be conducted to identify and resolve any problems.

Accurate coding is essential for billers to combat the overwhelming effects of the automated review system. Incorrect or missing codes, mistakes in coverage periods, or duplicate billing can all trigger RAC audits.

Although training billers on proper coding techniques is important, staff education must include all departments. “A SNF claim is not produced in a vacuum. All disciplines that impact a claim must know their responsibility in supporting reimbursement,” Hynes says.

Ultimately, the most important way to prepare for the RAC program is through staff education, and facilities which neglect this process tend to have a higher risk of being audited.

Policies change. Complex processes need clarification. Taking the time to ensure that all staff members are properly informed could save a SNF from a painful encounter with its new RAC.

Take the pain out of immunizations with roster billing

If your facility administers influenza or pneumonia vaccines to large groups of beneficiaries, the thought of submitting a UB-04 form to bill for each beneficiary’s vaccine may seem like more work for your billing office than the reimbursement is worth.

Some facilities simply don’t bill for vaccines because they don’t think it’s worth it, says Yelena Koltsova, vice president of Wern & Associates Long Term Care Consultants in Warren, OH.

“That’s not the right approach,” Koltsova says. “You still have to do it, so why not get reimbursed?”

Think of it this way: If your facility administers 100 vaccinations, the reimbursement adds up, she says.

For example, if the administration reimbursement for an influenza vaccine was $21, and the reimbursement for the vaccine was $18.20, the facility that administered the 100 vaccinations would bring in $3,920. Vaccine and administration fees vary by location, so check with your fiscal intermediary or Medicare administrative contractor to find out your reimbursement rate.
Roster billing can help your billing department cut down on the time it takes to process immunization bills.

Roster billing basics

Because roster billing combines multiple beneficiaries on the same claim, billers don’t have to submit a separate UB-04 form for every beneficiary who received a vaccination.

Although you don’t have to use the roster billing method to bill for immunizations, “roster billing is wonderful for billers because it provides a quick and easy way to bill vaccines for multiple beneficiaries,” says Cindy Dunne, president of ECS Billing & Consulting, Inc., in Dublin, OH.

Roster billing can be used to bill for influenza and pneumococcal vaccines, according to a Medicare quick reference sheet that CMS published in February.

Vaccines are covered under Medicare Part B benefits, since they are excluded from Medicare consolidated billing, Koltsova says. Therefore, even if a resident is on a Part A stay, vaccinations are still billed to Part B, she says.

Influenza and pneumonia immunizations, classified as preventive vaccines, are not Medicare Part D–covered drugs, according to CMS.

Your facility can also roster bill for vaccines provided to people who are not SNF residents, such as residents of an assisted living facility or members of the public who received vaccinations during an immunization day at your facility, Dunne says.

The right reimbursement

Before your billing department can start roster billing for immunizations, billers need to gather some specific information.

One key piece of information is how much your facility will charge per beneficiary for vaccinations.

Koltsova recommends checking the Medicare fee schedule when determining your vaccination charge. Your charge should be higher than the Medicare fee schedule, she says.

“Sometimes people charge less than the [Medicare] reimbursement because that’s what they were reimbursed in the past,” Koltsova says. “They could have gotten paid

> continued on p. 6

Roster billing troubleshooter

Roster billing can make billing immunizations easier, but the process still has some pitfalls.

Billing experts Yelena Koltsova, vice president of Wern & Associates Long Term Care Consultants in Warren, OH, and Cindy Dunne, president of ECS Billing & Consulting, Inc., in Dublin, OH, present some common problems encountered by billers and explain how to overcome them:

➤ “The computer only lets me add 10 beneficiaries.”
You can add more than 10 beneficiaries by pressing PF9 to save your entries and repeating the steps required for roster billing, Koltsova says. (For a step-by-step guide to roster billing, see p. 6.)

➤ “Some of the residents who received vaccinations are on Medicare Part A stays. Can I still roster bill their vaccines?” Even if a resident is on a Part A stay, you can still bill Medicare Part B for his or her vaccination, Koltsova says.

➤ “Can I use a UB-04 to bill for a resident’s immunization?” You can use a UB-04 to bill for vaccinations, Dunne says, adding that roster billing is not required for vaccinations, but it does offer billers a quick way to bill multiple beneficiaries.

➤ “The resident or the resident’s family does not remember or have a record of the resident’s last inoculation.” Medicare will still reimburse providers for vaccinations administered to residents who are unsure of their inoculation histories, Koltsova says.

➤ “How often are pneumonia vaccines covered by Medicare Part B?” Usually once per lifetime, but Medicare may provide more vaccines based on risk, Dunne says.
Key beneficiary information. This includes the beneficiary’s name as it appears on Medicare documents, the beneficiary’s health insurance claim number, date of birth, and sex.

The HCPCS code for the vaccine. The influenza HCPCS codes are:
- Administration: G0008

Roster billing: A step-by-step guide

To initiate a roster bill for the influenza or pneumococcal vaccine, follow these steps:
1. At the Enter Menu Selection prompt, enter 87
2. Press Enter

To enter data for a roster bill for the influenza or pneumococcal vaccine, do the following:
1. Enter the Medicare provider number. This is a 10-character alphanumeric field.
2. Enter the service date of the mass immunization in the Date of Service field.
3. Enter the appropriate bill type in the Type of Bill field. Only the first two digits of the bill type are required.
4. Enter the National Provider Identifier number. This is a 10-character alphanumeric field.
5. Enter the 10-character alphanumeric taxonomy code in the TAXO.CD field.
6. Enter the nine-character alphanumeric provider or subpart ZIP code in the FAC.ZIP field.
7. Enter all appropriate revenue codes, HCPCS codes, and per-beneficiary charges in the Revenue Code, HCPCS, and Charges Per Beneficiary fields, respectively. Do not enter the total charges for all beneficiaries, as this will result in overpayments.
8. Enter all required patient information (i.e., health insurance claim number, last name, first name, middle initial, date of birth, and sex) in the respective fields. Note: Up to 10 entries may be made per roster bill.
9. The roster bill, as well as inpatient Part B services (i.e., 12X and 22X bill types), require the following fields to be completed:
   - Admit date. This field identifies the date of the patient’s admission. This is a six-digit field entered in MMDDYY format.
   - Admit type. This field identifies the code indicating the priority of admission. This is a one-digit field. The valid values are 1 (emergency), 2 (urgent), 3 (elective), 4 (newborn), and 5 (trauma center).
   - Admit diagnosis. This field identifies the diagnosis code describing the inpatient condition at the time of the admission. This is a six-character alphanumeric field.
   - Patient status. This field identifies the code indicating the patient’s status at the ending service date in the period. This is a two-character alphanumeric field.
   - Source of admission. This field identifies the way a patient was referred to the hospital for admission. This is a one-character alphanumeric field. Valid values include 1 (physician referral), 2 (clinical referral), 3 (HMO referral), 4 (transfer from a hospital), 5 (transfer from a SNF), 6 (transfer from another healthcare facility), 7 (emergency room), 8 (court/law enforcement), 9 (information not available), A (transfer from a critical access hospital), B (transfer from another home health agency), and C (readmission to the same home health agency).
10. Press PF9 to update or store the roster bill entry.
11. Repeat steps 1–10 for each additional roster bill entry.

Source: Yelena Koltsova, vice president, Wern & Associates Long Term Care Consultants, Warren, OH.
The pneumococcal HCPCS codes are:
- Administration: G0009
- Vaccine: 90669, 90732

The HCPCS vaccine codes correspond to specific vaccines. For example, vaccine code 90658 is used for influenza vaccine, split virus, for use in individuals aged 3 years and above for intramuscular use.

Billers should find out exactly what vaccine was administered and get the proper corresponding code. “The billing department should not be guessing,” Dunne says. “They should be getting the exact vaccine that was given from the nurses.”

The revenue code for the vaccine and administration.
- Vaccine revenue code is 636 and the administration revenue code is 771.

The related diagnosis codes.
- V04.81: Influenza vaccine and administration only
- V03.82: Pneumonia vaccine and administration only
- V06.6: Pneumonia and influenza vaccine when beneficiary receives both vaccines

The correct bill types.
- Use the 22X bill type for a patient residing in the Medicare-certified portion of your facility. Use the 23X bill type for all other beneficiaries who received vaccinations.

Billing for ambulance services: Combat common problems and reduce costs for your facility

Since the introduction of the SNF PPS in 1998, SNFs across the nation have struggled with billing for ambulance services. Although confusion on the topic is common, improper billing for ambulance services can result in a host of problems, such as reimbursement errors or claim rejection. To avoid these problems, medical billers must not only possess a complete understanding of the rules and exclusions, but also share this knowledge with SNF staff members. After all, situations that lead to ambulance billing mistakes often occur outside of the billing department, so ensuring that everyone knows what to look out for is a key component in prevention.

You can help avoid common ambulance billing mistakes and reduce your facility’s costs by understanding what constitutes medical necessity, communicating with the nursing department, and knowing how to account for ambulance services on the UB-04.

Medical necessity is not enough

For an ambulance service to be covered by Medicare, it must be considered medically necessary, which means the resident cannot safely be transported any other way. However, many people are unaware that Medicare does not pay for all medically necessary ambulance transports, says Lee A. Heinbaugh, president of the Heinbaugh Group, a long-term care consulting company in Lakewood, OH.

For example, Medicare never covers ambulance rides to a physician’s office. Facilities must pay for medically necessary ambulance transports to and from routine services and doctor’s appointments.

“It is a common misconception that just because a resident needs to be transported by ambulance, Medicare will cover the cost,” Heinbaugh says.

SNFs are required to provide such services to their residents, regardless of whether or not they will be reimbursed separately by Medicare.

Although knowing when the facility will incur the cost of ambulance transports may not reduce their expenses, awareness will better prepare the SNF to deal with the bill.

> continued on p. 8
Ambulance  
< continued from p. 7

The fine print of excluded services

After establishing medical necessity, it must be determined whether the ambulance ride is considered an excluded service. An excluded service is something CMS considers to be outside of the financial responsibility of the SNF, enabling the ambulance vendor to bill directly to Medicare for payment. Therefore, excluded services are not subject to SNF consolidated billing and are not included in the PPS daily rate.

However, not all ambulance services that occur during a Part A stay are excluded from consolidated billing. Instead, CMS has identified certain situations in which Medicare will pay separately for the cost of ambulance transports. Unfortunately, these highly detailed exclusionary rules are the root of many recurring problems with billing for ambulance services.

One area of confusion is the Major Category I exclusions for certain hospital outpatient services considered to be beyond the scope of the SNF.

Major Category I exclusions consist of the following services:

- Cardiac catheterization
- CT scans
- MRIs
- Radiation therapy
- Angiography, lymphatic, venous, and related procedures
- Certain ambulatory surgeries involving the use of a hospital operating room

According to the Medicare Claims Processing Manual, Chapter 6, Section 20.3.1, ambulance transports to and from these excluded Major Category I services are also excluded from consolidated billing.

However, for these Major Category I services to be excluded from consolidated billing, they must be rendered in the outpatient department of a Medicare-participating hospital or critical access hospital—a stipulation that often goes overlooked, says Claudia Reingruber, CPA, managing shareholder of Reingruber & Company, PA, in St. Petersburg, FL.

“One common problem occurs when a nurse is unaware that a resident is in a Part A stay and arranges for one of the excluded services to be provided in a setting other than a hospital outpatient department,” Reingruber says. “If the nurse schedules the service at a freestanding clinic or other nonhospital setting, the nursing home not only has to pay for the medical service, but the ambulance as well.”

Billers must communicate with other departments and share their knowledge of excluded-service specifics. Ensuring that staff members understand the details of what constitutes an excluded ambulance transport can save a facility a considerable amount of money.

Revenue code 540

Although many of the situations that lead to ambulance billing problems occur on the floor, errors by the billing staff are not unusual and can cause a claim to be rejected. One issue that billers frequently encounter is determining how to account for the cost of ambulance services, because the 540 revenue code, or ambulance revenue code, cannot be used on a Part A claim, says Felice Landry, senior billing consultant at Reingruber & Company.

“Billers are told to charge everything during a Part A stay to the UB-04. Unfortunately, the 540 revenue code is not an acceptable code on a SNF Part A claim, type of bill 21X,” Landry says.

Using the 540 revenue code will result in rejection of the claim and leave many billers confused. The correct way to reflect ambulance services is to include the ambulance expense in the ancillary cost center.

For example, if a patient received an MRI in a freestanding facility and had to be transported by ambulance, the cost of the ambulance would be bundled with the cost of the test, Reingruber says. Nursing homes can never include the 540 revenue code.
Simple steps to reduce ambulance costs

Identifying problems that plague the process of billing for ambulance services is bound to reduce the number of such occurrences.

To better control ambulance costs, a SNF can take the following steps:

➤ **Ensure that the criteria for medical necessity are met.** Medicare has never covered nonambulance modes of transportation.

If a non-Medicaid resident is moved by an alternate method, such as a wheelchair van, the resident may be charged for the transportation as long as proper notification of financial responsibility for this noncovered service was provided in advance.

➤ **Make the information available.** Consider providing your staff with a list detailing which services Medicare pays for and which are the SNF’s responsibility, says Brenda Morgan, director of nursing at Carelton-Willard Village in Bedford, MA. Educating staff members and providing them with the necessary resources is vital to preventing problems.

➤ **Do not assume that all bills received from vendors are accurate.** Billing for ambulance services is

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**Medicare ambulance billing responsibility (medically necessary only)**

<table>
<thead>
<tr>
<th>Ambulance services provided</th>
<th>SNF responsible (included in consolidated billing)</th>
<th>SNF not responsible</th>
<th>Beneficiary responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial transport to SNF upon admission</td>
<td>✅</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transport to and from dialysis services at renal dialysis facility</td>
<td>✅</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transport provided in conjunction with Major Category I excluded services, only if services are rendered on an outpatient basis at a hospital or critical access hospital (CAH)</td>
<td>✅</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transport upon discharge from SNF:</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>To hospital or CAH for inpatient admission</td>
<td></td>
<td>✅</td>
<td></td>
</tr>
<tr>
<td>To home (if the resident does not return to that SNF or another SNF before midnight of the same day)</td>
<td>✅</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To home (if the resident returns to that SNF or another SNF before midnight of the same day)</td>
<td>✅</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To another SNF</td>
<td>✅</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transport to and from physician’s office</td>
<td>✅</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transport provided in conjunction with services not included in Major Category I exclusions (e.g., chemotherapy or wound clinic)</td>
<td>✅</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transport to and from services that are not medically necessary and excluded from SNF consolidated billing, when the beneficiary has been given proper advance billing notification</td>
<td>✅</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Adapted from Medicare Claims Processing Manual, Chapter 6, § 20.3.1.
Ambulance < continued from p. 9

confusing for everyone, not just SNFs, and ambulance companies make mistakes as well.

➤ **Explore discrepancies.** If the SNF’s ambulance expenses differ drastically from expectations, further investigation may reveal problems to avoid in the future.

➤ **Ask questions.** Ambulance billing is a complicated process that does not get any easier with practice for most people. Turn to coworkers, fiscal intermediaries, and Chapter 6, Section 20.3.1 of the *Medicare Claims Processing Manual* for help.

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**LTC billing IQ: Test your skills with this quiz**

Think you’re a long-term care billing pro? Test your knowledge of SNF billing with the billing scenarios below.

1. Mr. Johnson was admitted to the hospital March 2 and discharged to the SNF March 6. Dr. Evans ordered an evaluation and treatment by occupational and physical therapy, along with orders for a complete blood count and gauze dressings with Bactroban ointment for his hip incision. Dr. Evans also ordered an MRI to be completed one week after admission to the SNF.

Which of the following indicates the correct occurrence span code and dates to show the qualifying hospital stay when completing Mr. Johnson’s UB-04 claim form?

- a. Span code 70, Dates 03/02–03/05
- b. Span code 70, Dates 03/02–03/06
- c. Span code 71, Dates 03/02–03/05
- d. Span code 71, Dates 03/02–03/06

2. In the above scenario, which of the following would be the correct combination of revenue codes to represent most of the services described?

- a. 250, 270, 305, 420, 430
- b. 250, 270, 340, 440, 410
- c. 250, 270, 290, 420, 401
- d. 250, 290, 340, 440, 460

3. Mr. Johnson is finally discharged from the SNF April 19. When submitting his final claim to the fiscal intermediary, the SNF will use which of the following date ranges and number of days to indicate the covered period?

- a. 04/01–04/18, 18 days
- b. 04/01–04/20, 19 days
- c. 04/01–04/19, 18 days
- d. 03/31–04/18, 19 days

4. Consider the scenario in number 3. However, instead of being discharged, Mr. Johnson no longer needs SNF care and the criteria for skilled rehabilitation are no longer being met. Mr. Johnson’s responsible party does not agree with the determination that skilled rehabilitation is no longer needed and requests that Medicare review this determination. When the SNF reports Mr. Johnson’s claim, it will be reported as which of the following?

- a. A Regular Part A claim
- b. A Medicare Secondary Payer bill
- c. A no-pay bill
- d. A demand bill

5. Which of the following is the correct condition code to indicate a waiver of the three-day qualifying hospital stay for Medicare Advantage beneficiaries that disenroll?

- a. 21
- b. 57
- c. 58
- d. 74

Stumped? Wondering whether you got them right? Find the correct answers on p. 12.
Editor’s note: “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, e-mail Associate Editor MacKenzie Kimball at mkimball@hcpro.com.

Our nursing facility is learning to use the tools available to us from CMS. However, we still struggle with some of the features of the CMS Common Working File (CWF). For example, we are not always sure what the status of our claim is when we go online to review. We would appreciate if you could give us some assistance with this issue so that we can better manage our Medicare claims.

My first recommendation is to search your fiscal intermediary’s Web site for a direct data entry manual. This manual will give you details on each of the CWF screens. But to answer your question, below are the details you will need to understand when you perform a claim inquiry:

Status/location (S/LOC) identifies the condition and location of your claim within the Medicare system.

The first character is the claim’s current status code. The most common codes are:

- D (denied claim)
- P (paid/processed claim)
- R (rejected claim)
- S (suspended claim)
- T (claim returned to provider [RTP] for correction)

The second character denotes the claim’s processing type:

- M (manual)
- O (online)
- B (batch)

The third and fourth characters denote the location of the claim within the Fiscal Intermediary Standard System (FISS). The most common codes used in these positions are:

- For D claims:
  - 99 (session terminated)

- For P claims:
  - 99 (session terminated)
  - 75 (postpayment)

- For R claims:
  - 99 (session terminated)

- For S claims:
  - 01 (S/LOC)
  - 60 (additional development request [ADR])
  - 90 (CWF)

- For T claims:
  - 99 (session terminated)

> continued on p. 12
Q&A  
< continued from p. 11

The fifth and sixth characters denote additional location information. The most common codes used in these positions are:

- 00 (batch process)
- 01 (CWF)
- 96 (payment hold [OBRA hold])
- 97 (final online)
- 99 (waiting for CWF response)

When these codes are put together, the result will look like one of the following examples:

**Roster billing troubleshooter**

The answers to the billing quiz on p. 10 are:

1. **b.** The correct occurrence span code is 70, which indicates a three-day qualifying hospital stay that will qualify the resident for the SNF level of care being billed on the claim. The correct date range is the admission date to the hospital, March 2, through the admission date to the SNF, March 6. For more information, see *Transmittal 81*.

2. **a.** When determining revenue codes, 250 indicates pharmacy, 270 indicates medical supplies, 305 indicates laboratory services, 430 indicates occupational therapy services, and 420 indicates physical therapy services. See *Transmittal 81*.

3. **c.** Field locator 6 indicates the covered period for which the claim is submitted. Value code 80 would be used to show the number of covered days. The SNF would submit 04/01–04/19 for field 6 and 18 as the number of covered days, since the day of discharge is not counted as a utilized or payable day under PPS. See *Medicare Claims Processing Manual*, Chapter 6 § 40.3.5.

4. **d.** A demand bill occurs when the SNF believes that a covered level of care has ended but the beneficiary/responsible party disagrees. Special occurrence codes are also used. See *Medicare Claims Processing Manual*, Chapter 6 § 40.7.

5. **c.** The correct condition code is 58 (terminated managed care organization enrollee).

- D B9997 (denied medical review claim, need to file redetermination)
- P B7501 (postpayment review)
- P B9996 (claim is waiting to be released, awaiting the payment hold)
- P B9997 (claim has processed and finalized)
- R B9997 (claim rejected, need to submit an adjustment to correct)
- S B6000 (claim awaiting the creation of an ADR)
- S B6001 (claim awaiting provider response to an ADR)
- S B9000 (claim ready to go to CWF)
- S B9099 (claim waiting for a response from CWF)
- T B9900 (RTP claim, not yet available for provider to fix)
- T B9997 (RTP claim, can now be corrected online)

Hopefully this will help as you review your claims using the FISS online system. It is the best way to monitor claims status and ensure proper cash flow.

**We are not sure how to get a copy of an ADR from Medicare using the online system.**

You should do a claim inquiry by selecting 12 on the Inquiry Menu screen (MAP1702). The claim summary inquiry screen (MAP1744) will appear. Type in the beneficiary’s health insurance card number and National Provider Identifier and press Enter. The claim being held due to an ADR will have status code S B6001. Type S in the SEL field and press Enter. The ADR letter will start on p. 7.

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