On April 16, President Obama signed the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 (H.R.2) into law. The move gained national attention both within and beyond the healthcare provider community for its effective repeal of the sustainable growth rate (SGR) formula—a payment methodology intended to tamp down physician spending by tying Medicare reimbursement in the pricy sector to economic growth factors. But provider advocates say the irreparably flawed formula fell out of sync with soaring healthcare costs shortly after its enactment by the Balanced Budget Act (BBA) of 1997, thereby threatening physicians’ operations and beneficiaries’ access to essential primary care. MACRA—known colloquially as the “doc fix” bill for its physician reimbursement safeguards—replaces the SGR formula with a more timely payment strategy.

But despite the heavy public emphasis on the legislation’s landmark reforms in the physician sphere, MACRA also holds significant implications for the postacute care (PAC) provider community, whose reimbursements have been skimmed repeatedly to fund the 17 short-term patches implemented over the years to suspend the disastrous effects of the SGR: Physicians would have seen a 21% slash to Medicare payments in April if this year’s bill hadn’t passed. Provider representatives fear this consequence—or the fallout from its continual staving off—could have reverberated across the entire care continuum.

“Every time Congress did a patch or a fix for the short term, there was a dipping into payments for both hospitals and postacute as pay fors,” says Cheryl Phillips, MD, senior vice president of public policy at LeadingAge, a Washington, D.C.–based trade organization for nonprofit aging services providers. “What was increasingly evident was that these pay fors were getting more and more and more expensive.”
Payment changes

In the wake of SGR, MACRA will see in new value-based purchasing (VBP) mechanisms (i.e., payment incentives linked to performance on certain quality measures) to fuel the transition from fee-for-service to pay-for-performance in the physician setting, a shift that’s already occurring to varying degrees throughout healthcare. In the meantime, instead of binding payment to fluid economic factors, MACRA provides modest but consistent increases to physician Medicare payments for the next few years. After a short-term freeze to physicians’ reimbursement rate, which was in effect from the bill’s passage until June, the legislation bumps up payments in the sector by 0.5% for the remainder of the year, and will continue to raise rates by the same increment annually from 2016 through 2019.

To fund these payment boosts, MACRA directs Medicare to once again reach into PAC providers’ pockets, this time by restricting the fiscal year (FY) 2018 payment rate increase to 1% for the entire sphere. But while this rate is marginally lower than the update SNFs are used to seeing through the annual rulemaking process, Phillips says it’s preferable to the steepening payment hits they had been experiencing and would have continued to face if the SGR formula hadn’t been retired.

“There is a freezing of the market basket ... but it’s much less painful than it would have been had we not done anything,” she explains, adding that the direct blow to SNFs has also been softened by MACRA’s balanced distribution of the financial burden among various healthcare settings and certain high-income beneficiaries, who may now experience greater premiums for Part B and Part D service coverage.

Phillips says this funding dynamic would have been considerably bleaker for PAC providers had the patchwork SGR splints remained in play much longer.

“Congress had the belief that there was a lot of gleaning to yet be had in the postacute sector,” she explains.
“Our rationale for pushing so hard for resolution was that if SGR were not repealed, there would be a continually tempting dip into the well.”

While Congress drew from reimbursements across the care continuum to fund the SGR patches during the formula’s lengthy run, Phillips says that big-ticket providers like hospitals were becoming tapped out, prompting legislators to increasingly set their sights on their PAC counterparts to make up the difference—a strategy she says was based on deceptive information about financial health in the sector. For example, Phillips says that the robust profit margins the Medicare Payment Advisory Commission attributes to SNFs (estimated to be 13.8% in 2012) are misleading, as they over-represent the industry’s small proportion of large, for-profit chains and overlook the significant population of nonprofit providers that currently subsist on margins as small as 1–4%. Phillips believes these margins would have continued to shrink under the strain of the SGR quick fixes.

“Our concern was that the nonprofit postacute providers, many of whom have been in their communities for decades, would start to disappear because they couldn’t sustain the continued pay [impact],” she says. “So we saw [MACRA] really as a vital, vital step in sustaining nonprofit postacute providers across the continuum.”

Thus, although SNFs may feel the effects of the meager FY 2018 payment increase, they can breathe easier knowing the temporary freeze will promote long-term stability, says Colin McCarthy, JD, associate at Hancock, Daniel, Johnson & Nagle, P.C., a health law firm based in Richmond, Virginia.

“It’s a one year sort of sacrifice to make up for having several more years—who knows how long—of uncertainty and potentially larger cuts,” McCarthy explains.

In addition, he points out that MACRA grants SNFs ample time to brace for the potential impact of the FY 2018 rate update. McCarthy sees this advance notice as a major improvement over the rushed timelines of the patches, which he believes bred payment instability and provider insecurity.

“Every year, [providers] were not sure how [the SGR] was going to affect their payments for the next year,” he says. “The benefit [in MACRA] is there’s certainty now that they know what to expect in 2018; they can prepare for it.”

To that end, McCarthy advises SNFs to start alerting their investors of anticipated disruptions to their bottom line while at the same time emphasizing the temporary nature of these effects, two actions that can solidify trust and preserve essential business relationships during the payment hiccup.

**Therapy cap exceptions persist**

Although most of the public clamor over MACRA revolves around the bill’s SGR-based reforms, the legislation’s reach extends beyond annual pay rates. In addition to its direct reimbursement dealings, MACRA implements a handful of other provisions aimed at cutting Medicare spending and improving care quality and access to key beneficiary groups. Of particular import to SNFs and their patients is the bill’s two-year extension of the Medicare Part B therapy cap exceptions process, which was slated to expire on April 1 but which will now remain in effect through calendar year 2017.

The exceptions process was introduced by the Deficit Reduction Act of 2005 to remedy the unanticipated shortfalls of therapy caps—another unpopular BBA cost-saving measure—though this fix has proven more durable than the annual rotation of SGR patches.

Therapy caps restrict the amount of Medicare coverage a beneficiary can receive for Part B outpatient therapy services in an effort to protect the Medicare program against fraud and abuse. However, they also restrict the mobility of a critical SNF department that is tasked with keeping patients at their optimal level of physical functioning, says Kris Mastrangelo, OTR/L, MBA, LNHA, president and CEO of Harmony Healthcare International (HHI), a consulting and talent management firm for PAC providers in Topsfield, Massachusetts.

“When you put a cap on Part B, you actually squelch the involvement of therapists,” Mastrangelo explains, underscoring the consequent importance of the exceptions process in mitigating this damaging side effect. “The biggest win is that this cap has exceptions, and it [allows] clinicians to readily treat the patients who need care.”
Mastrangelo’s qualms about the caps were echoed especially loudly in the period between their introduction and the implementation of the exceptions process. Phillips says that during the caps’ infancy, providers, legislators, and consumers quickly discovered that while these limits could accommodate the conditions of many patients, other individuals with more intensive rehabilitation needs were hitting their coverage amounts well before they achieved their therapy goals, a systemic shortcoming with far-reaching implications.

“For lots of people with straightforward, uncomplicated rehab needs, they can get their therapies under the cap, but for those who have much more complex needs, hitting the therapy cap can be really devastating to them and their families, both financially, but also in terms of their ability to access ongoing needed services,” Phillips explains.

To deal with the public backlash from this restricted access, legislators introduced a multi-level exceptions process to extend the cap limits for qualifying beneficiaries. For an individual to attain a higher coverage allowance, his or her therapy provider must document the medical necessity of continued therapy by writing a sufficient explanation in the person’s medical record and including the appropriate modifier on the claim related to the additional services.

If this petition is successful, the 2015 cap amounts—which are $1,940 for physical therapy and speech-language pathology services combined and another $1,940 for occupational therapy services—can be extended up to $3,700 for each of the two categories.

If a beneficiary’s therapy needs surpass even this threshold, CMS will direct the facility’s designated MAC to conduct a manual medical review before awarding more coverage to the individual, though McCarthy says the $3,700 allowance provides sufficient service leeway for many patients who require exceptions.

Although Phillips says the exceptions process comes with a few challenges—it shoulders providers with more paperwork and constitutes a remedial measure rather than a proactive, long-term fix—she sees it as a generally meaningful, effective solution to a shortsighted regulation.

For these reasons, MACRA’s two-year extension of the process represents a hard-fought, albeit incomplete, victory for the many PAC organizations that had lobbied for a total repeal of therapy caps during negotiations for the bill.

Although LeadingAge was among those at the forefront of this movement, Phillips acknowledges that the caps repeal was a necessary casualty of compromise, as its late introduction into the conversation could have jeopardized the bill’s passage in time to head off the staggering physician payment slashes that were slated to take effect under the SGR.

“While we would have loved to have therapy cap resolution included in the final SGR bill, we knew that to try to do that would have opened up a very problematic window,” she explains, adding that LeadingAge and other trade associations continue to champion therapy cap reform and hope to propel implementation of a more permanent variation on the exceptions process in the eventual aftermath of arbitrary coverage limits.

To that end, she says that LeadingAge has proposed to legislators a replacement method for verifying the necessity of therapy services that resembles the medical review process already used in the exceptions process, a model she thinks will gain traction in future bills.

“What we have proposed is that there should be a permanent repeal of the caps process, but in place put a medical review process much as what is in place right now for the exceptions, and that’s likely what any legislative proposed language would look like in 2017 as we move it forward,” she explains.

In the meantime, providers should capitalize on legislators’ recent attention toward Part B therapy by evaluating the strength of their current internal practices in this domain, says Elisa Bovee, MS, OTR/L, vice president of operations at HHI.

“Part B is a focus now—there’s no question about it,” she says. “You have to be diligent with looking at all of the expectations for documentation, specific to published Medicare contractor guidance.”

She urges providers to develop comprehensive peer review processes to verify that documentation illustrates the need for skilled services and ensure therapists are regularly satisfying all technical care requirements.

**Powerful legislative predecessors**

Although MACRA saw in the landmark SGR repeal, it’s not the first bill of its kind, but rather, the latest
piece of SGR-centered legislation to carry the doc fix moniker, and for the SNF sector, it might not even be the most influential over the long term, according to Phillips.

While previous iterations of the doc fix may have only put forth temporary SGR fixes, Phillips says last year’s version, officially titled the Protecting Access to Medicare Act (PAMA) of 2014 (H.R.4302), also calls for the phasing in of a significant new metric for gauging performance and future payment starting later this year: the SNF 30-day all-cause readmission measure (SNFRM).

As provisioned by PAMA (and further fleshed out in the FY 2016 proposed rule), SNFs will be required to submit rehospitalization data to CMS beginning October 1 (the kickoff date of FY 2016) to help the Secretary of Health and Human Services specify the scope of the measure, which she is instructed to do by the beginning of FY 2017.

By FY 2018, the Secretary must devise a methodology to ensure the validity and reliability of the measure and soon after must begin publicly reporting SNFs’ performance on Nursing Home Compare. Ultimately, performance on the SNFRM will influence facilities’ pay grade when the setting’s VBP program is rolled out in FY 2019. At that point, CMS will reduce SNFs’ reimbursement rate by 2% and redistribute a portion of the savings among high-performing providers.

Reducing readmissions

Because of the reporting and payment implications attached to the nearing SNFRM, both Phillips and Mastrangelo stress the importance of revitalizing efforts to prevent rehospitalizations.

“We need to be gearing up in the postacute world, particularly on the nursing home side, to find ways to reduce unnecessary hospital readmissions because there are direct penalties linked to that,” Phillips explains.

She says this initiative should emphasize strong communication within the facility and consistent collaboration with outside service partners, particularly physicians and hospitals. She urges SNFs to evaluate their virtual access to clinical staff, including physicians, nurse practitioners, and physician assistants, as expedient communication with these professionals can often prevent a resident’s return to the hospital after a problematic condition change.

She and Mastrangelo also recommend that facilities conduct a root cause analysis to determine the primary reasons behind avoidable readmissions among their residents and remedy flaws in any related clinical processes, such as staffing or quality improvement.

To support these efforts, Mastrangelo urges SNFs to ensure they have some kind of mechanism in place for tracking rehospitalization statistics and general patient demographics, which can reveal important information on facility lapses and opportunities.

“Know and analyze why... patients are returning to the hospital,” she says. “Data’s important, and it doesn’t have to be some sophisticated software program.”

But providers need not restrict these monitoring efforts to past failures. Phillips suggests that SNFs also look into the array of organizational tools available for monitoring condition changes to head off hospitalizations. She points specifically to Interventions to Reduce Acute Care Transfers (INTERACT), a quality improvement program centered on monitoring and managing problematic conditions changes in the most at-risk long-term care patients. The program offers a host of setting-specific, free, downloadable tools to fuel everyday communication, clinical, and care planning processes.

MACRA just one piece of the puzzle

Phillips urges SNFs to contextualize MACRA—including the nominal payment ramifications it carries—within the greater PAC legislative landscape, which she says is abundant with fuller-bodied regulatory focuses poised to shape the future of SNF care and reimbursement, such as the expansion of bundling, accountable care organizations, and managed care, as well as a host of new quality measures, including PAMA’s rehospitalization metric.

“My admonition to postacute and long-term care providers is, yes, pay attention to the SGR. It’s a good thing it passed. Yes, there will be some payment hits... but what you really need to be paying attention to is: What are some of the proposed payment model changes,” she explains. “There’s a whole lot of clinical process...
change that frankly I think has way more import than
the cuts that SGR repeal gave us.”

While Phillips emphasizes the relatively limited
scope of MACRA, Mastrangelo considers the bill a
“great lead in” to the more sweeping SNF reforms on
the horizon, and therefore a means of easing providers
into the significant yet exciting changes ahead.

“It’s all going in the right direction,” she says. “I
think that every provider should be thrilled with this
bill.”

Communication skills to fuel success throughout
the facility

As regulatory and legislative changes continue to
reshape care and payment paradigms throughout
healthcare, providers need to ensure their core opera-
tional and clinical practices are sustainable—a reality
confirmed by respondents to a current HCPro feedback
survey, who have thus far identified staffing concerns
(e.g., education and retention), quality care, and com-
pliance as top SNF priorities for the year ahead.

Each of these domains can benefit from another
foundational, albeit often less tangible focus: communi-
cation. For example, strong communication promotes
staff stability and competency by fostering supportive
relationships and discussion that reinforces important
policies and techniques. These practices in turn boost
care and compliance by encouraging collaboration to
meet governing regulatory requirements and clinical
principles.

For these reasons, SNF leadership should share
the following time-tested strategies with staff to bol-
ster communication between professionals across
the facility—and with service partners across the care
continuum.

Critical communication skills
The following four skills are critical when it comes to
effective communication:

• **Listen.** Don’t assume you know what someone
  is going to say. Don’t interrupt. Just as you want
  other staff members to listen to your problems
  or concerns, be sure to listen to theirs. If you’re
  confused, say so. Try to see the situation at hand
  from the other person’s perspective.

• **Be honest.** Suppose a piece of equipment broke
  when you were using it. You may be afraid of
  punishment, and keep the information from your
  supervisor because you think he or she will be
  angry. Instead, explain what happened calmly and
  clearly. Don’t leave your mistake for someone else
  to discover.

• **Be understanding.** If other staff members don’t
  respond to you immediately, understand that they
  are busy and may have other things on their mind.
  Although your concern may be important, your col-
  leagues may have more urgent issues to deal with
  before they can address it.

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• **Steer clear of defensiveness.** Suppose you tell your supervisor about a coworker whom you believe is mistreating a resident. He or she responds abrasively and asks whether you can prove this serious allegation. Because of this jarring reaction, you think your supervisor doesn’t believe you, and you become angry. It’s common to become defensive when you think someone doesn’t understand or believe you, or that he or she isn’t listening to you. Instead, stay calm, and explain the situation again.

**Avoiding common problem-solving missteps**

In an ideal world, everyone would communicate freely and honestly, and there wouldn’t be any barriers to getting information to the necessary person within an agreed-upon time frame—even if this information casts a colleague or specific action in a negative light.

In reality, though, there are several reasons why staff may not speak up about a problem or concern. For example, facility hierarchies can be intimidating and may not encourage open communication. Supervisors are often busy with their own duties and may not regularly check in with their staff. Managers may be poor communicators and discourage conversation.

To break down some of these walls, consider the following scenarios, which pose common communication problems and viable solutions:

• **Staff members are scared to make waves.** Some staff members may be worried that their voiced concerns will sound like complaints, or will make them look like busybodies. Supervisors should let these individuals know that it’s okay to express their concerns without fear of being negatively judged or retaliated against.

• **Staff members don’t want to get anyone in trouble.** SNF staff members work in close proximity to one another and often form friendships, making it more difficult to objectively look at a situation involving a coworker. Regardless, it is the responsibility of each and every facility employee to put the needs and rights of his or her patients first.

• **Staff members may feel neglected.** Avoid power distinctions between management, supervisors, and aides whenever possible, as they may cause some staff to feel that they are not respected or appreciated, or that their input doesn’t matter.

Although an individual staff member’s decision to stay mum about a perceived issue may seem like an isolated decision that’s negligible in the grand scheme of operating a nursing home, such actions can create a problematic culture of passivity. For example, if CNAs, who are often the eyes and ears of a facility, are reluctant to raise their voices, there’s a good chance no one will. For the same reason, staff members should not shy away from reporting a problem because they assume that management is already aware of it.

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**MSP claims—when billers must be detectives**

*By Janet Potter, CPA, MAS, Manager, FReR Healthcare Consulting, Inc.*

Medicare as Secondary Payer (MSP): the claims so many billers dread. Many MSP situations are discovered after the fact, which makes gathering the necessary information to complete them even harder. While no one can make these claims go away altogether, we can make the process easier by taking steps up front.

When the program first began, Medicare was primary to all other payers except Workers’ Compensation. In 1980 Congress enacted the MSP provisions to make Medicare secondary to most other insurances. There are no exceptions to the MSP rules; they take precedence over all other state and federal laws. Providers are required to screen for other insurances that are primary to Medicare, and to bill those insurances first.

Many Medicare beneficiaries have additional health insurance coverage that is primary to Medicare. Group employer health plans or retirement health benefits may still be in effect (either through the beneficiary’s own coverage or that of a spouse) after the individual has qualified for Medicare. When there is an accident...
involved there may be an auto or home owner’s liability, or no-fault policy or Workers’ Compensation. Some beneficiaries may have other insurance due to a medical condition, such as black lung or end stage renal disease (ESRD).

A thorough screening for MSP policies is the biller’s best defense for avoiding tricky situations later. The earlier the MSP policy is identified, the better. It is imperative to review the HIPAA Eligibility Transaction System (HETS) prior to admission. HETS will identify any other open insurance policies. On the MSP screen, any insurance policies listed with an effective date and no termination date will be considered primary to Medicare until those policies are closed. It is important to check HETS multiple times throughout a beneficiary’s stay, as sometimes MSP policies will appear later due to timing and notification issues by the third-party payers. You can check the HETS information at: www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/HowToGetConnectedHETS270271.html.

A difficulty arises when an old policy is still listed as open when it actually terminated years ago. When this situation occurs, the SNF will need to work with the resident and family to close the old policy. The beneficiary can call the Benefit Coordination Recovery Center (BCRC), formerly known as the Coordination of Benefits Contractor (COBC), with the updated information. If the beneficiary is unable to make the call personally, the facility staff can call with the beneficiary in the room. The other insurance can also update the records by submitting a request to the BCRC on its letterhead.

Providers are also required to complete an MSP questionnaire. There is no standard form, but questions to include are provided in Chapter 3 of CMS’ Medicare Secondary Payer (MSP) Manual. Your MAC may also have a form. Upon admission and readmission, the MSP questionnaire should be completed. The questionnaire, which must be kept on file for 10 years, is used not only to identify potential other payers (such as employer group health plans or liability insurance following an accident), but also to begin gathering information for billing the other insurance primary.

When another policy is discovered, that’s when the real detective work begins. Billers must investigate the plan with the beneficiary and family to determine if it is current, and then with the insurer to determine what can be billed to the plan and how.

It is very important to follow the Medicare MDS schedule for all residents, including those who are

### Explanation codes

<table>
<thead>
<tr>
<th>Two-Position Explanation Codes</th>
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<tbody>
<tr>
<td>NB - Not a covered benefit</td>
</tr>
<tr>
<td>PC - Pre-existing condition</td>
</tr>
<tr>
<td>FG - Patient did not follow guidelines of HMO or Workers’ Compensation plan</td>
</tr>
<tr>
<td>BE - Benefits are exhausted (include date benefits exhausted)</td>
</tr>
<tr>
<td>DA - 120 days have passed since primary insurer billed (include date primary insurer billed)</td>
</tr>
<tr>
<td>DP - Delay in payment from primary insurer</td>
</tr>
<tr>
<td>LD - A response is received from the liability insurer stating that it feels it is not responsible for the claim</td>
</tr>
<tr>
<td>PP - Patient was paid by liability insurer (only if provider is not expecting payment from patient)</td>
</tr>
<tr>
<td>PE - Personal injury protection has been exhausted (need copy of exhaustion letter on file)</td>
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</tbody>
</table>

Source: FR&R Healthcare Consulting, Inc.
MSP. If Medicare is to pay secondary or if it is later determined Medicare is primary, it is vitally important to have those required assessments completed. In addition, MSP residents should be placed in a Medicare certified bed. For example, if the primary insurance denies the claim because the policy benefits are exhausted, or another similar reason, then Medicare will pay the claim if it is for Medicare covered services and meets all other Medicare criteria. If the resident was not in a Medicare bed, that would lead to a technical denial. And if there was no MDS assessment completed, the facility will only be able to bill at the default rate.

The UB-04 for MSP claims is very similar to a regular Medicare claim, but with additional information included. Occurrence codes are required to describe the event and the date the event occurred. In addition, value codes and amounts that describe primary payer source and amounts paid are required. You will complete the name of the primary insurer in line 50A of the UB-04, and list Medicare as secondary payer in line 50B of the UB-04. Be sure to include the complete address information for the primary insurer listed in the Remarks section as well as an explanation code that is also required to indicate to Medicare why the primary insurance is not paying the claim. (See grids throughout this article for common MSP codes.)

Steps to follow when there is another payer include:
- Immediately upon determining there is a primary payer, notify the A/R manager (or other facility designee).
- Determine if the facility has a contract with the payer.
- Obtain a copy of the policy when possible.
- Call the payer to determine:
  - Coverage criteria
  - Benefits covered, including days available and ancillaries allowed
  - Billing requirements
  - MDS requirements
  - Preauthorization requirements
- Maintain records of all contacts with the insurance company. Document the following:
  - Phone calls, emails, information obtained from the organization’s website
  - Web address and retrieval date of any information downloaded from website
  - Date and time of contact
  - Individual’s name

### Occurrence codes

<table>
<thead>
<tr>
<th>Code Type</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workers’ Compensation</td>
<td>04 + date of injury/illness onset</td>
<td>15 with 000000 as amount</td>
</tr>
<tr>
<td>Black Lung</td>
<td>24 + date of denial</td>
<td>41 with 000000 as amount</td>
</tr>
<tr>
<td>Medical payments</td>
<td>01 + date of accident</td>
<td>14 with 000000 as amount</td>
</tr>
<tr>
<td>No-fault</td>
<td>02 + date of accident</td>
<td>14 with 000000 as amount</td>
</tr>
<tr>
<td>Liability</td>
<td>03 + date of accident</td>
<td>47 with 000000 as amount</td>
</tr>
</tbody>
</table>

Source: FR&R Healthcare Consulting, Inc.
Editor’s note: This article was modified from HCPRO’s latest long-term care title, *ICD-10 Compliance: Process Improvement and Maintenance for Long-Term Care*, written by Maureen McCarthy, BS, RN, RAC-MT, and Kristin Breese, BSN, BSed, RN, RAC-MT. The complete book helps facilitate ongoing ICD-10 success by arming SNF readers with information and strategies that target the preparation, implementation, and maintenance phases of the fast-approaching coding transition. For more information or to order, call customer service at 800-650-6787 or visit www.hcmarketplace.com.

Success with MSP claims is all about persistence, documentation, and attention to detail. While the temptation to ignore these bills and hope they go away is strong, resist and begin early to get the information needed to file them. The clock for timely filing is always ticking, and it is easy for MSP claim payments to be lost because of delays in action. Put on your detective cap right away and begin the investigation to get each claim properly paid.

### Internal auditing strategies for ongoing ICD-10 success

To ensure that preparations made over the past months (or years) ultimately pay off, SNFs should start laying the groundwork for regular facility-wide audits of ICD-10 systems in the aftermath of implementation—a proactive approach that can help providers verify the strength of ongoing transition efforts and catch any snags before they disrupt essential facility processes.

Thus, although the word “audit” can provoke fear and anxiety in providers—often connoting scrutiny and penalties when administered by Medicare contractors—facilities can head off these unsavory external audits, or at the very least reduce negative outcomes, by conducting their own internal varieties.

In a broader sense, frequent self-audits can promote overall business vitality by facilitating the development and maintenance of sustainable processes across the facility, particularly in the face of the impending overhaul to coding methodology and practice.

<table>
<thead>
<tr>
<th>Insurance Type</th>
<th>Payer Code</th>
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<tbody>
<tr>
<td>Working Aged</td>
<td>A</td>
</tr>
<tr>
<td>Disability</td>
<td>G</td>
</tr>
<tr>
<td>Workers’ Compensation</td>
<td>E</td>
</tr>
<tr>
<td>Black Lung</td>
<td>H</td>
</tr>
<tr>
<td>Automobile, No-fault, or any liability insurance</td>
<td>D</td>
</tr>
<tr>
<td>Liability</td>
<td>L</td>
</tr>
<tr>
<td>Medicare</td>
<td>Z</td>
</tr>
</tbody>
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Source: FR&R Healthcare Consulting, Inc.
The scope of self-audits

The Office of Inspector General (OIG) considers ongoing monitoring and evaluation important elements of a healthcare organization’s compliance program and identifies two overarching types of reviews:

1. Standards and procedures reviews, which measure whether internal standards are current and complete, or are in need of an update to reflect regulatory changes
2. Claims submission audits, which gauge whether coding, billing, and documentation are in compliance with payer and government contractors, as well as whether services performed are reasonable and support medical necessity

The OIG states that self-audits, which generally fall into the second category of reviews, can accomplish an array of verification processes. More specifically, the agency explains that these audits can be used to determine whether:

- Bills are accurately coded and reflect services provided
- Documentation is complete and correct
- Services or items provided are reasonable and necessary
- Any incentives for unnecessary services exist

The baseline audit

SNFs should launch a baseline audit after the first three months of ICD-10 implementation. This initial evaluation will help providers identify areas that need improvement or education, or could form a basis for future audits.

To shape baseline (and subsequent) audits, facilities should consider the following list, which identifies key aspects of major operational areas the ICD-10 transition is likely to affect:

1. Documentation
   - Detail and specificity
   - Medical necessity
   - Components of chief complaint, history, examination, or medical decision-making
2. Coding/billing in the electronic health record system
   - CPT, ICD-10, and HCPCS codes
   - CCI edits and LCDs
   - Modifiers
3. Guidelines
   - Interpretation of gray areas
   - Consultations
   - New versus established patients
   - Signatures
   - Incident-to services
   - Medicare guidelines
4. Education
   - Physicians
   - Staff responsible for coding (e.g., MDS, rehab, nursing)
   - Billers
   - Others (e.g., admitting staff, unit clerks)

Introducing HCPro’s Billers’ Association for Long-Term Care:
The premier national membership community for long-term care billers

At HCPro, we recognize that long-term care billers are a largely underserved professional population. While long-term care has national associations for nearly every type of nursing home professional, no membership association for billing professionals has existed—until now.

HCPro’s Billers’ Association is a national membership community specially designed for long-term care billers. The much-anticipated association fills a major industry void by:

- Providing a credible, go-to source for billing, regulatory, and reimbursement resources (including tailored guidance, educational information, and training tools) that billing professionals need to be successful in their roles
- Offering valuable resources, including a community of fellow billers with whom to network, collaborate on claim submission quandaries, and share trade insights
- Empowering billing professionals to make sense of all the shifting expectations and requirements at play in the evolving world of long-term care billing

For more information or to become a member of HCPro’s unrivaled association for long-term care billers, visit www.hcmarketplace.com.
5. Strategic considerations
   a. What problems have been identified, and how will they be resolved?
   b. How will future problems be identified and reported?
   c. How often will audits be performed?
   d. Should an external auditor be hired?

Subsequent audits

Once SNFs have completed their baseline audits, they should analyze the outcomes to develop an auditing compliance plan, which can function as staffs’ blueprint for future documentation, coding, and billing.

The ICD-10 task force, or transition team, should appoint a post-ICD-10 committee to review initial implementation results, evaluate success against established criteria, and identify what works and doesn’t work, especially in the revenue cycle, health information management, and IT realms.

Prior to the October 1 kickoff, this committee should determine which measures will be tracked, and collect related preliminary data.

Following the go-live date, this committee—and the facility at large—must be on the lookout for significant post-implementation issues, including claims denials and rejections or coding backlogs. The committee must quickly identify such issues, create feedback loops, and follow the established solution path to remediation—a task that’s best facilitated by routine auditing of both claims and supportive documentation in a patient’s medical record.

Facilities should track all ICD-10 submissions and receipts for 3–6 months after the transition. Quality assurance monitoring should focus on ensuring proper receipt of ICD-10 codes by vendors and payers. Providers should also be sure to address all communications from these sources, as well as trading partners and CMS.

Key takeaways

Routine review of ICD-10 coding will soon become an essential function of all facilities’ quality monitoring systems and resulting performance improvement plans. Auditing documentation for sufficient data to support specificity in ICD-10 diagnosis coding should begin 2–3 months prior to the transition and continue well after October 1.

Conducting ongoing auditing is crucial to update or solidify processes that underlie, facilitate, and support ICD-10 coding and claim submission, thereby ensuring a hassle-free conversion to the new system.

The table below can serve as a template for tracking progress and results related to key ICD-10 monitoring and auditing initiatives.

<table>
<thead>
<tr>
<th>Task</th>
<th>Date Started</th>
<th>Date Completed</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitor ICD-10 submissions/receipt</td>
<td></td>
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<tr>
<td><em>(Total estimated time to complete: 3–6 months)</em></td>
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<tr>
<td>Monitor submission and receipt of ICD-10 codes</td>
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<tr>
<td>Monitor communications from trading partners for possible errors with codes</td>
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<tr>
<td>Monitor payments to ensure they are the expected amounts for the service(s) provided</td>
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<tr>
<td>Conduct audits of ICD-10 coding to ensure staff are using the best possible codes</td>
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</table>