Medicare Accounts Receivable Management Strategies

Your Speakers

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Objectives

• Determine ways to improve the facility’s Medicare accounts receivable balances and its management.
• Manage coinsurance and bad debts and avoid costly errors and delays in receipt of payments.
• Build an appropriate team to respond to and monitor additional development requests and audits.
MANAGING ACCOUNTS RECEIVABLE

Start Prior to Admission

• As we discussed yesterday, the admissions process is vital to a good stay in the facility – both from the perspective of the resident and the facility

• Communication begins before the resident ever comes to the facility and continues throughout the stay
Confirming the Payer Type

- Before admission, the HIPAA Eligibility Transaction System (HETS) should be checked for all residents:
  - Confirm Medicare A and B eligibility
  - Check for Medicare Advantage and other primary plans
  - Look for open Medicare as Secondary Payer (MSP) files
  - Determine if there are open home health or hospice episodes
  - All of these items will affect the accounts receivable and its management

Accounts Receivable

- By definition, accounts receivable is money owed to an entity in exchange for goods or services that have been delivered or used but not yet paid for, usually within a relatively short time period (generally less than one year)
- In the healthcare world, once a facility provides services to its residents and bills Medicare or another payer, the amount billed is an account receivable until payment is received or the balance is written off as uncollectible
Accounts Receivable

- Accounts receivable is often used as a measure of financial stability
- It is used in several key financial ratios
  - Used to secure bank loans and lines of credit
  - Monitored by the Board and top leadership as a way to determine “how we’re doing”

Days Sales Outstanding

- Measures the number of days of revenue uncollected
- Accounts receivable/(revenues/360 days)
  - Example: there are 50.23 days of revenue uncollected
  - Medicare pays in approximately 14 days
  - Private should be collected within 30 days
Days Sales Outstanding

Days Sales Outstanding

Accounts Receivable \( \frac{\$600,000}{\frac{\$4,300,000}{360 \text{ Days}}} \)

Revenue/days = 50.23 Days

Accounts Receivable Aging

Accounts Receivable Aging Report

<table>
<thead>
<tr>
<th>Current</th>
<th>30-60 Days</th>
<th>60-90 Days</th>
<th>Over 90 Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>$230,000</td>
<td>$150,000</td>
<td>$120,000</td>
<td>$100,000</td>
</tr>
</tbody>
</table>

Total A/R = $600,000

Percentage over 90 days:

\( \frac{\$100,000}{\$600,000} \) = 16.67%
Uses of Accounts Receivable

• Available borrowing under line of credit
  – Will vary based on lender
  – Example
    • 80% of accounts receivable less than 90 days outstanding
  – May have to calculate and report monthly to lender
  – Lender could also require monthly, quarterly, or annual financial statements
    • Audited, reviewed, or compiled

Accounts Receivable Aging

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Calculation

\[
\begin{align*}
&\text{Available Borrowing} \\
&= \frac{\text{Current} + 30-60\text{ Days} + 60-90\text{ Days} + \text{Over 90 Days}}{\times .80} \\
&= \frac{230,000 + 150,000 + 120,000 + 100,000}{\times .80} \\
&= \frac{500,000}{\times .80} \\
&= 400,000
\end{align*}
\]
STREAMLINING MEDICARE BILLING

Streamlining the Process

• The more Medicare claims that are paid when first submitted to Medicare, the fewer collection issues later on
• Ensure that claims are clean when sent to Medicare
  – No missing dates or codes
  – HIC numbers match names and other demographic information
  – All ancillary charges on the claim
  – Physician names and National Provider Identifiers (NPIs) correct
Streamlining Processes

- Is the Medicare billing process working smoothly?
  - Does information have to be keyed in more than one time?
  - Can steps which are repeated be combined?
  - Does the business office know what the clinical team is doing and what information they have available, and vice versa?

Segregation of Duties

- Audit procedures such as separating accounts receivable and accounts payable must be in place
- Internal audit controls for cash management: payments received input by someone who did not do the initial billing
- However, while these processes are put in place care should be taken to avoid duplication of efforts
Medicare

- All Medicare claims must be billed on a monthly basis
- On a weekly basis, follow up on claims in the Fiscal Intermediary Shared System (FISS)
  - Look for paid claims
  - Return to provider claims
  - Suspended claims

Medicare

- All Additional Documentation Requests (ADRs) must be promptly answered
  - If the medical record documentation is not received within 30 days, the claim will be denied and an appeal will be necessary
- Appeals should be filed for all denials, including line item denials
  - Follow facility guidelines
  - Involved therapy or other ancillary vendors as appropriate
Timely Filing

- Medicare claims must be submitted within one calendar year of the through date on the claim
- Delays due to incomplete claims or errors on claims which cause the claim to be rejected can result in Medicare accounts receivable delays and consequently cash flow issues

Timely Filing

- Many organizations require Medicare billing to be submitted no later than the 10th of the month
- After the current monthly billing is submitted, the next step should always be to follow up on the prior month’s outstanding claims
  - Any open claims should be investigated and rebilled or corrected as appropriate
Common Rejection Reasons

- Incorrect beneficiary HICN (Medicare number)
- Overlapping claim dates
- No 3-day qualifying stay
- Hospital discharge is more than 30 days from SNF admission
- Resident is enrolled in an Medicare Advantage (MA) plan
- Overlapping hospice election period
- Open home health episodes

Insurance/Medicare Advantage

- Monthly claims should be mailed and/or electronically submitted to the appropriate company
  - Include all charges as allowed by the policy
- Many plans have stricter billing time frames than Medicare
- Claims should be followed up on a monthly basis
- Any requests for more information should be promptly addressed
- All denied claims should be appealed within the guidance of the CFO, Administrator, or other authority
DEDUCTIBLES AND COINSURANCE

Medicare Coinsurance and Deductibles

• Medicare coinsurance and deductibles have special rules that must be followed
  – Should be incorporated into the policy and procedure
• Must be billed and collected appropriately as a condition of Medicare participation
When You Can Bill Coinsurance

• From the Claims Processing Manual, Chapter 1, Section 30.1.1
  • SNFs may not require, request, or accept a deposit or other payment from a Medicare beneficiary as a condition for admission, continued care, or other provision of services, except as follows:
    • A SNF may request and accept payment for a Part A deductible and coinsurance amount on or after the day to which it applies.

When You Can Bill Coinsurance

• From the Claims Processing Manual, Chapter 1, Section 30.1.1 continued
  • A SNF may request and accept payment for a Part B deductible and coinsurance amount at the time of or after the provision of the service to which it applies.
  • A SNF may not request or accept advance payment of Medicare deductible and coinsurance amounts.
When You Can Bill Coinsurance

- From the Claims Processing Manual, Chapter 1, Section 30.1.1 continued
  - A SNF may require, request, or accept a deposit or other payment for services if it is clear that the services are not covered by Medicare and proper notice is provided. See Chapter 30 for instructions about ABNs and demand bills.
  - SNFs, but not hospitals, may bill the beneficiary for holding a bed during a leave of absence if the requirements in §30.1.1.1 are met.

Coinsurance and Deposit Guidelines

- Facilities cannot require a deposit from a Medicare admission
  - However, on day 1 of the resident’s private pay stay, following the termination of Medicare services, a deposit can be collected following the same procedures as for a regular private pay resident.
Coinsurance Guidelines

- But, for services that Medicare does not normally cover, advanced payment can be requested
  - For example, if a resident requests a private room that is not medically necessary, the facility can request advance payment for the private room differential

Coinsurance Procedures

- A written coinsurance policy and procedure should be included in the facility policy manual
- Once the coinsurance has been billed, collection procedures should mirror other collections for same payer type
  - Private pay
  - Insurance
  - Medicaid
Crossover Billing

• Allows Medicare coinsurance to be crossed over to supplemental plans automatically through FISS
• Can be sent to any supplemental plan that Medicare has a trading partner agreement with
  – A list of current crossover billing partners can be found at [http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/ProviderServices/](http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/ProviderServices/)
  • In the downloads section

COBC

• Coordination of Benefits Contractor (COBC)
  – Maintains trading partner agreements for Medicare, supplemental insurance, and some Medicaid plans
  – Processes the crossover claims and sends them to the secondary insurance
    • Returns the claims if they don’t pass through edits
    • Successful cross-over doesn’t guarantee payment
Updating Information with the COBC

- COBC processes all the MSP information and claims
- CMS released MLN Matters article #SE1416 with information on how to update beneficiary information with the COBC

If the provider calls the COBC with the beneficiary present
- The first call (after April 1, 2011) will result in the file being updated
- After that all updates must be made in writing (via fax or mail) on the insurer or employer’s letterhead

If the beneficiary is not present, the COBC will update information given over the phone
Crossover Billing

• If cross-over billing is not available for a particular secondary insurer, contact the insurance company to determine the process for submitting a coinsurance claim.

• Typically, a copy of the UB-04 along with a copy of the remittance advice showing Medicare payment will be necessary.

Part A Coinsurance

• Unpaid Part A coinsurance may be claimed on the Medicare cost report after all collection efforts have been exhausted:
  – Must be traditional Part A coinsurance; Medicare Advantage programs do not qualify
  – Auditors will ask for proof of efforts so it is important to complete and document all steps

• The collection efforts must continue for a minimum of 120 days for non-dual eligible residents

• The debt must be written off in the general ledger the same year as claimed on the cost report.
Medicare Bad Debts

- An unpaid Part A coinsurance on a covered Medicare claim may be considered a bad debt for cost reporting purposes, if certain criteria are met.
- Unpaid deductibles and coinsurance that do not meet the criteria for cost reporting, should still be written off on the financial statements.
  - Confirm facility policy with your CFO or outside accountant.

Bad Debts Reduction

- SNFs are currently reimbursed at 65% for private pay and 76% for dual eligible’s (in states which do not pay for Medicaid residents) bad debts on their Medicare cost report – for fiscal year 2014.
  - Only for Part A co-insurance.
  - Michigan is currently paying for dual-eligible coinsurance.
- Both private pay and dual-eligibles will be at 65% for fiscal year 2015.
Part B Coinsurance and Deductible

- Medicare does not allow Part B coinsurance and deductibles to be claimed as bad debts on the cost report
- However, these amounts must be written off, if not collected, on the financial statement
  - Again, follow facility policy and work in tandem with the CFO or outside accountant

COLLECTION POLICIES
Collection Policies

• A complete and thorough collection policy is necessary
  – Part of a good compliance program
  – Necessary to prove good faith effort to collect
• Should include procedures for all payer sources
  – Private pay
  – Insurance
  – Co-insurance
  – Medicare
  – Medicare Advantage

Collection Policies

• Policy must be consistently followed
  – No skipping steps
  – Include only the procedures you want to follow for each case
  • Don’t include sending a case to a collections agency at a particular level unless you want to send every bill at that point
Collection Policies

- Must be in writing
- Should be approved by the Board or other authority within the organization
- Must be accessible by all staff who are involved with the procedure
- Staff need to be informed of changes in the policies when they happen

Consistency

- When the policy is followed consistently, it allows the facility to write off bad debts
  - Medicare will not allow bad debts without a consistently followed collection process
  - Courts will also look for consistency in following the collection policy
OTHER ACCOUNTS RECEIVABLE ISSUES

Pre-certifications

• Many private insurance policies and Medicare Advantage contracts require pre-certification prior to covering a nursing facility stay
  – The insurer or Medicare Advantage plan may approve a set number of days of SNF care prior to needing another certification

• The facility may have to submit documentation or proof of need of the services/stay
  – May be required to discuss with a nurse case manager via phone
Prior Authorizations

- Prior authorizations are frequently required by insurance policies or Medicare Advantage plans to approve professional services or supplies
  - Durable medical equipment
  - Physician services
  - Therapy
- Many Part D plans require prior authorizations of certain tiers of drugs before paying

Charge Structure

- A consistent charge structure is a requirement of Medicare
  - No payers may be charged less than Medicare
- Private pay residents may not be given an automatic discount from the Medicare (or other) rates
ADDITIONAL DEVELOPMENT REQUESTS

Review Topics on MAC Websites

- Beginning September 5, 2014 must post on their websites any issues currently under review
- It is also suggested that MACs post detailed information on what documentation is required for ADRs on each issue
- Utilize this information to your benefit by reviewing periodically
Work Flow

- Before an ADR is received, all members of the team must know their part in responding to the request and their time frame.
- Should be a written policy and procedure including specific forms to use, timeframes for completing and responsibilities.

Preparing the ADR Packet

- Review the ADR letter carefully for what is being requested.
- Before the information is submitted verify:
  - Time periods
  - All requested information has been included
  - Correct beneficiary.
Preparing the ADR Packet

- Beneficiary name and HIC number on each sheet
- Time period on each sheet
- Include a copy of ADR on top of the packet
- Include a copy of the as-filed UB-04
- Include a cover letter
- Make sure all copies are legible
- Include facility name, address, provider number, contact person name, and phone number in the packet
- Keep a copy of the entire packet

ADR Guidelines

- Paper medical records must meet the following requirements:
  - Free of staples and paperclips
  - Pages should be top faced and face up
  - Photocopy must be of good quality and legible
  - Include a copy of the Additional Documentation Request Letter (medical record request letter)
  - Records may be copied on both sides; top faced and face up
Things to Remember Regarding Medical Documentation

- Send everything they ask for
- Don’t send extra documentation
- Send documentation for the correct time periods only
- Ensure MDSs that were utilized to establish the assessment reference date (ARD) are included
- If amending medical records, always sign and date the amendment per facility policies

Prepare Your Medical Review Team

- Who?
  - Should be interdisciplinary, including clinical and billing
- Representatives from the following departments should participate at a minimum:
  - Nursing
  - MDS
  - Therapy
  - Social Services
  - Specialty Units
  - Billing
  - Compliance Officer
Team Leader

- While all members of the team provide valuable contributions, no team can be 100% effective without a clear team leader
  - Oversees the distribution of duties
  - Provides accountability to the other team members
  - Determines communication methods and meetings
- Determine the team leader at the first meeting
  - Not necessarily the person who is highest on the organizational chart

Team Communication

- Determine upfront how the team will communicate
  - Dedicated meetings
  - Part of another meeting
  - Via e-mail, online chat or phone (if in remote locations)
- And how frequently
  - Only when there are reviews in process
  - Ongoing basis
Documentation Pitfalls

- Lack of documentation
- Not submitting documentation when requested
- Lack of detail
- Orders, certifications not signed/dated
- Medical necessity not shown
- Inconsistencies among disciplines and clinicians
- Missing dates of signatures
- Documentation and signatures illegible

Reviewing Documentation

- Prior to submitting any documentation for an audit or medical review, it should be reviewed for accuracy and completeness
  - Addenda can be added if properly dated and signed and following facility policy
  - Errors may be found that cannot be fixed for this particular claim but will notify the team of necessary procedural changes
    - Ex. missing beneficiary notices
After the Audit

- Review audit results for application to other claims within the facility
- Follow up with the contractor if there are questions about why adjustments/denials were made
  - Ask for guidelines used including copies of local coverage determinations (LCDs) or national coverage determinations (NCDs)
  - Ask about educational opportunities for staff
- Incorporate changes needed into the corporate compliance program
- Update facility policies and procedures where needed

FINAL THOUGHTS
Final Thoughts

- Consistent application of collection policies and procedures will allow write-offs and bad debts to be properly treated
- Completing weekly, monthly and annual procedures on a regular basis will help minimize bad debts
- Good internal procedures will help keep the accounts receivable clean

Document Everything

- Document, document, document
- Include names and dates and methods of communication
- Save all e-mails, faxes and letters
- Send letters with return receipt
- Document, document, document
Daily Steps

• Input charges received from outside vendors and internal sources (barber and beauty, medical supply tracking) into the accounts receivable as they come in
  – Whenever possible automate the process
• Document all phone calls and letters received in relation to collections or accounts receivable
• Prepare a tickler file of collection letters to be sent; every day send any that are now due
• Record all payments received in the general ledger

Weekly Steps

• Review FISS system for suspended or return to provider claims
• Determine if there are any insurance or Medicare Advantage claims to follow up with
• Submit any ADRs that have come in, or follow-up with other departments if waiting for documentation
Monthly Steps

• Send out all billing within facility set timelines
• Review accounts receivable aging for overdue accounts
  – Review with CFO or other deemed party
  – Follow-up on all overdue accounts is a must
• Prepare any collection letters needed for the coming month and add to the tickler file

Annual Steps

• Prepare bad debt information including all required documentation for cost report preparer
• Write off any uncollectible accounts with the approval of the CFO or outside accountant
• Management should review the policies and procedures and update as needed
  – Board should approve all changes
  – All staff must be trained in new policies and procedures
Questions and Discussion