The Medicare Admissions Process and Strategies for Success

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Your Speakers

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Objectives

• Examine your admissions process for potential missed steps.
• Review the admissions packet for current forms and completeness.
• Improve communications between departments and the resident and family during the admissions process.
THE ADMISSIONS PROCESS

Setting the Stage

• Whether you have a stand alone facility, a large campus setting or multiple facilities, having a consistent admissions process and policy will reduce errors and lead to a smoother process
  – Consistent training
  – Utilize best practices
  – Changes approved by management/corporate
Setting the Stage

• Accountability
  – With consistent process, content and training should come consistent results
  – Compliance
  – Timeliness

• Hospitality Focus – incorporate the facility’s/organization’s mission statement into the process
  – Welcoming
  – Helpful
  – The resident/family they have chosen our community
    • Assisting them is not a burden – it is our pleasure
Who is the Admissions Team?

- Admissions Department
- Nursing
- Business Office
- Social Services
- All must work together and not duplicate efforts or miss steps

Preadmission

- Before the resident arrives at the facility much of the admission process should already be completed
  - Screening for eligibility/coverage
  - Determining payor(s)
- Good communication with hospital discharge planners is vital
Verifying Eligibility

- Who verifies eligibility for Medicare through HETS?
- When is it completed?
- Coverage determination should be made prior to hospital discharge
  - Can we care for the patient?
  - Which services(s) are skilled?

Medicare Card Information

- Take the information from the Medicare card exactly as it appears on the card:
- Additional information from the Medicare card
  - Hospital insurance
    - Resident has Part A coverage
  - Medical insurance
    - Resident has Part B coverage
  - Effective date (hospital and medical)
    - Medicare will not pay for any services prior to date shown on I.D. card
Technical Requirements for SNF
Part A

• Technical requirements that must be met:
  – 3-day qualifying hospital stay (3 inpatient midnights)
  – Admission within 30 days of a hospital or SNF discharge
  – Available days in benefit period

Three Day Qualifying Stay

• The hospital said the resident was there from 1/5/14 - 1/8/14…that is 3 midnights.
  – Was the resident formally admitted to an inpatient bed on 1/5/14?
  – Or ... was the resident in an observation stay on 1/5/14 and admitted to an inpatient bed on 1/6/14?

• When observation stays are involved, facilities must only count midnights when the resident was in an inpatient hospital bed
Benefit Periods

• A benefit period begins with the first day (not included in a previous benefit period) on which a patient is furnished inpatient hospital or extended care services by a qualified provider in a month for which the patient is entitled to hospital insurance benefits.

• A benefit period ends with the close of a period of 60 consecutive days during which the patient was neither an inpatient of a hospital nor an inpatient of a SNF.

In other words, a benefit period begins with a 3-day qualifying hospital stay during a month when the beneficiary is entitled to Medicare benefits.

• It ends when the beneficiary was not in a SNF or a hospital for at least 60 days in a row.

OR

• If the beneficiary remains in a SNF, but does not receive skilled care in the SNF for at least 60 days in a row.
The HIPAA Eligibility Transaction System (HETS) allows the provider to verify current coverage and status of a resident’s Medicare benefits.

Must check Medicare eligibility for each admission inquiry:
- Don’t wait until the resident has been admitted and the paperwork has reached the business office to check HETS.
- Should be checked prior to resident's arrival at facility.

Even when an admission appears to be a straight-forward, original Medicare Part A admission be sure to check HETS for any “surprises”:
- Medicare as Secondary Payer (MSP)
- Medicare Advantage
- Home Health episodes
- Hospice elections
**Level of Care**

- Section 42 CFR 409.31 – Level of Care Requirements
  - According to Medicare, skilled nursing and rehabilitation requires the following
    - Ordered by a physician
    - Requires the skills of technical or professional personnel such as RN, LPN, PT, OT, SLP, and
    - Are furnished directly or under the supervision of such personnel
    - Is reasonable and medically necessary

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**Coverage Criteria**

- Section 42 CFR 409.31(b)(i)
  - Services are provided for a condition for which the beneficiary received inpatient hospital or inpatient CAH services, or
  - Which arose while in a Part A stay, or
  - Medicare Advantage plan may approve a SNF stay without a 3-day qualifying hospital stay
Daily Skilled Services

- Section 42 CFR 409.31(b)(i)
  - Daily skilled services must be ones that as a practical matter can only be provided in a SNF on an inpatient basis
    - Based on the individual’s condition and the availability and feasibility of using more economical alternatives
    - The SNF stay cannot be provided simply because it is more convenient
    - If transportation to the closest facility would be:
      - An excessive physical hardship
      - Less economical
      - Less efficient or effective than an in-patient institutional setting

Physician Certification (Certs) and Recertification (Recerts)

- No payment can be made to the facility without a timely certification/recertification (cert/recert)
- Statements regarding cert/recert must be obtained and maintained by the facility – they are not transmitted
- No specific method or procedure
Certs and Recerts

• Certification and recertification may be completed by a physician, nurse practitioner, and/or a clinical nurse specialist with no employment relationship to the facility
• The initial physician certification, as well as the re-certifications, may be a phone order as long as the signed certification is present prior to the services being billed

Physician Orders

• Physician orders are required for all services provided in order to be covered by Medicare
• Lack of physician orders is a technical denial and cannot be appealed
30-Day Transfer Rule

• The beneficiary must transfer to a SNF within 30 days of discharge from the 3-day hospital stay
  – Can return home first, then go to the SNF
• Unless it is medically appropriate to delay the SNF stay for more than 30 days

Medically Predictable

• If SNF admission is delayed more than 30 days after the hospital stay it must be medically predictable at the time of hospital discharge
  – A beneficiary with a hip fracture may not be weight bearing and ready for therapy at the time of hospital discharge, but SNF admission would be appropriate 4 to 6 weeks later
  – Best practices: physician should document medical predictability at time of hospital discharge
New Admissions Must Receive

- Resident Contract (consent to treat)
- Federal patient’s bill of rights
- Copy of all rules and regulations governing conduct and responsibilities during the facility stay
- Medicaid "Know Your Rights" booklet
- List of noncovered items and services, as well as the costs, for which the resident may be charged
New Admissions Must Receive

- Facility’s patient trust fund policy
- Facility’s policies on advance directives
- Facility policy regarding the availability of hospice care
- Facility bedhold policy
- The name, specialty and contact information of the physician responsible for their care

New Admissions Must Receive

- Information about how to apply for Medicare and Medicaid
- Privacy notice
- How to file a complaint
- Release of Information/Assignment of Benefits
- Medicare as Secondary Payer screening form
Privacy Notice

- Required by the Health Insurance Portability and Accountability Act (HIPAA)
- This form outlines the facility’s privacy practices and details the resident’s rights under these privacy practices
- Only needs to be included in the packet upon first admission or if the privacy notice changes

Release of Information Assignment of Benefits

- Release of Medical Information form
  - Grants facility the right to release medical information regarding the resident
- Assignment of Benefits form
  - Assigns the beneficiary’s Medicare benefits to the facility so the facility can bill and be paid directly
- Third Party Payer Authorization form
  - Combines Release and Assignment for third party payers
The MSP screening form must be completed and on file for all residents
- Should be completed for all admissions
- Review and update information annually

Questionnaire looks for other payers such as the Federal Black Lung program, no fault and liability policies, worked aged, etc.

Other Forms and Information

- Waiver of Medicare Benefits
- Coinsurance Obligation Form
- Medicare Information Sheets
- Insurance Verification Form
Waiver of Medicare Benefits

- Must be signed in the following situations:
  - A Medicare bed is available, but resident does not wish to occupy a bed in the certified section
  - No certified beds available: resident wishes to occupy a non-certified bed until a certified bed is available
    - If a facility is whole-house certified, the only instance where this would apply is if the resident did not want to use their Medicare Part A benefits

- If the resident does choose to sign the form, he or she should understand that the bill will have to be paid privately
- Facility cannot guarantee the resident that a certified bed will become available in the next 30 days
- The facility should inform the resident that he or she may seek a Medicare bed in another facility
Coinsurance Obligation Form

- Informs resident of coinsurance obligation of either:
  - $152.00 per day for Part A (in 2014)
  - 20% of the fee schedule for Part B
- Also informs the resident of the facility’s policy on coinsurance billing – if it is done by the facility on behalf of the resident and any specific instructions

Medicare Information Sheet

- Communication tool to be used to let resident know a little about the Medicare program and how it works
- Explains amounts, some coverage, and other general information
Insurance Verification Form

• A tool used to determine potential payers as well as gather policy information
• Can be used to help catch supplemental plans and other primary or secondary policies

Admissions Checklists

• Can be completed by facility staff to ensure that all steps in the admissions process have been followed and documented
  – Medicare
  – Insurance
  – Best practices: create a facility specific checklist
Consolidated Billing

• A brief explanation of consolidated billing should be provided to all Medicare Part A admissions outlining the requirements
  – Most services are the responsibility of the SNF during a Part A stay even if done by another provider
  – Residents/families should always coordinate offsite services with a knowledgeable facility staff member
Courtesy – Technical Denial Letter

- There are several situations when a formal Notice is not required, but the resident and family are informed of why Medicare will not cover the stay such as:
  - No 3-day qualifying stay
  - No Medicare benefits
  - Benefits exhausted

Notice of Non-coverage

- CMS combined the generic and detailed notices for beneficiaries with Original Medicare or Medicare Advantage
  - Generic notice = CMS-10123, NOMNC (Notice of Medicare Noncoverage)
  - Detailed notice = CMS-10124, DENC (Detailed Notice of Noncoverage)
Generic and Detailed Notices

• The NOMNC and DENC cannot be modified in any way except for the provider to add information in the designated areas
• The NOMNC form must remain 2 pages (can print double sided)
• Not issuing a NOMNC will render the facility financially liable
• Can be given in an electronic format (fax or e-mail) if the beneficiary or representative has opted for it over a paper copy
  – Must meet all HIPAA requirements

SNF ABN

• While providers may use either the SNF ABN or the denial letters (non-coverage letters) per the regulations, facility’s should determine their own best practice
• Used when Medicare Part A services are not covered, reduced or eliminated and the beneficiary remains in the SNF
  • At a non-covered level of care
  • At a custodial level of care
  • Or will be receiving Part B services only
COMMUNICATION

Preadmission

- Contact with the beneficiary and family prior to admission can set the stage for the entire stay
  - Can the family/beneficiary ask questions?
  - Do they know who to contact for follow up?
  - Are all policies explained to them prior to arrival?
- Make sure all facility staff know and can communicate the same information
  - Consistent information provided to the family is essential
  - The message should always be the same, no matter who is giving it
Facility Tours

• When a facility tour is offered, be sure all staff conduct the tour in the same way – again consistency helps eliminate misunderstandings
• Remember Resident’s Rights and HIPAA when taking potential residents/families through the facility

Admissions Interview

• The more paperwork that can be completed prior to the actual admission will reduce the stress of the admission
  – Introduce the new resident to their immediate caregivers
  – When appropriate have other departments introduce themselves – activities, social services, clergy members, business office
Admissions Communication

- Are all team members conducting admissions procedures the same way, or is everyone “making it up as they go?”
- Could anyone step in and take over at any point and make it look seamless to the family and new resident?

Admissions Packet

- Has the packet been reviewed and updated for any recent changes in procedures/forms?
  - Should be completely reviewed at least annually
- Who is completing the forms in the packet?
  - Are all forms executed and signed within a reasonable time period?
- What checks and balances are in place?
Wrap Up

• Follow best practices to ensure a smooth admission and fewer troubles later on
  – Confirm admissions packet is up-to-date, including the resident contract
    • Consider having healthcare attorney review contract
    • Are all required forms included?
  – Ensure all forms are being signed within 48-72 hours of admission
  – Review procedures to eliminate any duplicated efforts

Questions and Discussion