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Billing Alert
for Long-Term Care

Excerpted from
Volume 18
Issue No. 1

JANUARY 2016

A collaborative approach to ongoing benefits verification

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Admissions department and billing office staff know the importance of verifying benefits for prospective residents. By establishing a procedure to evaluate a beneficiary's payer source prior to admission, SNFs can reduce possible claims adjudication issues and facilitate the receipt of payments in a timely manner.

With beneficiaries increasingly enrolling in new healthcare programs, it's becoming essential to supplement preadmission verification with periodic reviews of payer information throughout a resident's entire stay (e.g., on a monthly basis). Recognizing the value of ongoing verification, knowing the right questions to ask, and documenting findings will help SNFs avoid any hiccups on the road to reimbursement.

First steps

To kick off verification activities, providers should obtain copies of a prospective resident's insurance cards, and, if the resident is a Medicare beneficiary, a copy of his or her supplemental plan card.

Beyond this requisite collection, specific verification measures will often depend on the combination of plans a beneficiary holds. The following sections outline key considerations for common SNF payer types.

Medicare Part A

When verifying benefits for a Medicare resident on a Part A stay, the Common Working File (CWF) has historically been the first place to look. But billers shouldn't get too dependent on this process—CMS plans to ultimately discontinue the CWF and replace it with the HIPAA Eligibility Transaction System (HETS). Until the CWF goes officially "dark," though, providers can use both systems to review a potential resident's benefits.

First, ensure that the beneficiary has had a three-day qualifying hospital stay prior to the intended SNF admission. Work with the referral source to confirm that the individual was in the hospital as an inpatient for three midnights. While some accountable care organizations and bundled payment initiatives have begun waiving the

three-day stay requirement, CMS still considers it a coverage criterion for traditional Medicare admissions.

Next, confirm that Medicare is the primary payer source. Ensure that the potential resident is entitled to Part A benefits by taking the following measures:

- Confirm the beneficiary's effective date
- Look to see that he or she is not enrolled in a Medicare Advantage policy
- Check the system for any open Medicare Secondary Payer cases

After reviewing these areas, determine whether the beneficiary has benefit days available for use in the facility, and note any days that have already been used. Don't rely solely on the CWF or HETS to collect this information, as these systems won't reflect days that haven't yet been billed by a resident's previous providers. Always ask the resident and family about prior SNF stays, and confirm the number of days used at other facilities.

Supplemental policies

Verifying benefits for supplemental policies is less common than for primary payer sources, but it's just as important in today's variable payer climate.

It is no longer true that if Medicare pays, the supplement will pay the remaining balance. An array of plans are currently on the market, and their coverage can vary wildly. To prevent financial fallout from misunderstanding the terms of a supplemental policy, contact the supplemental payer and ask several questions:

- Does the policy provide benefits for long-term care?
- What is the policy's coinsurance schedule?
- Are we required to be in-network for the plan?
- Are we required to obtain prior authorization for the plan?

If any of the payer's responses would have a financial impact on the beneficiary during the SNF stay, such as lack of long-term care coverage, you must notify the prospective resident as soon as possible to explain the

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resulting financial obligation, and assign the proper payer in your system.

Medicare Advantage

Medicare Advantage (also called Medicare Part C or Medicare replacement) policies are required to provide, at minimum, the same benefits as a traditional fee-for-service Medicare plan. However, they can also offer additional benefit days beyond the 100-day benefit period for Medicare fee-for-service, waive the three-day qualifying hospital stay, require prior authorization, and have payment methodologies that differ by plan.

In addition, if your facility is out-of-network with a given Medicare Advantage plan, the payer may assign a higher percentage of payment responsibility to the prospective resident. It is imperative to notify the beneficiary of this possibility in advance so that he or she can determine the feasibility of paying higher costs out of pocket.

Because no standard verification systems like the CWF and HETS exist for Medicare Advantage plans, SNF staff can confirm the benefits for these policies in a number of ways. A good place to start is by calling the provider services number for each plan to inquire about its specific benefits verification process.

Adapting to an evolving payer landscape

As the world of healthcare grows and evolves, so do healthcare plans and coverage. In the past, verifying benefits at the point of admission may have been sufficient, but now providers should consider performing this review for their entire census on a monthly basis. While this may seem at first like a time-consuming duplication of work, it can save billing staff from significant claims denials and reimbursement delays.

During the annual open enrollment period, a resident can elect to switch from one Medicare Advantage plan to an entirely new Medicare Advantage plan, or even back to Medicare fee-for-service. In addition, a beneficiary who is residing in an institution, such as an LTC facility, is qualified for a special enrollment period. This means that a SNF resident can theoretically change his or her plan on a monthly basis, which translates to three times during the course of a 100-day stay. Such payer fluidity could pose a challenge when a switch is made from a plan that did not require prior authorization to one that does, or from a plan that had a benefit period longer than 100 days to one with only 100 days after the resident has already passed the 100-day mark.

Given this range of potential complications, putting a process in place to verify benefits on a monthly basis

Quick tips for successful verification

Implement the following strategies to improve consistency, accuracy, and ease of verification across the SNF:

- Use the variety of verification means at your disposal. These include:
  - Intranet portal
  - Phone
  - Fax
  - Internet
- Document each new verification activity in the beneficiary's file, especially if it wouldn't otherwise leave a paper trail. For example, if you have verified a resident's benefits over the phone, note the name of the person you spoke to, as well as the date, time, and reference number as applicable.
- Standardize the verification process across the entire facility. Taking the time up front to develop a worksheet for staff can pay off in the long run by fostering consistency, removing guesswork, and promoting seamless receipt of reimbursement. Some key elements to include on the document are:
  - Beneficiary information, such as name, date of birth, policy number(s), address, and phone number
  - Confirmation of the beneficiary's prior three-day qualifying hospital stay
  - Significant payment details of each plan the beneficiary holds, such as coverage limitations or the plan's method of reimbursement
  - Whether an authorization requirement exists
  - The facility's network status
  - An area for the staff to sign and date the verification

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allows the facility to reach out to residents, or their responsible parties, when new circumstances arise to confirm related information and to explain any expected financial impact.

The interdisciplinary team should discuss who at the facility can perform these post-admission verification activities. Determine whether the job can be done by one staff member, or whether it should be divided among the team by payer type, by floor, or alphabetically by last name.

When the admissions department and the billing office are able to communicate, work together, and put a standardized process in place, benefits verification can run smoothly and support timely reimbursement. It goes without saying, but an efficient process without surprises is better for everyone.

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