HCPro Advisory Services | PROPEL Long-Term Care Journal

Volume 2 Issue No. 11 November 2019

INSIDE THIS ISSUE

Tips for SNFs

Implementing a comprehensive QAPI program in your SNF

Credit: Cnora. Image Source: www.gettyimages.com

Quality Assurance and Performance Improvement (QAPI) programs are essential for creating a safe environment in skilled nursing facilities (SNFs). The current QAPI regulation, §483.75(c), requires facilities to establish program feedback, data systems, and monitoring that should be updated biennially, according to CMS.

The current QAPI regulations are found in the October 2016 final rule (CMS-3260-F). They are currently (at the time of publication) required to be fully implemented by November 28, 2019.

How CMS-3347-P affects Phase 3 QAPI requirements

A proposed rule by CMS, Medicare and Medicaid Programs; Requirements for Long-Term Care Facilities: Regulatory Provisions to Promote Efficiency, and Transparency (CMS-3347-P), would allow SNFs a year extension to meet these Phase 3 QAPI requirements.

An additional year to prepare for QAPI would give SNFs the opportunity to fine-tune their QAPI preparation and plan. Prior to a CMS survey, surveyors inspect a SNF's CASPER and quality measure (QM) data. SNFs should use their QAPI program as a tool to identify shortcomings and develop a plan for improvement prior to survey visits, recommends **Reg Hislop III, PhD,** managing partner at H2 Healthcare LLC, and author of Reg's Blog.

Five key elements of a QAPI program

The five key elements of a successful QAPI program, as outlined by CMS, are:

Design and scope: A QAPI program must be comprehensive and ongoing. The programs should address all staff and managerial aspects of resident care. The program should stress clinical intervention while still emphasizing autonomy and resident choice.

Governance and leadership: Leadership should create an environment that seeks input from residents to improve quality. It is leadership's responsibility to set "expectations around safety, quality, rights, choice, and respect by balancing safety with resident-centered rights and choice."

Feedback, data systems, and monitoring: Systems should be implemented to monitor care and services. Performance indicators should be utilized to track, investigate, and monitor events within the SNF. Resident feedback should be used to identify gaps within the facility, and should be considered when creating improvement plans.

Performance Improvement Projects (PIP): Focus should be concentrated on areas of improvement, or the facility as a whole when necessary. These projects should be all-encompassing when addressing an issue.

Systematic analysis and systemic action: A systematic approach should be taken to understand and solve problems that arise. After issues are identified and rectified, a system of continual learning and improvement should be implemented to ensure the issue doesn't continue.

During annual surveys, surveyors look for any deficiencies in SNFs, ranging from gaps in resident care to safety issues within the facility. If deficiencies are identified, CMS requires that facilities develop a plan of correction, which, according to the Center for Medicare Advocacy, should:

- *Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;*
- *Address how the facility will identify other residents having the potential to be affected by the same deficient practice;*
- *Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;*
- *Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and*
- *Include dates when corrective action will be completed*

Creating a successful QAPI plan

In its publication, QAPI at a Glance: A Step by Step Guide to Implementing Quality Assurance and Performance Improvement (QAPI) in Your Nursing Home, CMS identifies task items SNFs need to be compliant. They are:

- Using data to not only identify your quality problems, but to also identify other opportunities for improvement, and then setting priorities for action
- Building on residents' own goals for health, quality of life, and daily activities
- Bringing meaningful resident and family voices into setting goals and evaluating progress
- Incorporating caregivers broadly in a shared QAPI mission
- Developing Performance Improvement Project (PIP) teams with specific "charters"
- Performing a root cause analysis to get to the heart of the reason for a problem
- Undertaking systemic change to eliminate problems at the source
- Developing a feedback and monitoring system to sustain continuous improvement

The first step in putting a QAPI program to use is to identify problems within the facility. SNFs should look at previous state survey results, patterns of hospitalization, and resident complaints, according to CMS.

After identifying problems within the facility, a successful QAPI program should start from the top with engagement from the SNF's medical director. While buy-in may be tough, a common downfall SNFs face when implementing a QAPI program is failing to involve the medical director, as this person already has a sizable workload, says Hislop.

While all staff members in a SNF should be involved in QAPI, the required Quality Assessment and Assurance (QAA) committee should consist of a smaller group. There is no requirement as to who should be on the committee, how often they meet, or how they choose to conduct their meetings. All of this is up to the discretion of individual SNFs, according to CMS. QAA committees should be created to address deficiencies found during state surveys.

CMS has provided an example in *QAPI at a Glance* of what a successful QAPI program should look like in action:

The Issue: *Your nursing home, Whistling Pines, received deficiencies during their annual survey because residents had unexplained weight loss, and weights and food intake were not accurately and consistently documented.*

What Whistling Pines did: *The QA Committee developed a Plan of Correction, which contained the following components: Re-weighing all residents, and updating the weight records for the affected residents; in-servicing the Nursing Department on obtaining and documenting weights and intake. They stated they would conduct 3 monthly audits of weight and intake records, with results reported to the QA committee.*

There are several steps SNFs should take to ensure a comprehensive QAPI program, according to CMS:

Leadership must take responsibility and accountability

- Develop a steering committee that provides QAPI leadership
  - This committee should create teams dedicated to solving specific problem areas relating to quality
  - The SNF administrator should be actively engaged in measures to promote quality
- Leadership must provide applicable resources, including equipment and training
  - Create a schedule that allows staff to attend relevant training while their duties are being covered by another staff member
  - Provide relevant equipment such as computers, resource books, webinars, etc.
- Promote open communication and respect
  - Maintain an open-door policy for both staff and residents
  - Emphasize communication between different shifts and departments

Create a deliberate environment of teamwork

- Create task-oriented teams that focus on specific problems
- Use performance improvement project (PIP) teams to focus on long-term quality issues
- Be mindful when assembling PIP teams to include members whose job duties closely align with the specific project; for example:
  - A task force to ensure residents get outdoors time should include the groundskeeper
  - A pharmacist should be included on any task force that aims to resolve an issue with medication

Conduct self-assessments in your SNF

- CMS has developed a free self-assessment tool to identify areas of improvement in your QAPI program
- Identify guiding principles in your organization
- CMS has developed a tool, "Guide for Developing Purpose, Guiding Principles, and Scope for QAPI," to assist the staff's understanding of the facility's QAPI program

Develop your QAPI plan

- Tailor the plan to fit the specific needs of your SNF
- Be flexible, as your facility's needs can change depending on the residents at any given time

Conduct a QAPI awareness campaign

- Communicate the QAPI plan with all staff often
- Include ongoing education
- Ensure that all consultants and contractors are aware of the QAPI plan

- Have an open discussion with staff on all aspects of the plan and openly answer any questions that may arise
- Speak with residents and ensure they understand what to expect from staff, and receive input from them to identify quality shortcomings

Develop a strategy to collect and use QAPI data

- As a team, decide what data collected should be routinely monitored. Common areas may include:
  - Clinical care, such as falls, infections, and pressure ulcers
  - Medications
  - Resident complaints
  - Resident satisfaction
  - Staff satisfaction
  - Hospitalizations
  - State survey results
  - MDS resident assessment results
  - Administrative processes
- Create target goals and benchmarks throughout improvement processes

Identify gaps and opportunities for improvement

- Survey the staff and facility to find areas of improvement to focus on

Prioritize opportunities for improvement and charter PIP teams

- Create PIP teams to address the gap areas found

Plan, conduct, and document PIPs

- Plan (who, what, when, where, why?)
- Do (carry out, document, record)
- Study (analyze, compare results, summarize)
- Act (determine what changes will be made, repeat process as needed)

Get to the root of the issue

- Conduct a root cause analysis to identify contributing factors that lead to underlying problems

Take systemic action

- After identifying the root cause(s) of the problem, implement corrective changes and actions that reduce the chance of the problem from reoccurring ■

Coding for SNFs

What PDPM means for coding in SNFs

For the first time since ICD-10 coding implementation in October 2015, the application of it in SNFs is changing with the induction of the Patient-Driven Payment Model (PDPM). PDPM has shaken up the focus of SNFs when it comes to billing. Accurate coding is now more important than ever, as Medicare reimbursement is dependent on diagnosis codes chosen. Unlike RUG-IV, ICD-10 coding under PDPM directly affects reimbursements.

PDPM's effects on SNF coding

Under PDPM, residents are placed in one and only one of the five case-mix adjustment components: physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), nontherapy ancillary (NTA), and nursing, according to CMS. After a resident is placed in one of those categories, ICD-10 codes are used to document any comorbidities the resident may have. For example, if an individual has a stroke, this will be listed as the primary diagnosis as it's the reason the person is being admitted to a SNF. But if the individual also has gout and diabetes, these can be documented as comorbidities.

PDPM also includes a "variable per diem (VPD) adjustment," which adjusts the per diem rate over the course of a resident's SNF stay, says CMS.

After selecting one of the case-mix adjustment components, ICD-10 codes are then mapped on the Minimum

Data Set (MDS) to a PDPM clinical category. The clinical categories accepted under PDPM are as follows:

- Major Joint Replacement or Spinal Surgery
- Non-Surgical Orthopedic/Musculoskeletal
- Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)
- Acute Infections
- Medical Management
- Cancer
- Pulmonary
- Cardiovascular and Coagulations
- Acute Neurological
- Non-Orthopedic Surgery

CMS offers a free ICD-10 mapping tool to assist in accurate coding.

Synching medical records with MDS records also bears more weight under PDPM. All comorbidities and services provided must be documented in MDS. If a service provided wasn't coded in MDS, SNFs will not receive reimbursement for it, even if it was recorded in the medical record, says **Maureen McCarthy, RN, BS RAC-MT, QCP-MT, DNS-MT, RAC-MTA,** president and CEO at Celtic Consulting.

In addition to SNFs needing to accurately code in the MDS, they also need to communicate with hospitals to fill any gaps in medical records prior to submitting coding in the MDS, according to **Reta Underwood, ADC,** president at Consultants for Long Term Care, Inc.

It's especially important for SNFs to communicate to hospitals any discrepancies in medical records in a timely manner, as CMS allows a seven-day observation window in which all documentation needs to be submitted in the MDS, says Underwood. During this seven-day observation window, it is the SNF's responsibility to communicate any missing or incomplete documentation with hospitals, and failure to do so may end in rejected Medicare claims.

Table 2.1 illustrates the PDPM assessment schedule.

Table 2.1: PDPM Assessment Schedule

Medicare MDS assessment schedule type	Assessment reference date	Applicable standard Medicare payment days
Five-day PPS assessment	Days 1–8	All covered Part A days until Part A discharge (unless an IPA is completed)
Interim payment assessment (IPA)	The date the facility chooses to complete the IPA relative to the triggering event that causes the facility to choose to complete the IPA	ARD of the assessment through Part A discharge (unless another IPA assessment is completed)
PPS discharge assessment	PPS discharge: Equal to the end date of the most recent Medicare stay (A2400C) or end date	N/A

Source: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM_Fact_Sheet_MDS_Changes_Final.pdf

CMS "MDS Changes Fact Sheet", August 30, 2019

Therapy services under PDPM

Since the implementation of PDPM, the biggest issue reported by SNFs is a shift in focus away from therapy services.

The payment system prior to PDPM, RUG-IV, allowed SNFs to bill for therapy services they deemed necessary, but some took advantage of that leniency by ordering superfluous therapy services to gain additional reimbursement from Medicare. PDPM seeks to stop this practice. The new payment model states that therapy minutes cannot account for more than 25% of services rendered to a resident.

The 25% rule came about after CMS, in tandem with the Office of Inspector General (OIG), compiled 20 years' worth of data regarding how much therapy was necessary for each kind of morbidity or injury, according to McCarthy in the June 2019 webinar "Improving Revenue Integrity Under PDPM," which can be purchased on-demand here.

Because of the limited Medicare reimbursement for therapy hours, some SNFs have resorted to laying off therapists and lumping residents into group therapy sessions, according to Modern Healthcare. This, however, may raise a red flag for CMS. If SNFs suddenly make significant changes in the amount of therapy coded in their MDS after the implementation

of PDPM, it will open the door for CMS to audit SNFs and look for previous cases of overbilling for therapy, according to Underwood.

While unrelated to PDPM, October 1 also saw a new definition of "group therapy" under the 2020 final payment rule. Prior to October, group therapy in SNFs was defined as therapy services rendered to exactly four residents, but the new rule changed the requirement to between two and six residents. This, in conjunction with the 25% rule under PDPM, gives SNFs the opportunity to group together residents with similar therapy needs, when they previously would have required individual therapy if four residents in the SNF did not require the same services.

CMS outlines how to calculate whether or not therapy provided is compliant with the concurrent/group therapy limit:

Step 1: Total Therapy Minutes, by discipline (O0425X1 + O0425X2 + O0425X3)

Step 2: Total Concurrent and Group Therapy Minutes, by discipline
(O0425X2 + O0425X3)

Step 3: C/G Ratio (Step 2 Result / Step 1 Result)

Step 4: If Step 3 Result is greater than 0.25, then non-compliant

Return to Provider (RTP) codes

SNFs should be aware that under PDPM, there are several RTP codes.

Commonly used RTP codes that were accepted under RUG-IV but will be denied under PDPM are listed on the CMS SNF PDPM Clinical Category Mapping document as:

- Muscle weakness
- Falls
- Unspecified diagnoses
- Failure to thrive
- Dehydration
- Unsteady gait/Abnormal gait/Difficulty walking
- Debility
- General weakness

While all RTP codes should be avoided, there is one that stands out more than others. Unlike under RUG-IV, unspecified codes do not cross over into PDPM and can be a major pain point for SNFs, says McCarthy. For instance, suppose a resident sustains an arm fracture. Under RUG-IV coding, "arm fracture" would have been sufficient. But under PDPM, it would be denied as an unspecified code because now it's necessary to specify which arm the fracture is in, right or left. So SNFs need to be much more specific now with coding than was required in the past.

When Medicare submissions are returned to a provider because of a coding issue, the claim cannot be contested or revised, and SNFs need to submit a new claim altogether, according to CMS.

Tips for successfully navigating PDPM

Coding is key under PDPM. As reimbursement is a vital part of SNF operations, coding isn't something that is typically outsourced, according to McCarthy. While some SNFs do have certified coders, it isn't mandatory to be certified, so a majority of coding is often the responsibility of the MDS coordinator, along with some lighter coding from nurses and rehabilitation personnel. McCarthy notes that accurate and detailed notes taken by nurses can assist in proper coding later on. McCarthy suggests that nurses brush up on proper documentation standards to ensure that notes they take are up to par.

It's also important for SNFs to be cognizant of how they are faring under PDPM, and the best way to gauge where SNFs stand with PDPM is by checking out their Quality Reporting Program (QRP) results, which can be considered a report card for SNFs, says McCarthy. ■

*PROPEL***Long-Term Care Journal** (ISSN: 2576-4411 [online]), the newsletter of *PROPEL***Long-Term Care**, is published monthly by HCPro, a Simplify Compliance brand. *PROPEL***Long-Term Care Journal**, 35 Village Road, Suite 200, Middleton, MA 01949.

Q&A: Consolidated Billing Under PDPM

Editor's note: *The following information was covered during HCPro's live webinar, SNF Consolidated Billing Under PDPM, with* ***Jennifer Matoushek, MBA/HCM, CPC****. View it now on demand.*

Under PDPM, if there is a less-than three-day interruption with a hospital, are any of the services during that interruption included in CB?

Something very important to note with CB, if your resident is not in the facility at midnight, nursing facility would not bill for services provided on that day under CB. You want to be sure that when SNFs are reviewing their census report, they're accurate, that residents were truly in the bed at midnight. If not, the billing office should be notified to properly bill.

> "I do encourage staff members to be well aware of Medicare Advantage and other replacements , to have a great understanding of the information they need to in order to bill properly."
>
> - Jennifer Matoushek, MBA/HCM, CPC.

Is chemotherapy always excluded from SNF CB?

No, not always. Only the specific chemotherapy agents listed in the Help file are excluded. The SNF is responsible for the payment to the other provider for non-excluded chemotherapy drugs. That's why I stress for facilities to access that HELP file – 2019 Part A MAC Update (https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/2019-Part-A-MAC-Update.html). To guide through what codes are included or excluded in consolidated billing.

When you have a Medicare Part A stay resident receiving dialysis treatment, is the SNF responsible for the ambulance transportation?

No, the SNF is not responsible as long as the dialysis is being done at what is categorized as an end-stage renal disease facility.

Do the consolidated billing rules apply to Medicare replacements?

So as far as Medicare replacements, such as Medicare Advantage or Medicare HMOs, they all their own rules. Many times, they do follow the Medicare fee-for-service rule for consolidated billing. However, providers need to make sure they're asking each of their plans to follow to ensure what consolidated billing rules they have in place. I do encourage, with the change of PDPM, a lot of other commercial insurances are changing their requirements, especially for billing under PDPM. Providers should work with these and Medicare replacements to make sure you're billing properly.

I do encourage staff members to be well aware of Medicare Advantage and other replacements, to have a great understanding of the information they need to in order to bill properly.

If a Medicare Part A patient goes to the ER and is out of the SNF at midnight, but is not admitted to the hospital and is back within 24 hours, do we discharge the patient?

If the resident is in the SNF at midnight, the SNF is responsible for services provided that day under consolidated billing. If the resident is not in the facility at midnight, the facility would not bill for those services that occurred during the day.

What are the main points facilities need to keep in mind to make sure they're billing accurately under PDPM?

The biggest takeaway: Ensure that you have your admissions process down. Understand what questions need to be asked ahead of time before admitting a resident. Ensure you're not admitting a resident and having to pay for a certain procedure or drug that the SNF may not be reimbursed for. Educate staff on that admissions process and firming up the front end to ensure the backend billing process is correct and accurate and the SNF is getting reimbursed for those services. ■

Updates for SNFs

Key takeaways from the 2020 final payment rule

CMS issued its final rule, Fiscal Year 2020 Payment and Policy changes for Medicare Skilled Nursing Facilities (CMS-1718-F), in July. The new payment rule aims to "strengthen the Medicare program by better aligning payment rates for these facilities with the costs of providing care and increasing transparency so that patients are able to make informed choices." Within the rule are three major updated provisions that will affect the operation of SNFs: the Prospective Payment System (PPS) payment policy, the Value-Based Purchasing Program (VBP), and the Quality Reporting Program (QRP).

SNF payment policy under PPS

The main takeaway of the PPS update is the definition of group therapy. Prior to the fiscal year (FY) 2020 update, the definition of group therapy, as pertains to SNFs, was therapy provided to exactly four residents. In other postacute care (PAC) settings, group therapy is defined as therapy provided to a minimum of two individuals. In order to promote consistency across PAC settings, group therapy in SNFs will now be defined as two to six individuals doing the same or similar activities, according to the CMS fact sheet for the final rule.

This change will be especially helpful to SNFs with a smaller population, where it's unlikely that there will be many instances of having four residents with the exact same therapeutic needs. This provision would "allow increased flexibility so that patients in smaller SNFs, presumably where a group of exactly four patients may be difficult to attain, could utilize and benefit from group therapy," according to CMS.

While the new definition of group therapy gives SNFs more flexibility as smaller groups are eligible to receive therapy together, "SNFs need to take caution and heed CMS warnings about wholesale, quick shifts to group therapy. It is unlikely that patient characteristics and needs have shifted dramatically and, therefore, care provision in terms of how and how much should remain essentially unchanged," says **Reg Hislop III, PhD,** managing partner at H2 Healthcare LLC, and author of Reg's Blog.

SNF Value-Based Purchasing Program

The SNF VBP began offering incentive payments to SNFs in October 2018 based on their quality measure performance. SNFs are currently scored based on their hospital readmission rates, but the new rule aims to measure potentially preventable hospital readmissions, as some are simply unavoidable, says CMS.

The incentives program has been renamed in 2020 to "Skilled Nursing Facility Potentially Preventable Readmissions after Hospital Discharge." There has also been an update to the SNF VBP Program's scoring and operational policies, which are as follows:

- An update for the Skilled Nursing Facility Potentially Preventable Readmissions (SNFPPR) Measure's name
- Updated public reporting requirements for SNFs with less than 25 eligible stays during the baseline period or performance period for a Program year, and SNFs with zero eligible cases during the performance period for a Program year
- A 30-day deadline for Phase One Review and Corrections requests

SNF Quality Reporting Program

QRP reporting must begin on the first day of the quarter following a SNF receiving its CMS certification number (CCN) and every quarter thereafter. The MDS data that must be reported quarterly is submitted through the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system.

Currently, SNFs are subject to a 2% reduction in the market basket percentage update if they fail to submit required quality data to CMS. As extenuating circumstances sometimes prevent SNFs from submitting this data on time (often missing or incomplete documentation from hospitals at resident transfers), beginning in 2020, CMS will now take into consideration whether certain health information is provided to SNFs at transfer or discharge of a resident. The two new measures adopted for FY 2020 are:

1. Transfer of Health Information to the Provider – Post-Acute Care
2. Transfer of Health Information to the Patient – Post-Acute Care

"Both measures simply require a SNF to document that the transfer of medication information took place. The Transfer of Health Information measures serve as a check to ensure that a reconciled medication list is provided as the patient changes care settings," according to the CMS rule.

While this measure aims to reduce the number of rejected claims due to incomplete documentation, it may cause a headache initially for SNFs. They need to be aware of the requirement to acknowledge and code the medication list received from the hospital at discharge, says Hislop.

Resident records (including medication lists) can be transferred between hospitals verbally, on paper, or via electronic communication, and incomplete or missing records because of poor communication is cited by CMS as the third most frequent root cause in sentinel events.

To give SNFs the opportunity to see where they stand with QRP, every year SNFs have a 30-day window to view their Provider Preview Reports prior to being published on Nursing Home Compare. These reports contain information on the following publicly reported quality measures:

- Discharge to Community – Post-Acute Care (PAC) SNF QRP
- Potentially Preventable 30-Days Post-Discharge Readmission Measure for SNF QRP
- Medicare Spending Per Beneficiary–PAC SNF QRP
- Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function – NQF #2631
- Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) – NQF #0674
- Percent of Residents or Patients with Pressure Ulcers that are New or Worsened – NQF #0678

CMS offers several recordings and presentations for QRP training that can be accessed here.

A summary of what SNFs have to say about the new rule

1. As the medical records that SNFs receive from hospitals at patient discharge aren't always all-encompassing, SNFs have sometimes struggled to submit timely data in their MDS. A rule was proposed in November 2015, Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies (80 FR 68125), that if passed would ensure hospitals provide SNFs with all necessary medical documentation used for both care planning and coding in as timely a manner as possible, as called out in the comments in the new rule. While the rule was never finalized, the timely transfer of data is now more important than ever with the introduction of PDPM in October.

"SNFs need to take caution and heed CMS warnings about wholesale, quick shifts to group therapy. It is unlikely that patient characteristics and needs have shifted dramatically and, therefore, care provision in terms of how and how much should remain essentially unchanged."

Reg Hislop III, PhD, managing partner at H2 Healthcare LLC, and author of Reg's Blog.

On the other hand, some commenters believe that this measure will add a burden to SNFs, with one commenter saying, "There will be additional burden to collect and report data for these two measures in part because most PAC providers do not have access to [electronic health records] or health information technology systems that facilitate their ability to electronically share this information."

2. Overall, the change in definition to group therapy was well received by individuals commenting on the new rule. Several commenters stated that the revised definition will afford smaller SNFs the ability to conduct group therapy sessions, when

they previously could not if four residents did not require the same therapy. Others, however, called this new definition "misguided," stating that residents in SNFs require different levels of care, and this new provision might end with residents being lumped into group settings when they would be better served in one-on-one therapy sessions. Several commenters stressed the impact of the group therapy definition changing simultaneously with the implementation of PDPM. Concern has arisen that CMS will find a correlation between an increase in group therapy and PDPM, with the two not related but instead a result of some residents being eligible to have group therapy, when in the past they were restricted to one-on-one therapy.

Table 3.1 summarizes the cost and benefits of each 2020 payment update. ■

Table 3.1: Summary of costs and benefits

Provision description	Total transfers
FY 2020 SNF PPS payment rate update	The overall economic impact of this final rule is an estimated increase of $851 million in aggregate payments to SNFs during FY 2020.
FY 2020 updates to the SNF QRP	The overall annual cost for SNFs to submit data for the SNF QRP for the provisions in this final rule is $29 million.
FY 2020 SNF VBP changes	The overall economic impact of the SNF VBP program is an estimated reduction of $213.6 million in aggregate payments to SNFs during FY 2020.

Source: https://www.federalregister.gov/documents/2019/08/07/2019-16485/medicare-program-prospective-payment-system-and-consolidated-billing-for-skilled-nursing-facilities

How billers can support revenue cycle management in PDPM

With the implementation of the Patient-Driven Payment Model (PDPM), SNF's bottom lines are more at risk than ever before.

In these early days of PDPM, SNFs may find it difficult to project revenue and profitability for their Medicare Part A covered patients because so many factors, (e.g., patient acuity, clinical documentation, accurate ICD-10 coding) impact payment, says **Kim Cusson, CCS, CPC,** a consultant with Crowe Healthcare Risk Consulting, LLC.

SNFs must protect their financial stability by maximizing their revenue cycle management (RCM) practices. Well-run revenue cycles increase margins and mitigate debt, Cusson says.

Billing specialists play a key role in the facility's revenue cycle. How you manage revenue cycle processes can impact cashflow, which is critical for SNFs, says **Erin Shvetzoff Hennessey, CEO** of Health Dimensions Group.

"The margins in skilled nursing and senior living are low, and we often have to wait a long time to receive payments. Billers constantly look at cashflow to ensure the facility is getting enough cash in the door to pay all the vendors that are critical for us to continue providing care to patients," Hennessey says.

As facilities navigate PDPM, billers can help safeguard cashflow by supporting accurate completion of the MDS, utilizing their software to its fullest potential, and implementing process improvements when issues arise.

Defining revenue cycle management

Before diving into how billers can enable a healthy revenue cycle, it's important to understand what RCM is.

"I describe RCM as the process we use to make sure we get paid for the great care we give patients, but also making sure we do not get a dollar more," says Hennessey.

RCM centralizes these often-fragmented activities and pulls them together as one integrated process that follows revenue from pre-admission to payment. This wholistic viewpoint allows SNFs to align and streamline processes, which reduces debt and increases profitability, says **Barbara Reimer,** consultant with the Fox Group.

RCM encompasses functions integral to receiving reimbursement dollars in a timely manner and protecting those payments, including denials management,

revenue integrity, and chargemaster processes. Components of the revenue cycle include:

- Preadmission screening
- Point-of-service registration
- Utilization review
- Charge capturing and coding
- Claim submission
- Payer processing
- Remittance processing
- Denials
- Payment posting
- Appeals
- Collections

To make each of these RCM processes as efficient as possible, billers should review several key performance indicators (KPIs), says Cusson.

Common KPIs include:

- Accounts receivable (A/R)
- Accounts aging comparisons
- Days in A/R
- Collections as a percentage of revenue

Benchmark current performance for each KPI currently and monitor it overtime. If you notice delays or slowdowns, determine what processes the appropriate department (e.g., admissions, clinical team, billing) can modify or overhaul to bring cash in more quickly, Cusson says.

Tip: Billers should also compare the KPIs pre- and post-PDPM to identify how the new payment model affects the SNF's cashflow.

Understand how the MDS can impact RCM

PDPM links the MDS to the revenue cycle in a way that SNFs never experienced in the RUG-IV payment methodology.

"When you think about the revenue cycle, you tend to focus on A/Rs, but in PDPM, the MDS plays a big role in your revenue cycle," says Reimer.

The new PDPM assessment schedule creates an opportunity for SNFs to bring reimbursement monies in more quickly. Because PDPM only requires a 5-day initial assessment and discharge assessment, billing specialists should be able to turn claims over more quickly

"I'm sure there will be a lot of patients only requiring only 5-day and discharge assessments, so claims submission can happen [faster] because we will not have to wait for so many MDSs to be transmitted," Reimer says.

However, SNFs will only realize this benefit if they have strong clinical documentation and accurate ICD-10 coding.

The number of MDS sections that impact reimbursement increases significantly in PDPM. Patients' clinical characteristics and outcomes as captured on the MDS drive PDPM reimbursement. This makes capturing coded revenue on the MDS an essential part of your revenue cycle in PDPM.

"Medicare says that PDPM is budget neutral, but if we're not getting the full clinical picture or the right diagnoses, then patients will fall into lower clinical categories, which means lower reimbursement rates. In that way, PDPM may not be budget neutral for some facilities," Cusson says.

The MDS coordinator and interdisciplinary team (IDT) must ensure the documentation fully reflects patients' conditions and comorbidities and the ICD-10 codes on the MDS most accurately reflect those clinical characteristics.

However, billing specialists are a great line of defense to ensuring the claims do not get kicked back for partial or non-payment. Actively communicate with the MDS coordinator and IDT and flag return-to-provider codes (RTP) that will automatically generate an error if included on the MDS or claim, Reimer says.

Billers also know better than anyone else in the facility what causes payers to issue denials. During regular Medicare meetings, billing specialists should not hesitate to speak up if they notice the primary diagnosis, the projected HIPPS code, documentation, certifications, or other items are not in order, Cusson says.

Additionally, if your facility does not do so already, billers should advocate that the IDT participate in a triple check process. Because PDPM has so many

more complexities than RUG-IV, the triple check is essential to ensuring the claim is clean. The IDT should meet and verify all the information on the claim one final time before you submit it. The triple check reduces errors that lead to denials, which cause your cashflow to take a hit, Cusson says.

Get the most out of your software

Clinical and billing software—whether they are the same system or not—should make your revenue cycle function more efficiently.

Many vendors released new features or functionality in preparation for PDPM. Get the most out of your software by participating in training opportunities, such as webinars or onsite education, and learning how to use programs to their fullest capabilities. Take the time to read the guides that vendors send out because they offer lots of time-saving tips, Reimer says.

Additionally, vendors will continue to update their systems to further optimize PDPM-related functions over the next several months. Establish an open line of communication and relationship with internal IT staff and the vendor. This way you will be aware of new feature releases and can ensure they're integrated into your system without issue, Reimer adds.

A word of caution. Your software systems also have the potential to hinder or slow your revenue cycle. As some billers experience in the transition to PDPM, new software features can also cause headaches for billers. You must confirm that information pulls over correctly either from one part of the system to another or between systems. Incorrect information flow can lead to incorrect data on the MDS and/or claim.

Whenever a vendor rolls out something new, perform regular audits to verify that the information populated onto both the MDS and claim is correct, Reimer suggests.

Conduct post-mortems

Learning from mistakes will help you strengthen the processes that make up the revenue cycle.

If you receive a denial or partial payment, billing specialists need to find out why.

"For example, if you're looking for a $5000 payment when the EOB comes through, and it's not there or not what you were expecting, you have to research to determine whether something was miscoded on the claim, if the data in the software was incorrect, if revenue, co-pay, or co-insurance calculations were incorrect," Reimer says.

Billers will often find that the issue is a one-off or related just to one patient. However, errors caused by a systematic issue have the potential to devastate your profitability. In these cases, billers should share their findings with a manager to take it through the proper channels for resolution, Reimer says. ■

PLTCJ is a monthly publication exclusively for members of *PROPEL***Long-Term Care.** To learn more about the growing *PROPEL***Advisory Services** family, visit *www.hcmarketplace.com/advisory-services* or email Advisory Services Manager Delaney Rebernik at *drebernik@hcpro.com.*