



## Say hello to 3.0: The new MDS' effect on billers

The October 1 implementation of MDS 3.0 means big changes for SNFs. The latest PPS assessment will demand much attention from MDS coordinators, especially leading up to its debut and during its first few months of operation, as there are a variety of new features, including adjustments to regulations involving therapy and the HIPPS coding system.

As a result, facilities should use the implementation of MDS 3.0 as an opportunity for process improvements, says **Rena Shephard, MHA, RN, RAC-MT, C-NE**, founding chair and executive editor of the American Association of Nurse Assessment Coordinators and president of RRS Healthcare Consulting Services in San Diego.

"I really encourage everybody to take the MDS 3.0 as a brand-new assessment, not look at it as sort of an upgrade or a revision of the 2.0, because there's so much in it that's different," Shephard says.

Those differences will have far-reaching affects, which emphasizes the value of taking a fresh look at the systems that support Medicare Part A, says Shephard.

The changes included in the new assessment also show that MDS coordinators will not be the only staff members who need to develop a thorough understanding of MDS 3.0, says **Carol Maher, RN-BC, RAC-CT**, director of clinical reimbursement at Ensign Facilities, Inc., in Mission Viejo, CA.

"I think there's a lot in the MDS 3.0 that's going to affect billers," Maher says. "I've already kind of given my company a heads up that the business office managers have to be very much involved in the MDS 3.0 training."

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—Carol Maher, RN-BC, RAC-CT

### IN THIS ISSUE

**p. 5 The details of default billing**  
Knowing when to bill for the default rate isn't easy. Get some tips here.

**p. 6 HIPAA in the headlines**  
Find out what happened with HIPAA in 2009 and how it will affect your SNF in 2010.

**p. 9 No longer a simple reimbursement issue**  
Columnist Barbara Griffin-Gulliver explains the intricacies of same-day transfers.

**p. 10 LTC billing IQ**  
Test your billing knowledge with these LTC scenarios and questions.

**p. 11 BALTC Q&A**  
Columnist Lee A. Heinbaugh discusses the Medicare IVR system and hospital stay requirements.

### According to Chapter 6

With the January 13 release of Chapter 6 of the *Resident Assessment Instrument (RAI) User's Manual*, Version 3.0, CMS sheds light on what that training will need to include. Based on the content, it appears the most significant piece of the MDS 3.0 that will affect billers involves the HIPPS codes.

"I think you can see from the table for the assessment indicator [see p. 4], this is a really big change," Shephard says. "If you look at the table of HIPPS codes in the 2.0 manual, it's a pretty simple thing."

It is important that billers know information is available in the new *RAI User's Manual*, Shephard adds. It's a resource that billing office staff members could certainly

> continued on p. 2

HCP Pro

## Say hello to 3.0

< continued from p. 1

benefit from, especially as they attempt to build an early understanding of the changes in MDS 3.0.

Among the changes present in the table are the new Other Medicare-Required Assessments (OMRA).

“The end-of-therapy OMRA is required, but the start-of-therapy OMRA is not,” Maher says. “So it will be interesting to see if facilities pick up on the start of therapy OMRA.”

It may be that MDS coordinators are so overwhelmed by a whole new instrument and all the things that go with it that facilities miss out on some billing opportunities, says Maher.

As a result, billers might need to take it upon themselves to understand the function of the OMRAs with the MDS 3.0, which is a worthwhile undertaking, Shephard says. The billing office staff should know as much as possible about the start-of-therapy and end-of-therapy OMRAs and how they should be used because that knowledge could go a long way in ensuring correct reimbursement.

“It’s easy to say, ‘Well, the billers just put this on the claim so they don’t have to worry about the MDS.’ But the billers I know really want to have it in context and they really do want to understand what it is they’re doing so they can provide another level of cross-check before the bill goes out,” Shephard says.

Unlike with the MDS 2.0, the MDS 3.0 is able to calculate a non-therapy resource utilization group (RUG) and therapy RUG on a single assessment. In other words, if a resident enters a facility and does not begin receiving therapy until a week after admittance, the start-of-therapy OMRA comes into play. It allows for the calculation of the non-therapy RUG during the resident’s first week and, starting the day of therapy, the new calculation with the therapy RUG.

“They’re going to want to know what these assessments are that affect the billing—the start of therapy, the end of therapy, and the MDS actually calculating in some cases the therapy RUG as well as a non-therapy RUG for Part A,” Shephard says.

### The potential of a RUG-IV delay

MDS 3.0 wasn’t supposed to be the only introduction October 1. The new assessment was supposed to coincide with RUG-IV.

However, at the time of publishing, there is an amendment in the Senate health bill, the Patient Protection and Affordable Care Act, which would delay the implementation of RUG-IV to October 1, 2011.

The amendment is not present in the House bill. Negotiations in Congress will determine whether the provision

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is included in the final bill sent to the president. Should it be upheld and RUG-IV is delayed one year, a crosswalk for the state case-mix systems between RUG-III and RUG-IV would be used with MDS 3.0, which could add an extra layer of confusion, Maher says.

“Trying to crosswalk a RUG system with an entirely different MDS is going to be very different, especially if it’s only going to be for one year,” she says. “That would be very difficult for everyone to be able to manage.”

The Senate bill states that the concurrent therapy adjustment and changes to the look-back period to ensure that only services provided after SNF admission are counted toward RUG placement, which are both components of RUG-IV, would still take place with the implementation of MDS 3.0 October 1.

But postponing implementation of the remaining components, such as the increase from 53 groups under RUG-III to 66 groups under RUG-IV, would still have profound affects on billers, SNFs as a whole, and software vendors, says **Jean Bean, RN, C**, director of clinical services at Covenant Retirement Communities in Skokie, IL.

“My biggest concern is that they’ve got all of these vendors who are ramping up for the electronic versions,” Bean says. “They haven’t been given any leeway that you can’t stop transmitting electronically, and if they’re building their software based on what they’re supposing to happen October 1 [2010], we could have a mess.”

### Software strategies

Not only is software instrumental in the eventual implementation of RUG-IV, it is critical in the use of MDS 3.0, as the HIPPS codes will be self-calculated by the software.

Shephard says this will be a big help and should limit the chances of incorrect codes being used, especially within facilities that have their MDS software communicating with their billing software. This allows the HIPPS code to automatically populate the claim.

However, that doesn’t mean person-to-person communication shouldn’t take place, says Shephard. The

software should be checked routinely to make sure it’s correctly doing what it’s supposed to, she says.

“People who are using the software need to use it as a tool but not rely on it in the absence of their own knowledge,” she adds.

Quality assurance reviews should be completed periodically to verify that the software is calculating properly. And to do this, billers and other SNF staff members must have a thorough understanding of the MDS 3.0. Being familiar with the material could save time as well as help billers avoid headaches should the software make an error or request action that is unnecessary.

Even with all of the changes that will take place due to the implementation of MDS 3.0 in October, Shephard says some things will remain the same.

“The key things—like making sure the correct service date is on there, which is the assessment reference date on the MDS, and making sure that they have the correct number of days that they’re billing and that there aren’t any nonbillable days on there—none of that is going to be changing,” she says.

Despite the ease with which information is electronically transferred, Shephard notes that someone from the billing office should continue to be present at weekly Medicare meetings, as this promotes accuracy and serves as a chance to confirm any questionable material with other SNF staff members.

“The whole team—therapy, [nursing, the MDS coordinator], and the billing office already have to be in strong communication, but I think there’s going to be even more need for strong communication between those disciplines after MDS 3.0 starts,” Maher says. ■

### Questions? Comments? Ideas?

**Contact Associate Editor  
Justin Veiga**

**Telephone 781/639-1872, Ext. 3933**

**E-mail [jveiga@hcpro.com](mailto:jveiga@hcpro.com)**

### Assessment indicator second digit table

Second Digit Values	Assessment Type	Impact on Standard Payment Period
0	Scheduled PPS assessment not combined with another assessment	No impact on the standard payment period (the assessment is not unscheduled). If the second digit value is 0, then the first digit must be 1 through 6, indicating a scheduled PPS assessment or an OBRA assessment used for PPS.
1	Either an unscheduled OBRA assessment or Swing Bed CCA Do NOT use if <ul style="list-style-type: none"> <li>➤ Combined with any OMRA</li> <li>➤ Medicare Short Stay assessment</li> </ul>	<ul style="list-style-type: none"> <li>➤ If the ARD of the unscheduled assessment is not within the ARD window of any scheduled PPS assessment, including grace days (the first digit is 0):               <ul style="list-style-type: none"> <li>– Use the Medicare RUG (Z0100A) from the ARD of this unscheduled assessment through the end of standard payment period.</li> </ul> </li> <li>➤ If the ARD of the unscheduled assessment is within the ARD window of a scheduled PPS assessment, not using grace days:               <ul style="list-style-type: none"> <li>– Use the Medicare RUG (Z0100A) from the ARD of this unscheduled assessment through the end of standard payment period.</li> </ul> </li> <li>➤ If the ARD of the unscheduled assessment is a grace day of a scheduled PPS assessment:               <ul style="list-style-type: none"> <li>– Use the Medicare RUG (Z0100A) from the start of the standard payment period for the scheduled PPS assessment.</li> </ul> </li> </ul>
2	Start of Therapy OMRA Do NOT use if <ul style="list-style-type: none"> <li>➤ Medicare Short Stay assessment</li> <li>➤ Combined with End of Therapy OMRA</li> <li>➤ Combined with unscheduled OBRA</li> <li>➤ Combined with Swing Bed CCA</li> </ul>	<ul style="list-style-type: none"> <li>➤ If the unscheduled assessment gives a therapy group in the Medicare RUG (Z0100A):               <ul style="list-style-type: none"> <li>– Use the Medicare RUG (Z0100A) from the unscheduled assessment's earliest start of therapy date (speech-language pathology services in O0400A5, occupational therapy in O0400B5, or physical therapy in O0400C5) through the end of standard payment period.</li> </ul> </li> <li>➤ If the unscheduled assessment does not give a therapy group in the Medicare RUG (Z0100A), do not use the unscheduled assessment RUG for any part of standard payment period. This is not a valid assessment and it will not be accepted by CMS.</li> </ul>
3	Start of Therapy OMRA combined with either an unscheduled OBRA assessment or a Swing Bed CCA Do NOT use if <ul style="list-style-type: none"> <li>➤ Medicare Short Stay assessment</li> <li>➤ Combined with End of Therapy OMRA</li> </ul>	<ul style="list-style-type: none"> <li>➤ If unscheduled assessment gives a therapy group in the Medicare RUG (Z0100A):               <ul style="list-style-type: none"> <li>– Use the unscheduled assessment Medicare RUG (Z0100A) from the earliest start of therapy date through the end of standard payment period.</li> </ul> </li> <li>➤ If unscheduled assessment does not give a therapy group in the Medicare RUG (Z0100A), do not use the unscheduled assessment RUG for any part of the standard payment period. This is not a valid assessment and it will not be accepted by CMS.</li> </ul>
4	Whether or not combined with unscheduled OBRA assessment and whether or not combined with Swing Bed CCA Do NOT use if <ul style="list-style-type: none"> <li>➤ Combined with Start of Therapy OMRA</li> <li>➤ Medicare Short Stay assessment</li> </ul>	Use the unscheduled assessment Medicare non-therapy RUG (Z0150A) from the day after the latest therapy end date (speech-language pathology services in O0400A6, occupational therapy in O0400B6, or physical therapy in O0400C6) through the end of standard payment period.
5	Start of Therapy OMRA combined with End of Therapy OMRA Do NOT use if <ul style="list-style-type: none"> <li>➤ Medicare Short Stay assessment</li> <li>➤ Combined with unscheduled OBRA</li> <li>➤ Combined with Swing Bed CCA</li> </ul>	<ul style="list-style-type: none"> <li>➤ If unscheduled assessment gives a therapy group Medicare RUG (Z0100A):               <ol style="list-style-type: none"> <li>1. Use the unscheduled assessment Medicare RUG (Z0100A) from the earliest start of therapy date through the latest therapy end date.</li> <li>2. Use the unscheduled assessment Medicare non-therapy RUG (Z0150A) from the day after the latest therapy end date through the end of standard payment period.</li> </ol> </li> <li>➤ If unscheduled assessment does not give a therapy group Medicare RUG (Z0100A), do not use the unscheduled assessment RUG for any part of the standard payment period. This is not a valid assessment and it will not be accepted by CMS.</li> </ul>
6	Start of Therapy OMRA combined with End of Therapy OMRA and combined with either an unscheduled OBRA assessment or Swing Bed CCA Do NOT use if <ul style="list-style-type: none"> <li>➤ Medicare Short Stay assessment</li> </ul>	<ul style="list-style-type: none"> <li>➤ If unscheduled assessment gives a therapy group Medicare RUG (Z0100A):               <ol style="list-style-type: none"> <li>1. Use the unscheduled assessment Medicare RUG (Z0100A) from the earliest start of therapy date through the latest therapy end date.</li> <li>2. Use the unscheduled assessment non-therapy RUG (Z0150A) from the day after the latest therapy end date through the end of standard payment period.</li> </ol> </li> <li>➤ If unscheduled assessment does not give a therapy group in the Medicare RUG (Z0100A), do not use the unscheduled assessment RUG for any part of the standard payment period. This is not a valid assessment and it will not be accepted by CMS.</li> </ul>

Source: RAI User's Manual, Version 3.0, CMS.

## The details of default billing

Although it may not be a SNF's ideal means of reimbursement, billing Medicare Part A for the default rate—and doing so correctly—is financially critical to any facility.

Missing an MDS assessment based on the assessment schedule, which is determined by when the assessment reference date is set, leaves a SNF with two options: receive no payment for that time period or, the better option, file a late assessment to receive payment at the default rate.

However, choosing the latter isn't always up to the SNF. The 2010 final rule did not include any changes from the default billing regulations that were clarified in the 2009 final rule. Those regulations limit a facility's eligibility to bill the default rate.

"When they first came up with default days, it was the interpretation that anytime you didn't have a completed MDS, you could bill default days. CMS changed that, or clarified that, and they said, 'No, that's not true, but there are some situations where default days can be used,'" says **Bill Ulrich**, president of Consolidated Billing Services, Inc., in Spokane, WA.

There are five approved default billing scenarios. Outside of those, if a MDS assessment was not completed in accordance with the assessment schedule, the SNF will not receive payment for that time period.

### Permitted default billing scenarios

The consolidated billing final rule for fiscal year 2009 set the precedence for situations in which it's acceptable to bill for the default rate, which put to rest an ongoing debate over the topic.

That debate stemmed largely from *Transmittal 196*. Released in March 2007, it was intended to update SNF PPS medical review policies.

"It all goes back to *Transmittal 196*," says **Theresa Lang**, vice president of clinical services at Specialized Medical Services, Inc., in Milwaukee. "*Transmittal 196* is really what started this whole thing. It's where [CMS] came up with

the rules of when you can bill the default. Up until that point, basically the industry standard was if you got a late or a missed assessment, you just bill the default."

The rules that were specified in *Transmittal 196* allowed for only two scenarios when facilities could submit a late assessment and bill for the default rate, a stark contrast to the previous industry interpretation. In 2008, CMS cited three more circumstances in which SNF billers could use the HIPPS code "AAA00" on Part A claims to receive payment at the default rate, bringing the total to five:

- **The stay is less than eight days within a spell of illness** (cited in *Transmittal 196*). If a resident expires or is transferred within the first eight days of the benefit period, a SNF should prepare an assessment as best as possible so a HIPPS rate code can be assigned within the assessment schedule; however, if an assessment is not submitted in this case, a claim using the default rate code is accepted.
- **The beneficiary requests a demand bill** (cited in *Transmittal 196*). If a SNF determines that care of a beneficiary isn't covered or if the beneficiary hasn't met the SNF stay technical requirements, the facility is not required to assess the beneficiary for purposes of classifying the individual into a resource utilization group category. Instead, the SNF is eligible to submit a claim using the default rate code to ensure payment should the SNF reverse its coverage determination.
- **The SNF is notified on an untimely basis or is unaware of a Medicare Secondary Payer denial.** If an assessment hasn't been performed and the resident exhausted primary payer benefits, the SNF can bill at the default rate.
- **The SNF is notified on an untimely basis of the revocation of a payment ban.** The date the payment ban is lifted becomes day one of the Medicare assessment schedule.
- **The SNF is notified on an untimely basis or is unaware of a beneficiary's disenrollment from a**

> continued on p. 6

## Default billing

< continued from p. 5

**Medicare Advantage (MA) plan.** If a SNF discovers after discharge that a resident had disenrolled from the MA program, the SNF can bill at the default rate.

All five exceptions were included in Chapter 6 of the *Resident Assessment Instrument (RAI) User's Manual*, Version 3.0, and will carry over to MDS 3.0 in October.

## Communicating for cohesiveness

Much of the past confusion involving default billing stemmed from a lack of understanding as to when the default rate could be used, Lang says. Outside of that, however, there are other contributing factors, one of which may be a lack of communication between the billing office and clinical staff, she adds. Billers need to have access to information that is necessary in terms of a resident's standing with Medicare Part A. By creating an open dialogue with nursing, this information can more easily be shared.

Additional issues may occur if the billing and nursing departments are using different software programs, as even more direct communication will be required to

ensure that both sides are receiving the correct information, Lang says.

Also, software vendors' interpretation of the CMS default billing regulations could have an effect.

"If billers don't understand the clinical process and the software does something incorrectly, it's impossible [to correctly file a claim]," Lang says.

Potential default billing issues can be taken care of through simple due diligence, says **Missy Tieken**, vice president of operations at Consolidated Billing Services. "I think they need to make sure that they are getting everybody on the MDS schedule right from the get-go," Tieken says. "If they're doing their Common Working File checks and finding out what the benefits are with these HMOs prior to residents coming, so if they're actually doing these verifications of benefits, I don't think they're going to have as much of an issue."

By verifying information up front, Tieken says SNFs will be more apt to avoid default billing complications altogether. "It's just a matter of them being proactive on all of it," she says. ■

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## HIPAA in the headlines in 2009: Anticipate impact in 2010

The quality, efficiency, safety, and privacy of health-care in the United States were front-page news in 2009.

Specific developments weren't mere flashes in the pan; experts say the ripple effect will continue into 2010, with long-ranging effects for most.

Let's revisit the most significant events of 2009 and explore their potential effect in 2010.

### HITECH Act

► **The development:** The Health Information Technology for Economic and Clinical Health (HITECH) Act, which was signed into law February 17, 2009, is one provision of the American Recovery and Reinvestment Act of 2009. The HITECH Act aims to promote

use of federal stimulus money to advance the design, development, and implementation of a nationwide health information infrastructure that promotes the use and exchange of information via electronic health records (EHR).

Congress included stiffer penalties for noncompliance with HIPAA, greater breach notification requirements, and expanded enforcement to address growing privacy and security concerns. For example, business associates (BA) now must comply with the HIPAA security rule and HITECH's security provisions.

**Rebecca Herold**, president of Rebecca Herold & Associates, LLC, in Van Meter, IA, calls it one of the most significant developments.

“There are many times more business associates than there are covered entities,” Herold says.

Covered entities now must notify HHS of any breaches no later than 60 days after learning of them. They also must notify prominent media outlets in the state when a breach affects more than 500 individuals.

➤ **What to do now:** HHS began enforcing the amended breach notification provisions in February. Covered entities must fine-tune their processes now.

“This means that all personnel, volunteers, and agents need to know what to do if they discover a data breach,” says **Rebecca L. Williams, Esq., RN**, partner at Davis Wright Tremaine, LLP, in Seattle.

Covered entities had to amend their BA contracts by February 18. Organizations should work with their legal department to revisit existing contracts and ensure that they have the proper template for new ones.

Incentives for meaningful use of EHRs will begin in 2011. Congress would like stakeholders to purchase and implement EHRs in 2010 to prepare for 2011. However, stakeholders may be slow to react because of up-front costs.

“The push for healthcare providers to go paperless has created more electronic health records and repositories than ever before,” says Herold.

Take time to determine the timetable and EHR option that are most cost-effective for your organization.

### Major pharmacy company fined for breaches

➤ **The development:** On February 18, 2009, HHS and the Federal Trade Commission (FTC) fined CVS Caremark Corp. \$2.25 million for inappropriate disposal of protected health information (PHI). An investigation of CVS’ practices followed reports that the company discarded patient information in industrial trash containers outside some of its stores. CVS failed to secure the containers, making the PHI accessible to anyone, according to HHS.

The privacy rule requires health plans, healthcare clearinghouses, and most healthcare providers (covered entities), including most pharmacies, to safeguard the

privacy of patient information, even during its disposal.

Specifically, HHS said CVS violated the privacy of millions of its customers when it:

- Failed to implement adequate policies and procedures to appropriately safeguard patient information during the disposal process
- Failed to adequately train employees to discard such information properly

➤ **What to do now:** The CVS fines made it clear that HHS and FTC (and now OCR) currently operate under a sort of “zero tolerance” policy. The fines also served as a warning that anyone violating the privacy rule is subject to substantial fines and embarrassment.

Pursuant to the HITECH Act, HHS issued guidance April 17, 2009, requiring providers to shred or destroy any paper, film, or other hard copy media to ensure that no one can read or reconstruct the PHI.

### Celebrity privacy cases publicized in California

➤ **The development:** The problem of curious hospital workers who snoop inappropriately in medical records has long existed. During the past few years, it has become news as well. Celebrities, angry because healthcare workers have sold their information to tabloids, have fought back in California’s newspapers and state legislature.

Notable cases involved the late Farrah Fawcett in 2007 and Britney Spears in 2008. These high-profile cases inspired a bill that Gov. Arnold Schwarzenegger signed into law January 1, 2009. The new law permits the state to impose heavy financial penalties (as much as \$250,000) on healthcare providers who inappropriately peek in patients’ medical records.

It didn’t take long for the state to flex its newfound muscle. State regulators slapped the maximum penalty on Kaiser Permanente’s Bellflower (CA) Hospital in May 2009. Regulators found that Bellflower failed to prevent employees from snooping in the medical records of Nadya Suleman, who gave birth to octuplets in January 2009.

➤ **What to do now:** These high-profile cases cast

> *continued on p. 8*

## HIPAA

< continued from p. 7

a spotlight on inappropriate behavior in hospitals and pressure all providers to improve their processes. Conduct a risk assessment to determine whether your organization is vulnerable. Consider strategies such as monitoring system access logs or using “honeypots” to catch snooping staff members.

“It’s important for organizations to work harder to eliminate and detect snooping when workers look at the medical records of people they have no business looking at,” says **Michael C. Roach, Esq.**, of Meade & Roach, LLP, in Chicago.

### OCR became responsible for HIPAA security rule enforcement

➤ **The development:** HHS announced July 27, 2009, that it would transfer HIPAA security rule oversight from CMS to OCR. CMS had overseen the rule since it became effective in 2003.

➤ **What to do now:** Be prepared for greater enforcement of the HIPAA privacy and security rules; they both now fall under OCR’s umbrella. It is likely no coincidence that a plan for increased penalties for privacy and security violations is part of the HITECH Act that was enacted only four months earlier.

OCR now will evaluate whether HIPAA security standards preempt any state laws, impose financial penalties for violations, and issue subpoenas pertaining to security violations, according to HHS.

### Meaningful use—evolving definition, timetable, and application

➤ **The development:** In mid-July 2009, the Health IT Policy Committee approved a work group’s revised recommendations for defining the meaningful use of EHRs. This was the first step in a federal Medicare and Medicaid program that uses incentives to require physicians’ and hospitals’ financial commitment to EHRs.

The final definition of meaningful use could lead to:

- Easier exchange of patient information when necessary
- Greater availability of patient information
- Appropriate data and transmission security
- Better quality of care
- Greater efficiency

The work group also recommended that providers allow patients to access their personal health records by 2013. Its initial recommendations proposed patient access by 2015.

The new recommendations also require providers to participate in a national health data exchange by 2015.

“The verdict is still out on how beneficial the final definition of meaningful use will be to healthcare,” says **Chris Apgar, CISSP**, president of Apgar & Associates in Portland, OR. “It can have great value, and it can also hamper [health information technology] adoption if it is too expensive, requires too much, and/or is not well thought out.”

➤ **What to do now:** Privacy and security officers must do more than conduct research and prepare to implement EHRs. They also should prepare to strengthen their policies because violations may directly affect EHR incentives and reimbursement. The work group recommended that CMS withhold incentive payments until a provider resolves any pending HIPAA violation charges.

Meanwhile, providers must demonstrate meaningful use by ensuring that their EHRs:

- Allow patients to access their health records quickly
- Implement at least one clinical decision support rule for a specialty or clinical priority
- Provide patients electronic copies of discharge instructions and procedures
- Exchange health information where possible
- Submit insurance claims electronically
- Verify insurance eligibility electronically when it is possible ■



## Same-day transfers: No longer a simple reimbursement issue

*Editor's note: This article was written for **BALTC** by **Barbara Griffin-Gulliver**, director of Medicare policy at Zimmet Healthcare Services Group, LLC, in Morganville, NJ.*

For many years, SNFs were able to collect Medicare payment for a Part A resident who returned to an acute care hospital on the day of his or her SNF admission. It was one of the rare situations when a patient did not have to be in the SNF bed at census-taking time in order for the SNF to receive payment for the daily care provided.

In effect, SNFs were paid a cost report day for same-day transfer residents, but a SNF benefit day was not taken. A hospital benefit day was taken because that was where the individual resided at the time of midnight census.

Special coding on the SNF claim (condition code 40) in combination with a hospital discharge status of "02," and the "from" and "thru" dates of the claim being the same, permitted a cost report day payment to the SNF without the claim overlapping with the hospital admission. The related manual reference can be found in the *Medicare Claims Processing Manual*, Chapter 6, Section 40.3.3.

Although the reimbursement remains in place for this same-day transfer situation, the SNF's ability to collect payment has become more complicated since 2005.

Effective January 3, 2005, hospitals were required to bundle inpatient admissions for any individual who was discharged and was readmitted to the same hospital as an inpatient on the same day and for the same medical condition. CMS' goal in issuing this new policy was to curb early hospital discharges for medically unstable beneficiaries and to avoid payment of two separate hospital PPS diagnosis-related group amounts. The related instructions can be referenced in CMS' *MLN Matters* article, MM3389.

With the implementation of this new policy, same-day transfer claims from the SNF overlap the combined hospital stays. CMS' answer to this problem was to direct hospitals to pay the SNF for the Medicare cost report day

amount. The SNF must petition the hospital for the payment. Most SNFs do not find this to be an easy task.

SNFs can continue to submit same-day transfer claims for direct Medicare reimbursement if the resident is discharged:

- Back to the hospital on the day of admission for a different medical reason
- To a hospital other than the one from which the resident was originally discharged

Medicare has never reimbursed a cost report day for a same-day transfer resident who leaves the SNF against medical advice (AMA) or requests and receives transfer to another SNF on the day of admission. The first SNF may, however, privately bill the AMA resident for room and board using a facility invoice. It's unnecessary to bill Medicare for denials in this situation in order to privately bill the resident. The first SNF may also submit a claim to Medicare for ancillary services provided to a resident who transfers to another SNF on the day of admission. ■

*Illustration by  
David Harbaugh*



*"Would you say that your medical school experience helped develop your facility with unapproved abbreviations and prohibited acronyms?"*

## LTC billing IQ

Think you're a long-term care (LTC) billing pro? Test your knowledge of SNF billing by answering the following questions, which are based on the facts and information found in this issue's articles.

1. In the MDS 3.0, the start of therapy Other Medicare-Required Assessment (OMRA) and the end-of-therapy OMRA can potentially appear on the same assessment.
  - a. True
  - b. False
2. The amendment to delay the implementation of Resource Utilization Group, Version Four (RUG-IV), to October 1, 2011, appears in the:
  - a. House health bill
  - b. Senate health bill
  - c. Both bills
  - d. Neither bill
3. RUG-IV includes 53 groups.
  - a. True
  - b. False
4. The MDS assessment schedule is determined by when the assessment reference date is set.
  - a. True
  - b. False
5. The consolidated billing final rule for which of the following fiscal years set the precedence for situations in which it's acceptable to bill for the default rate?
  - a. 2003
  - b. 2005
  - c. 2007
  - d. 2009
6. *Transmittal 196*, issued in March 2007, listed five scenarios in which facilities were allowed to submit a late assessment and bill for the default rate.
  - a. True
  - b. False
7. In which of the following scenarios are SNFs not allowed to bill for the default rate?
  - a. The stay is less than eight days within a spell of illness (benefit period)
  - b. The beneficiary requests a demand bill
  - c. The SNF is unaware of a same-day transfer
  - d. The SNF is notified on an untimely basis or is unaware of a beneficiary's disenrollment from a Medicare Advantage plan
8. Beginning in 2005, hospitals were required to bundle inpatient admissions for any individual who was discharged and was readmitted to the same hospital as an inpatient on the same day and for the same medical condition.
  - a. True
  - b. False
9. SNFs can submit same-day transfer claims for direct Medicare reimbursement if the resident is discharged:
  - a. Back to the hospital on the day of admission for a different medical reason
  - b. To a hospital other than the one from which the resident was originally discharged
  - c. Both a & b
  - d. None of the above
10. Business associates are not required to comply with the HIPAA security rule and the Health Information Technology for Economic and Clinical Health (HITECH) Act's security provisions.
  - a. True
  - b. False

Are you stumped? Wondering whether you got the answer? Find the correct answers on page 12. ■

## BALTC Q&A

*Editor's note: "Q&A" was written by Lee A. Heinbaugh, president of The Heinbaugh Group, a long-term care consulting company in Lakewood, OH. To submit a question for upcoming issues, e-mail Associate Editor Justin Veiga at [jveiga@hcpro.com](mailto:jveiga@hcpro.com).*

**Q** I am new to working in a SNF billing office. I was reading through our policies and procedures for Medicare billing, and the Medicare Interactive Voice Response (IVR) system is mentioned several times. We use the Medicare online system to monitor our claims and verify eligibility; when should we be using the IVR system?

**A** The Medicare IVR system can be used for several tasks. Medicare eligibility can be verified using the IVR. Although this is often done using the Medicare Common Working File health insurance query access files, on the rare occasion when you can't access the online system, the IVR system can be used as a backup. This way there is no interruption in the verification process. To use the IVR system to check eligibility, you will need to do the following:

### Identify the facility

- Facility NPI number
- Facility Medicare number or Provider Transaction Access Identifier
- Facility tax identification number

### Provide resident information

- Medicare number
- Name
- Date of birth
- Date of service

### Verify items

- Effective and/or termination date of eligibility for Part A and Part B
- Date of death

- Medicare Secondary Payer (MSP)
  - Name of MSP
  - Type of MSP
  - Effective and/or termination date
- Medicare managed care plan information
  - Name of Medicare Advantage plan
  - Effective and/or termination date
- Last billing date
- Number of SNF days available
- Amount applied to the current year Medicare Part B deductible
- Amount applied to the current year therapy limits
- Hospice
  - Name of hospice
  - Effective and/or termination date

If your facility is receiving rejected claims due to an overlap in dates of service, the IVR will provide the name of the hospital and the dates the hospital billed to Medicare that are causing the overlap. This allows you

> *continued on p. 12*

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**BALTC Q&A**

< continued from p. 11

to review your census and correct your claim accordingly. Or in the event there is a mistake, you will know who to contact in order for corrections to be made to the dates of service used on their claim.

The other reason to use the IVR is to reactivate claims that are not available online. Some claims can be activated using the IVR, but you may still need to contact the provider relations department for some claims.

The use of the IVR system to verify benefits is easy and available any time. It is always good to have a back-up plan to access the eligibility information to be sure you have the necessary information when making an admission decision.

**Note:** If you enter the Social Security number using the telephone buttons, identify the alpha character by pressing “\*,” then the button that corresponds with the alpha character, and then pressing the number for the position of the alpha character. Example for the alpha suffix A: \*, 2, 1.

**Q** We do billing for a SNF and must find the regulations for the three-day qualifying hospital stay dates. We need to communicate to our nursing and admission staffs that we cannot bill Medicare Part A if the resident was not admitted to the hospital for three consecutive days. The hospitals in our area sometimes keep

**our residents in an observation status and do not admit them to the hospital as an inpatient. Where can we find the documentation we need to support what qualifies as an inpatient hospital stay?**

**A** This is a common problem. The three-day prior hospital stay requirements are included in Chapter 8, Section 20.1, of the *Medicare Benefit Policy Manual*. This chapter can be found on the CMS Web site at [www.cms.hhs.gov/manuals/Downloads/bp102c08.pdf](http://www.cms.hhs.gov/manuals/Downloads/bp102c08.pdf).

Please review and reproduce this section and share with your staff members and colleagues. It is imperative that the resident meet this qualification for coverage under the Medicare Part A program. ■

**LTC billing IQ answer key**

1. a. True
2. b. Senate health bill
3. b. False
4. a. True
5. d. 2009
6. b. False
7. c. The SNF is unaware of a same-day transfer
8. a. True
9. c. Both a & b
10. b. False

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