Medicare Part A

“Avoiding Claim Overlaps”

Presented by
Provider Outreach and Education

Disclaimer

This resource is not a legal document. This presentation was prepared as a tool to assist our providers.

This presentation was current at the time it was created.

Although every reasonable effort has been made to assure accurate information, responsibility for correct claims submission lies with the provider of services.

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Objectives

• Define duplicate claims
• Identify Skilled Nursing Facility coverage and payment guidelines
• Recognize the services excluded from Skilled Nursing Facility Consolidated Billing
• Describe “under arrangement” agreements between Skilled Nursing Facilities and other providers or suppliers
• Be familiar with Medicare policy on transfers
• Identify patient discharge/status codes
• Be able to identify and resolve overlap issues

DUPLICATE CLAIM SUBMISSIONS
Definition

• A duplicate claim is defined as a claim submitted to Medicare from the same provider, for the same beneficiary, for the same item or service, for the same date of service

• Elements:
  – HICN
  – TOB
  – PTAN
  – From and through dates of service
  – Total charges

Contributors to Duplicate Submissions

• Provider’s billing software is set up to automatically re-file

• Zero payment was initially made due to a denial or the allowed amount was applied to deductible and the claim is resubmitted for payment

• Eligibility is not verified prior to billing

• Billing company paid per claim submission
Preventing Duplicate Claim Denials

- Ensure claims’ software is **not** set up to automatically rebill every 30 days or at any other set intervals
- Ensure claims batching process is functioning properly
- Check claim status before resubmitting a new claim
- Verify benefits prior to submitting claims

Top Claim Submission Errors

http://www.cahabagba.com/part-a/claims/top-claim-submission-errors-how(resolve-them/)
Skilled Nursing Facility

• Background
  – The Balanced Budget Act of 1997 enacted the SNF Prospective Payment System reimbursement and CB requirement methodologies. Under the PPS, a SNF is reimbursed on a per diem basis for virtually the entire package of services that it furnishes during a resident’s covered Part A stay.
SNF Consolidated Billing

• Why Consolidated Billing?
  – Decrease potential for duplicate billing
  – Allows SNF the capacity to meet its responsibility to oversee, coordinate, and account for the care furnished to its residents
  – Needless expense for beneficiaries

SNF Consolidated Billing

• Services for which the SNF is responsible:
  – Nursing services
  – Physical therapy, occupational therapy, speech pathology
  – Drugs, supplies, equipment
  – Labs and x-ray services
  – Ambulance services
  – Room and board
  – Orthotics
  – Prosthetics
SNF Consolidated Billing

• Excluded Services
  – Physician services furnished personally by physician
  – Physician assistant working under physician supervision
  – Nurse practitioner and clinical nurse specialist working in collaboration with a physician
  – Certified nurse midwife
  – Qualified psychologist
  – Certified registered nurse anesthetist

Provider Action Needed

• Communicate with beneficiary and SNF

• Verify Part A benefit information

• Communicate with outside providers or suppliers
“Under Arrangement” Agreements

• SNF consolidated billing services must be furnished:
  – Directly
  – Under arrangement

• “Arrangement” should specify:
  – The arrange-for services the SNF is responsible for
  – The manner in which the SNF will pay for those services

• Claims by other entities for services subject to consolidated billing will not be paid

Agreements and Notifications

• Agreement between SNF and Supplier
  – 2 sample agreement forms which provide terms for ongoing arrangement between SNF and supplier

• Notifications
  – 7 sample notification forms which outlines SNF requirements for referrals, billing rules, etc...

www.cms.hhs.gov/SNFPPS/08_BestPractices.asp
OTHER OVERLAP ISSUES

Hospice Overlap

• Consistently a top claim submission error
  – Claims denied with reason code C7010
    • An inpatient, outpatient or SNF claim has service dates equal to or overlapping a hospice election period.

• How to prevent/resolve
  – Verify benefits with patient
  – Utilize the IVR/ELGA/InSite to access beneficiary eligibility information
  – If services unrelated to terminal illness, bill Medicare with condition code 07
Hospice Information

HMO Overlap

- Claims denied with reason code U5233
  - Service within HMO period and no hospice involvement or services within hospice period.

- How to prevent/resolve
  - Upon admission, review all insurance cards
  - Access eligibility utilizing IVR or ELGA or InSite
  - If HMO benefit elected, bill HMO plan directly
  - Access the MA Claims Processing Contacts directory, which contains a list of all active Medicare contracts and their corresponding plan type
Medicare Advantage Plan Directory


Patient Status Codes

<table>
<thead>
<tr>
<th>Status</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Discharged to Home</td>
</tr>
<tr>
<td>02</td>
<td>Transferred to short term hospital</td>
</tr>
<tr>
<td>03</td>
<td>Transferred to SNF (Skilled Nursing Facility)</td>
</tr>
<tr>
<td>04</td>
<td>Transferred to ICF (Intermediate Care Facility)</td>
</tr>
<tr>
<td>05</td>
<td>Transferred to another facility</td>
</tr>
<tr>
<td>06</td>
<td>Discharged/Transferred to home under care of Home Health</td>
</tr>
<tr>
<td>07</td>
<td>Left against medical advice or discontinued care</td>
</tr>
<tr>
<td>08</td>
<td>Transferred to home under care of home IV drug therapy provider</td>
</tr>
<tr>
<td>09</td>
<td>Admitted as inpatient to this hospital</td>
</tr>
<tr>
<td>20</td>
<td>Expired</td>
</tr>
</tbody>
</table>
Patient Discharge Status

- Improper use of discharge status codes can affect claims processing
  - Can result in overpayments
  - Can result in underpayments

- To correct this problem:
  - Have a basic understanding of Medicare policy on transfers
  - Determine and enter the correct discharge status code on claim
Provider Contact Center

- Alabama, Georgia, Tennessee
  - 877-567-7271

- Customer Service Representatives can provide the following information regarding overlapping claims:
  - Name of facility
  - Telephone of facility, if available
  - Dates of Service

Medicare Administrative Contractor Satisfaction Indicator (MSI)

- Administered by CMS to measure provider satisfaction with the performance of MACs
- Enables CMS and the MACs to gain insight about their customers and what specifically drives their satisfaction
- Survey available to providers June 15, 2015
2015 Cahaba Medicare Expo

• In-person educational workshop
  – Medicare training dedicated specifically to each line of business
  – One-on-one networking opportunities with Cahaba associates
  – Exhibitors onsite showcasing the latest products and services

• Date:
  – Part A providers – August 19, 2015
  – Part B providers – August 20, 2015

• Location:
  – Birmingham, Alabama

References

• Medicare Claims Processing Manual
  – Publication 100-04, Chapter 3, Section 40.3

• Medicare Claims Processing Manual
  – Publication 100-04, Chapter 6, Section 10

• CMS Agreements and Notifications

• Cahaba GBA, FISS Reference Guide
  – www.cahabagba.com/part-a/education/educational-materials/
Questions

Thank you!

Please complete the evaluation and post assessment.

Evaluation
http://listmgr.cahabagba.com/subscribe/survey?f=1709&x=12f95a33

Post-test
http://listmgr.cahabagba.com/subscribe/survey?f=1711&x=df1d69d7