



Tips for Reducing Common Medicare Billing Errors, Improving Performance and Increasing Reimbursements

By Mary Leber, Director of Consulting Services, Ecumen

Many in our profession find Medicare to be a Rubik's cube of regulation and complexity. Combine that with busy employees, large workloads, a lack of a minimum data set coordinator (MDS), and a care center can quickly find that it's not filing Medicare claims in an accurate, timely manner.

The good news?

Medicare problems tend to have similarities and can often be fixed quite easily. Reducing these errors means improving Medicare compliance and increasing reimbursements. Following are key areas that can become pitfalls and our tips on addressing them.

- **Qualifying Hospital Stay:** Most nurses know that a resident coming to the care center from the hospital must have a three-day qualifying stay to gain approval for a Medicare "A" stay. Problems occur when admission documentation fails to get the dates and times of admissions to hospitals accurately – or at all. Many seniors enter the hospital through the emergency room and they may not be seen for hours. Or they are held there until a bed is available. An entire day can be lost because a patient was not admitted until after midnight -- even when they entered the hospital at 8 p.m. The day of admission counts as a hospital inpatient day but the day of discharge does not.

Our Advice:

Verify the exact date and time the resident was admitted to the hospital. Pay close attention to transfer forms that note "admitted through the ER (emergency room)" or "came to ER from SNF (skilled nursing facility)". Also, double check on those admitted to the hospital close to the midnight hour to ensure that the day count is correct.

- **Thirty-Day Transfer:** A person admitted to a care center within 30 days of being discharged from the hospital and who meets the *qualifying stay requirement* may be admitted under Medicare "A." In determining the 30-

Our Advice:

Take out your calendar and count the days after verifying the 3-day qualifying stay was met. Pay attention to admission dates and make sure they are correct. Be certain that the person has daily skilled needs upon admission.

- **Hospital Swing Beds/Extended Care Units:** If your care community is located in a rural area with critical access hospitals that contain swing beds/extended stay units the admission document must make a crucial determination: Were the patients in swing beds prior to transferring to the care center? If so, you must count those days.

Our Advice:

Always ask if the resident was in a Medicare “A” stay in the swing bed or extended stay unit of the hospital. These days count toward the total of Medicare days. You have to know how many days they used. The person might not have to enter on “day 1” of their Medicare “A” stay with you depending on use in the swing bed. If he or she was in the swing bed for five days and covered, the person comes to you at day 6 of their Medicare “A” stay not day 1.

- **The Midnight Rule:** If a resident is not in the care center bed at midnight, the care center cannot bill Medicare for the day preceding midnight. That’s called the “Midnight Rule.” You can miss a day’s payment because of this situation. (This is especially prevalent during the holidays.) Medicare audits see this practice as proof that the person does not need a skilled level of care since they have done fine outside a skilled setting for long periods of time. Therefore, this situation doesn’t qualify for Medicare “A” reimbursement.

Our Advice:

The care team needs to be extremely diligent in evaluating if the resident qualifies for a skilled care center stay. If a person leaves the care center for extended time – beyond normal medical appointments – the person is not Medicare A eligible because Medicare feels that the

person does not need skilled care. Consider this: We are aware of one provider that is paying back more than \$2 million in reimbursements because it allowed leaves that did not adhere to Medicare regulations.

- **OMRA:** Known as “Other Medicare Required Assessment,” this test is often missed due to poor communication or tracking. The assessment must be completed eight to 10 days after rehab therapy has been discontinued and the patient continues to have skilled care requirements covered by Medicare “A” after therapy is discontinued.

Our Advice:

Determine whether Medicare coverage continues on all residents that are discharged from therapy services and remain in the care center. If they remain Medicare “A” coverable, get an “assessment reference date” (ARD) of day eight, nine, or 10 that can be used to qualify the person for a non-therapy resource utilization group (RUG) rate. This resets the rate of payment. Remember, OMRA does not require you conduct a resident assessment protocols (RAPS).

- **Presumption of Coverage:** In general, the Centers for Medicare and Medicaid Services (CMS) presume that beneficiaries admitted to a care center immediately after a qualifying hospital stay require a skilled level of care. This presumption of coverage policy applies to the Medicare stay from the date of admission to the ARD of the five day MDS. However, this presumption of coverage does not apply to any of the subsequent assessments.

Our Advice:

Residents must clearly have supportive documentation charted in their medical record that addresses their needs for skilled levels of care.

As you can see, the Medicare maze can be simplified. And with that simplification comes improved clinical performance and reimbursement.

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