Dignity Health
East Valley Rehabilitation Hospital

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BILLING		Page **1** of **12**
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Finance	9/12/19	
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References		

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY

All hospital billing shall be performed in a consistent manner that is compliant with all regulatory guidelines

PROCEDURES

This policy applies to all patient bills.

I. **6.2 Insurance Contracts**

Upon admission, each patient account requires editing and/or completion of the account information in Meditech to ensure accurate billing. The Staff Accountant/Designee shall review each new account for accuracy. Establishing the patient accounts with the correct insurance contract will ensure contractual allowances are properly recorded by the system. Utilizing the outliers/exclusions portion of the patient specific contract routine ensures that all eligible revenue is being recorded properly for these accounts.

A. Master Contracts

- A master contract may be selected in the Process Insurance Contract Data screen in Meditech for any insurance carrier listed in the dictionary.

- Verify the parameters of the master contract against the parameters identified during the insurance verification process. If variances do exist, contact the help desk to request a review and correction of the master contract parameters if needed.

BAR module > Dictionaries > Insurance Contracts > View.

B. Medicare Part A – Specific Instructions

Medicare Part A Master Contracts are already established in the Meditech System. A Master Contract will supersede all other information when it is the primary payor on

the account. Reimbursement and co-insurance rates are maintained and updated at the corporate level. Any errors or discrepancies should be reported to the Help Desk for correction. Upon admission, the Admission clerk/designee shall validate the benefit days entered into Meditech via the previously completed insurance verification. This entry will enable the Meditech system to properly calculate the last covered benefit day and prorate any applicable co-insurance.

Meditech will prorate the Medicare Part-B allowable charges whenever a patient account indicates the patient is eligible for Part-B benefits.

NOTE: This would include accounts that are not edited correctly leaving both Part A and Part B on the account.

Medicare Secondary Payer Provisions

Medicare is a secondary payer to automobile, liability insurance policies, or large group health plans. Federal law prohibits payment by Medicare if, "payment has been made or can reasonably be expected to be made *promptly* (as determined in accordance with regulations) under a workmen' s compensation law or plan of the United States or a State or *under an automobile or liability policy or plan (including a self-insured plan) or under no fault insurance."* [Emphasis added]. "Promptly" is defined by federal regulation to mean payment within 120 days after the earlier of the date a claim or lien is filed against a potentially liable third party or the date of service or, in the case of inpatient hospital services, the date of discharge. 42 C.F.R. Section 411.50(b).

To comply with federal law, providers should gather information during the admissions process regarding potential third party liability for all services to be rendered to an eligible Medicare beneficiary. If the provider has reason to believe that payment may be available from liability insurance, the provider must observe the following requirements issued by the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the Medicare Program.

1. Within the 120 day "promptly" period, the provider must bill only the liability insurer, unless the provider has evidence that the liability insurer will not pay within the 120 day period. If the provider has such evidence, it may bill Medicare with documentation that payment will not be made promptly by the liability insurer.

2. After the 120 day period has ended, the provider may, but is not required to, bill Medicare for payment if the liability insurance claim is not finally resolved.
3. If the provider chooses to bill Medicare, the provider must withdraw any claims or liens asserted against the liability insurer. In such cases, the payment made by Medicare is considered conditional in that the patient must reimburse Medicare from the proceeds of any third party recovery.

4. If the provider chooses to seek payment from the liable third party after the 120 day period, the provider may not also bill Medicare.

After the 120 day period has lapsed, providers have a choice between billing Medicare or pursuing a claim against a potential third party insurer. In reality, few personal injury claims will resolve within the 120 day period so providers should weigh the risks attendant to not collecting on a personal injury claim or collecting only partial charges when making the decision between billing Medicare or other liability insurance. While payment from a third party recovery will usually be greater than the payment from Medicare, Medicare payment is guaranteed and third party payment is not.

C. Patient Specific Contracts

There are four types of Patient Specific Insurance Contracts: Flat, LOC (Level of Care), FFS (Fee for Service) and Proration Rule (commercial accounts using MCR rates).

Master Examples can be created and copied from other patient accounts that have the same insurance. It is recommended that this be performed for patient accounts with the most frequently used insurance payor types, such as Aetna, Blue Cross and United Healthcare.

D. FLAT Contracts

The FLAT contract is used when the insurance company has agreed to reimburse at a per diem or flat daily rate, such as $900.00 per day. Often the insurance company will agree to reimburse exclusions such as specialty equipment, dialysis or surgical procedures in addition to the flat rate. If exclusions are applicable, adjust the amount to be reimbursed by the insurance company by utilizing the “Adj %” column on the Outlier tab for the exclusions.

E. Level of Care (LOC) Contracts

The LOC contract is used when the insurance carrier has agreed to reimburse at a per diem or flat daily rate based on the patient’s level of care. Generally there are two to four different levels that are reimbursed at different rates (i.e. Level 1 = $750. Per day, Level 2 = $800 per day). Often the insurance company will agree to reimburse for certain exclusions such as specialty equipment, dialysis, or surgical procedures in addition to the daily rate. Adjust the amount the insurance company is to be billed by utilizing the “Adj %” column on the Outlier tab for the exclusions.

F. Fee for Service (FFS) Contracts

A FFS contract is used when the insurance company has agreed to reimburse at a percentage of charges.

G. Commercial CMG

Commercial CMG's are used when an insurance company has agreed to reimburse at a CMG rate. If a master contract has been set-up with a contracted payor using the specific payors parameters, then that payors proration rule shall be utilized. If a master contract has not been established for the CMG payor, then the proration rules listed below shall be utilized:

Insurance Type	Proration Rule
Commercial	MCR COM
Medicare Supplemental	MCR COM
Medicare Advantage	MCR MGD

Note: There is a space between MCR and COM or MGD.

Commercial CMG's shall be billed in a manner similar to Medicare absent specific contract terms to the contrary.

H. Charity Fee For Service

When a patient does not have insurance benefits, or has exhausted his/her benefits and does not have supplemental insurance, he/she may qualify as a Charity patient (See Hospital specific charity care policy for eligibility details). If eligible, the Charity mnemonic shall be utilized which will prorate the account at the approved charity level..

I. Self-Pay

Patients who do not meet the financial indigence criteria shall be billed privately. Patients who are eligible for Medicare Part B benefits shall be responsible for the co-insurance amounts in addition to amounts not covered under Part-B.

II. **Billing of Patient Accounts**

The CBO/designee shall ensure all bills are printed and mailed. Meditech will generate detailed bills on a daily basis for patients with bills pending.

Final bill/claim diagnosis coding by the hospital HIMs department is required within 3 business days of discharge..

Billing cannot occur until all the medical record has been received, reviewed and final coded.

Outpatients are to be billed upon final coding. Recurring outpatients are to be billed at least monthly. Inpatient rehabilitation patients are to be billed upon discharge.

A. **Medicare IRF-PAI Audit**
The hospital shall audit 100% of Medicare and Medicare eligible charts using the IRF-PAI audit form. The IRF-PAI should not be transmitted to CMS nor the claims billed in Meditech until the audit is completed. The audit should include input from the business office, coding and PPS.

B. **Electronic Billing**
Electronic billing is performed on-line through network or Intranet connections. Certain States have the ability to accept Medicaid billing electronically.

Medicare Billing

Medicare Part A and Part B bills are generated by the Meditech system. Upon discharge, once the claims have been final coded, audited and the IRF-PAI submitted, they are ready to be transmitted electronically to Medicare.

Medicaid Billing

Claims will be billed daily for all patients discharged and claim is ready in Meditech (coding, FIM score and charges entered). Currently the Meditech and Medicaid software are not compatible in all States. In some States the claims can be hand keyed into the State Medicaid system via State Specific Software

Commercial Billing

Commercial claims shall be billed electronically through Meditech at discharge.

Each day, the Discharge Report shall be ran and reviewed to ensure the account has been final coded. Prior to billing, the hospital shall ensure:

- All charges are entered.
- All demographic data, including name, date of birth, insurance policy number and group number are correct.
- Pre-certification/authorization number is entered into Meditech.
- The insurance mnemonic is correct in Meditech

The CBO will:

- Perform a final review of Meditech to make sure no information is missing (they are not checking all information for accuracy, that is the responsibility of the hospital)

Download claim to SSI

Translate claim to SSI.

Confirmation report of electronic claims submitted.

Skip Claims report for payors that did not translate. In the event a payor is on the report, the following steps must be taken:

- o Verify that the insurance mneumonic is correct
- o Call help desk and open a ticket
- o Track ticket number

For Payors that will not accept Electronic Claims: The BILL PAPER function must be used in SSI.

Additional helpful steps for payors that will not accept electronic claims

1) Print an itemized bill and/or
2) Attach a copy of the LOA, and
3) Update notes in Meditech to indicate bill sent

Commercial Accounts with Stop Loss (Day 1)

- The account is to be set up in Meditech using the correct mnemonic.
- The Hospital to check daily to see if stop loss has been met
- Once Stop loss has been met, ensure the proration is applying the post stoploss reimbursement correctly.

Commercial Accounts with Stop Loss (Day 2)

- The account is to be set up in Meditech using the correct mnemonic.
- The Hospital to check daily to see if stop loss has been met via Cumulative Patient Charge Report
- Once stop loss has been met, enter the stop loss begin date in the demographics screen, see instructions below.

If Late charges come across after billing, then bill an adjustment claim (117 bill). Any late charges over $1,000 will be rebilled once initial claim has been processed by the payer. All late charges under $1,000 shall be adjusted off. If late charges do not impact the final payment, i.e., per diem or flat rate, the late charges will be adjusted off. All actions will be documented in Meditech system.

C. **Manual Billing**

The person responsible for billing the commercial accounts generally processes manual claims. All primary commercial claims should be mailed within two business days after claims are generated in order to expedite cash flow. Detailed bills are attached to the UB to provide an itemized bill for the insurance company, if required.

Supplemental insurance claims are submitted to insurance companies as primary payor receipts are received and posted. Some offices may wish to demand their claims manually when payments are received to accelerate cash flow. A copy of the RA (remittance advice) must be attached to the claim form.

Identify clearly the co-insurance and deductible amounts that commercial carrier is expected to pay.

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D. **Late Charges and Credits**

Late charges and late credits for Medicare Part-A and Medicare Part-B can be billed electronically to Medicare.

Late credits (even if there is no change in Medicare reimbursement) for Medicare Part-A and Medicare Part-B require an adjusted claim to be submitted to Medicare.

Late charges of less than $1000 (gross charges) per claim for Medicare Part-A and Medicare Part-B do not need to be billed. If the overall late charges are $1000 (gross charges) or more, then a late adjustment bill must be submitted to Medicare. These adjustments should be reviewed and made monthly.

If the late charge is a reversal of a previously posted charge and results in any amount due back to the Medicare program, it shall be re-billed.

Late charges for non-Medicare accounts reimbursed on a per-diem do not need to be billed unless the items provided are exclusions per the contract, or the payor contract stipulates that all charges be billed.

Late charges for non-Medicare accounts reimbursed on a percent-of-charges shall be billed if the net reimbursement is greater than $100 per claim.

The CBO/designee shall ensure that late charges and credits are billed according to policy guidelines. The primary reports below can be utilized to aid in this review:

“Late Charges Report” (Path = Meditech > Kindred Reports > Charge Analysis Reports)

“Print Late Chg Report” (Path = Meditech > Billing/A/R Main Menu > Batches)

“Lost/Late Charges Report” (Path = Meditech > Billing/A/R Main Menue > Bills)
The following reports are available to assist in this review process:

MediTech System Billing /AR Module => Daily Reports => Late Charge Report

This report captures Late Charges/Credits subsequent to a final bill being generated for a designated time period.

MediTech System Billing/AR Module => Claims => List Claims to be generated
This report captures Late Charges/Credits prior to and subsequent to a final bill being generated.

The Meditech System will place a hold on credit balance claims. The Medicare System cannot process claims with credit amounts. In order for the claim to pass the screening process, the credits must be identified and manually adjusted.

E. **Patient Request for Bill**

Upon patient request for detail bill, an itemized statement/bill shall be provided to the patient, or to appropriate survivor, within seven (7) days following discharge, and the bill shall:

1) Detail services provided by department.
2) Not include charges of hospital-based physicians if billed separately.
3) Not include any generalized category of expenses such as "other" or "miscellaneous" or similar categories.
4) List drugs by brand or generic name and not refer to drug code numbers.
5) Specifically identify therapy treatment as to the date, type, and length of treatment when therapy treatment is part of the statement.
6) In Florida, state on the bill "A For-Profit Hospital Licensed By the State of Florida".

III. **6.4 Information Billing**

The CBO/designee shall bill Medicare (using bill type 110 series) for dates of service after Medicare exhaust through discharge to appropriately notify Medicare of the continued stay during the spell of illness. This is known as a no pay claim. The CBO, in addition, shall bill (using bill type 111) a no pay claim for all Medicare Advantage plans.

Although no reimbursement will result from these claims, Medicare requires providers to submit this information to gather data such as End-Stage Renal days and beneficiary co-insurance amounts.

IV. **Payer Status Changes**

A patient's payer type may change subsequent to admission.

A. Medicare Exhaust Benefits

- Upon admission, the Admissions Clerk/designee shall enter the number of Benefit Days used by the patient prior to admission.

- The insurance verification form shall be used to create a contract for admissions with supplemental coverage. "Rollover" data in Meditech shall be edited to indicate the proper payer order for the new payer type.

- The Concurrent Review report in Meditech identifies the remaining days on accounts and an anticipated last benefit date.

Kindred Reports ☾ Concurrent Review Reports ☾ Concurrent Review Report

B. Medicare Replacement Plan Carrier Changes

The Medicare Replacement plan in place at the time of admission is responsible for payment of the entire stay.

C. Other Third Party Carrier Changes

The Staff Accountant/designee is responsible for making appropriate insurance and contract changes upon notification of such insurance change.

V. **Reversing and Demanding Bills**

When a patient's payer status changes subsequent to bills having already been dropped/demanded, those bills must be reversed, insurance and contract information changed, and bills re-demanded. This process reverses the original contractual adjustment(s) and posts the correct contractual adjustment(s) to the account, thereby accurately stating net revenue. Link to Instructions on How to Reverse and Re-Demand

After the facility month-end close process is complete, all interim claims established for in-house patients shall be reversed and then re-opened to accept new daily charges.

Meditech > Billing/A/R Main Menu > Close Day > Close Day Menu > Reverse Bills – Multi-Accounts

NOTE: If cash has been posted on the account, all cash will fall to the first bill that is re-demanded. The CBO/designee shall re-class cash to the appropriate claims, if necessary.

VI. **SSI Process**

The hospital CBO/designee reviews the unbilled claims report daily to identify claims that can potentially be billed. All claims are produced within 4 days of discharge.

The hospital CBO/designee will upon producing claims in Meditech ensure the claims are queued to SSI. SSI will edit claims for internal consistency. The CBO/designee shall review all claims in SSI on a daily basis to ensure that all edits are resolved and the claims released for transmission to the appropriate payers. Once claims have been submitted they are monitored to ensure one of three actions occur:

1) For claims that are paid the CBO verifies that the expected reimbursement matches the remittance and resolves any discrepancies.
2) For claims that are denied the CBO/designee shall contact the payor and the claims denial appeals process shall be initiated.
3) For rejected claims the cause of the rejections will be corrected and a new claim submitted.

VII. **Interrupted Stays**

3-day Interrupted Stays. If the patient returns to the discharging IRF within 3-days (patient is gone from the hospital for less than 3 midnight), the patient's readmission is considered a continuation of their original admission.
The hospital shall only be responsible for Medicare covered services if the patient leaves the building and returns the same day.

The hospital is not responsible for Medicare covered services, during the interrupted stay, if the patient was away from the facility for at least 1 midnight.

If no Medicare services were provided, then use revenue code 180 and occurrence span code 74.

If the patients returns the same day, then no interrupted stay is recorded in Meditech nor billed to Medicare.

If the interrupted stay lasts 1 or 2 midnights, then an interrupted stay shall be recorded in Meditech and on the bill to Medicare. Occurrence span code 74 shall be used to record the days away from the facility.