Practice Toolkit: Medicare Billing in Long-term Care

Save to myBoK

by Michelle Sims, RHIT

In order to accurately bill for long-term care, an organization must achieve consistency between the minimum data set (MDS) and the UB-92. The first step is to ensure compliance with the completion of the MDS. It is helpful to have a system that identifies the assessment reference date span and acceptable grace days for each required assessment.

In the worksheet presented here, entering the admission date automatically calculates the acceptable date ranges for each assessment (shown below) as well as the applicable payment days. Based on the type of assessment and the assessment date chosen, the applicable payment days may not always follow the assessment date. In addition, when a resident discharges, an assessment may still need to be completed for billing purposes. When the discharge date is entered on the worksheet, the applicable payment days are adjusted. This will define the dates for billing and help prevent errors such as missed assessments.

Understanding resource utilization groups (RUGs) and health insurance prospective payment system (HIPPS) modifiers is critical to the process. An organization may need to adjust the applicable payment days when an off-cycle assessment, such as an other Medicare required assessment (OMRA), is completed. When a HIPPS modifier is entered indicating an OMRA, the spreadsheet automatically adjusts the payment days based on the assessment reference date and HIPPS rate code to ensure billing at the appropriate RUG for the correct number of days.

MR#:	1000				
RESIDENT:	BROWN, CHARLIE		**HMO:**		
ADM DATE:	01/16/09		**DISCH DATE:**		04/01/09
Last Covered Day:	03/31/09		**Medicare Days Used:**		75
			Total Length of Stay:		75
	Ref Span		**Reference Date Span**		
	From Day	**To Day**	**From Date**	**To Date**	**Reason for Assessment**
DAY 5	1	5	01/16/09	01/20/09	Medicare 5 Day
Grace Days	6	8	01/21/09	01/23/09	
Significant Change and/or OMRA between 14 day & 30 day					SigChg / OMRA
DAY 30	21	29	02/05/09	02/13/09	Medicare 30 Day
Grace Days	30	34	02/14/09	02/18/09	SigChg / 30 Day
Significant Change and/or OMRA between 30 day & 60 day					SigChg / OMRA
DAY 60	50	59	03/06/09	03/15/09	Medicare 60 Day
Grace Days	60	64	03/16/09	03/20/09	SigChg / 60 Day
Significant Change and/or OMRA between 60 day & 90 day					SigChg / OMRA
DAY 90	80	89	04/05/09	04/14/09	Medicare 90 Day
Grace Days	90	94	04/15/09	04/19/09	Qtly / 90 Day

If combining with quarterly, R2b must be w/in 92 days of last OBRA R2b					Sig Chg / 90 Day
Primary Diagnosis:	V57.89				
Other Pertinent Diagnoses: (up to 8)	V54.15	250.00	V58.67		
		272.0	244.9	733.00	
(Spreadsheet continued below. The two parts are meant to be read side by side.)					

ICD-9-CM codes must be reported accurately, including the correct principal diagnosis, as well as any secondary codes that justify the use of services and reflect the conditions that qualify the resident for coverage. These diagnoses should also be reported on the MDS.

The worksheet below was created for this purpose. By inputting the facility's actual Medicare rate, it calculates the exact reimbursement based on days billed at each RUG, providing useful statistics for Medicare tracking.

Payment Days	**A3a Assess Date**	**Applicable Pmnt Days**		**Rug Category**	**HIPPS Modifier**	**# Days to Bill**	
		From	**To**				Type
1-14	01/19/09	01/16/09	01/29/09	RHB	11	14	Comp
		01/16/09	01/29/09			14	OR Full
15-30	01/29/09	01/30/09	02/14/09	RHB	07	16	Full
15-30		01/30/09	02/14/09			16	Comp
		0	0			0	
31-60	02/11/09	02/15/09	03/16/09	RHB	02	30	Full
31-60		02/15/09	03/16/09			30	Comp
		0	0			0	
61-90	03/15/09	03/17/09	03/28/09	RMB	03	12	Full
61-90		03/17/09	03/28/09			12	Comp
	03/29/09	03/29/09	03/31/09	CA1	08	3	
91-100		0	0			0	Full
91-100		0	0			0	Full
91-100		0	0			0	Comp
	NOTES:						

TRANSITIONAL HEALTH CENTER	MC REHAB DAYS	27	90.00%	**MONTH:**	March-05
FACILITY RUG SUMMARY	MC NURSING DAYS	3	10.00%	**Total Medicare Reimbursement:**	$9,497.13

	MEDICARE AVG LOS	75		**Average RUG Rate:**	$316.57
				Total # of Medicare Days:	30
				Total # of Other Days:	0

Developing a monthly summary can also be a useful tool. The summary shown below lists each assessment used for billing during the current month. Once the RUGs and number of days billed are entered, the worksheet calculates the total reimbursement based on facility-specific RUG rates. The worksheet also provides an average rate for the month, total number of Medicare days billed, and how many days (and percent of the total) were billed at a rehab-related RUG versus a nursing-related RUG. This information can be used for billing, budget planning, and utilization review.

Resident Name	**MR#**	**Payor**	**Rate**	**RUG**	**# MC days billed**	**# HMO days billed**	**Total Reim-bursement**	**Total MC LOS**
BROWN, C.	1000	MC	$335.35	RHB	15		$5,030.25	75
BROWN, C.	1000	MC	$318.36	RMB	12		$3,820.32	
BROWN, C.	1000	MC	$215.52	CA1	3		$646.56	

Michelle Sims *(MSimsRHIT@aol.com) is a long-term care consultant in Washington State.*

Article citation:
Sims, Michelle. "Medicare Billing in Long-term Care." *Journal of AHIMA* 76, no.6 (June 2005): 55,57.