LeadingAge Illinois

MOMENTUM

2023 ANNUAL MEETING & EXPO

Renaissance Schaumburg
Convention Center - Schaumburg, IL

Streamlining Your Admissions and Intake Process

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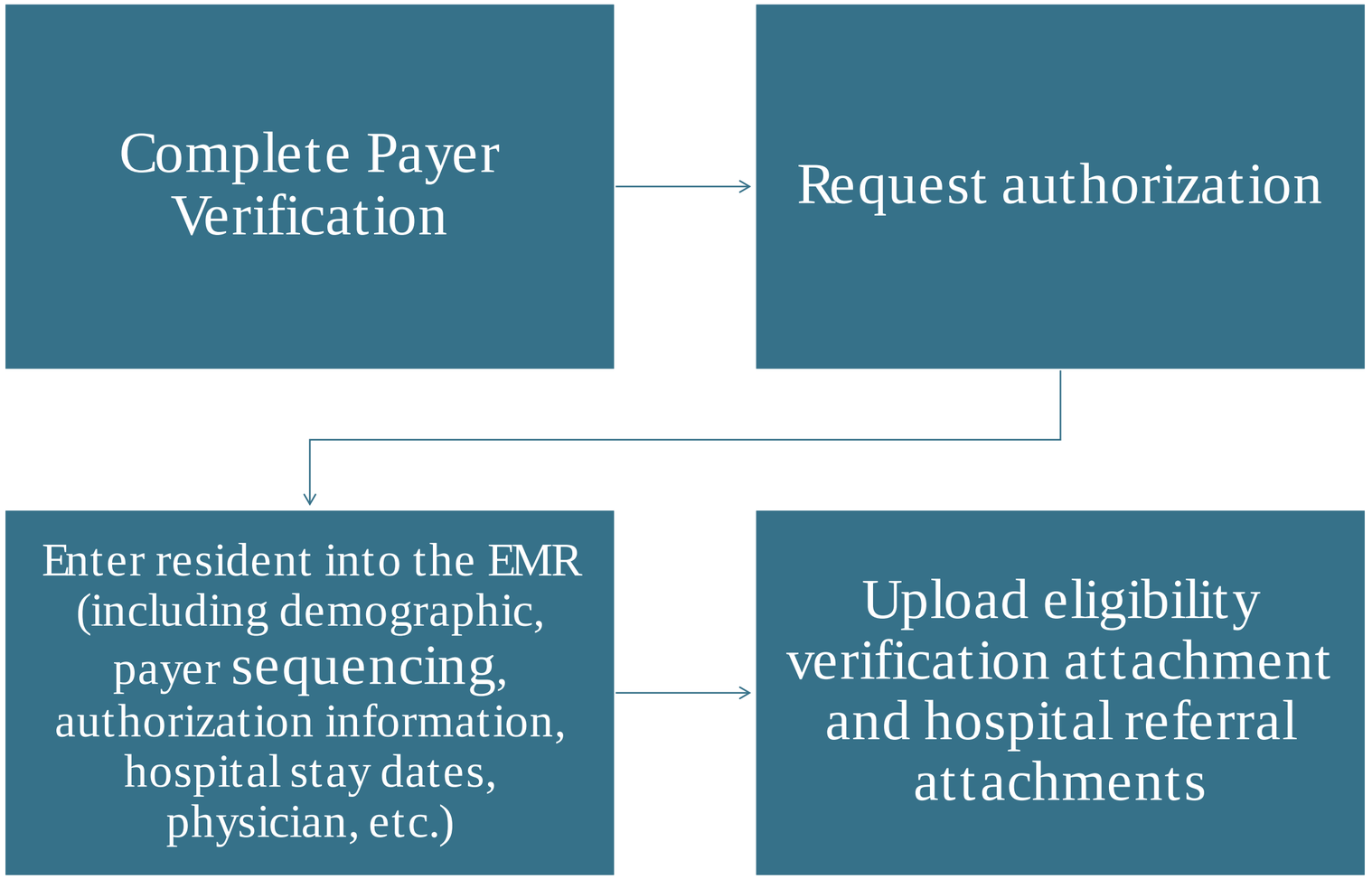
Centralized Intake Objective

- To create a centralized process for all inpatient and outpatient admissions
  - including Medicare, Managed Care, Medicaid, Private Pay, and Hospice admissions

Scope of Services

The centralized intake team provides eligibility verification, authorization confirmation and entry of prospective residents into the electronic medical record (EMR), in partnership with the community

Centralized Intake Responsibility



Turn Around Time

- Centralized Intake is available 7 days a week 7am – 7pm CST
- Our committed turn around response time
  - Inpatient: 30 minutes
  - Outpatient: 24 hours or the next business day by noon

Community Responsibility

- Review all referrals from a clinical and care perspective
- Once confirmed to accept, the community emails the referral to a shared Centralized Intake email box
- Centralized Intake opens the case in the EMR system as a preadmission and the campus formally admits the resident into the EMR with once the resident arrives with the specific date and time and bed assignment
- The campus is then responsible for completing the admission contract, obtaining copies of the insurance cards, and uploading a profile picture

What we ask to be sent to Centralized Intake

- Medicare Referrals
  - Referral attachment
  - Anticipated Admit Date
  - Physician
- Managed Care Referrals
  - Referral attachment
  - Anticipated Admit Date
  - Physician
  - Admitting Diagnosis/ICD 10 code

Obtaining Authorizations

- When requestion a prior authorization it is helpful to have the below information ready
  - Patient Name
  - Date of Birth
  - Anticipated Admit Date
  - Facility NPI
  - Ordering Physician and Facility Physician
  - Facility Physician NPI
  - Primary admitting diagnoses/ICD 10 code

Authorization Timing

- Once auth is obtained for admission the auth is typically only valid for so long
  - It's important to be careful if the admit gets pushed out to ensure authorization is still valid
  - Communicate the changed anticipated admit date and submit updated notes
- Some Managed Care companies require an admit notification within 24 hours of 'head in bed'
  - Designate and communicate who is responsible for this notification
  - Document the notification with the date, time, and reference #

What if I don't have a contract?

- Approach to negotiation letter of agreement
  - Identify leverage and prepare to explain why
    - Is the patient returning to 'home'
    - Are other facilities unable to accept/ no bed availability
    - Unique services the facility can provide
  - Explain projected treatment plan including therapy and nursing

Managed Care Cheat Sheets

- Instead of having to flip through every contract to find the specific information I created what we call 'Managed Care Cheat Sheets'

Insurance Name	Insurance Phone: 800-523-0023 Availity: Resource available to verify patient eligibility and benefits *Required to Notify* Humana as soon as possible within 24 hours of head in bed	Level 1 - $____ *Revenue Code: 191* Basic Services – Level 1 services include but are not limited to: • Room and Board - 24 hour nursing care • Prepared meals with/without special diet • Laboratory • Radiology • Medication administration • Medications unless otherwise excluded • IV administration and maintenance, including PICC lines, solution, equipment's, and supplies • Medical/disposable supplies • Discharge planning • Therapy; up to 1.5 hours of combined PT, OT, and ST per day at a minimum of six days per week. • Stage 2 wound care • Contact Isolation • Decomposition in functional status due to chronic COPD, CHF	Level 2 - $____ *Revenue Code: 192* Subacute Care – Level II services include but are not limited to: • Telemetry • Patient Controlled Analgesia Pump • Tracheostomy Care • Central Access Intravenous Lines • TPN administration • In House Dialysis provided by external vendor • Therapy: >1.5 hours of combined PT, OT, and ST per day at a minimum of six days per week. • Complex neurological patient requiring PT, OT, ST. G-Tube, J-tub • Wound Care for stage 3 • General post op surgical recovery i.e. patient – new ostomy care and education or joint replacement/repair due to fall • G-Tube, J- Tube • Includes all services in Level I
		Level 3 - $____ *Revenue Code: 193* Level III – services include but not limited to the following: • Ventilator Care, supplies, laboratory tests including pulse, pulmonary, and pulmonary rehab • Dialysis Services and Supplies, Hemodialysis and/or in OD when provided by facility • Wound care stage 4 • Respiratory Isolation – droplet precautions and negative pressure room • Plus Therapy: any combination of PT, OT, ST as clinically indicates • Includes all services in Levels I and II	Level 4 - $____ *Revenue Code: 194* Level IV – services include but not limited to the following: • Ventilator Care(weanable) and supplies, including all medical supplies, specialty laboratory tests, pulse oximetry, etc. • Extensive nursing and technical intervention defined as vital signs every two hours, neurological checks every two hours, and/or 1:1 extensive nursing care • Plus Therapy: any combination of PT, OT, ST as clinically indicates • Complex Bariatric Care >400 lbs. with multiple comorbidities • New organ transplant • Includes all services in Levels I, II, and III

Managed Care Cheat Sheets

Insurance Name	Eligibility, Benefits, and Prior Authorization P: 800-676-2583 Availity: Resource available to verify patient eligibility and benefits	Skilled Nursing Inpatient Care	____% of the Medicare Fee Schedule rates for reimbursement
		Outpatient Part B	____ % of the Medicare Fee Schedule rates for reimbursement
		Billing Deadlines	Provider shall use it's best efforts to submit claims within 30 days of the date of service, in no event may provider submit claims later than 120 days from date of service

Managed Care Cheat Sheets

Insurance Name	Online Services: www.availity.com Eligibility, Benefits, and Prior Authorization P: 800-676-2583	Level 1 – $___ *Revenue Code: 191*	Level 2 - $___ *Revenue Code: 192*
		Level 1 services include but are not limited to: - Nursing: Services up to 3 hours per day o Wound Care – Stage I o Routine Tracheostomy Care o Peripheral Lines for Hydration o Nebulizer Treatments - Rehab (PT/OT/ST) Less than 90 minutes, no less than 3 days/week - Oral, IV or Subcutaneous Drugs prescribed in conjunction with the diagnosis requiring the admission to a SNF up to $100/day when priced at Medicare's allowances	Level 2 services include but are not limited to: - Nursing: Services up to 5 hours per day o Wound Care – Stage II and III o Peripheral and Central Lines (complex and multiple) o Colostomy/ileostomy care o Respiratory Therapy (suctioning, oxygen, trache care, etc. - Rehab (PT/OT/ST) 90 minutes or more, no less than 3 days/week - Oral, IV or Subcutaneous Drugs prescribed in conjunction with the diagnosis requiring the admission to a SNF up to $110/day when priced at Medicare's allowances
		Level 3 - $___ *Revenue Code: 193*	Level 4 - $___ *Revenue Code: 194*
		Level 3 services include but are not limited to: - Nursing: Services up to 7 hours per day o Wound Care – Stages IIII and IV o Peritoneal Dialysis - Rehab (PT/OT/ST) 90 minutes or more, no less than 5 days/week - Oral, IV or Subcutaneous Drugs prescribed in conjunction with the diagnosis requiring the admission to a SNF up to $115/day when priced at Medicare's allowances	Level 5 services include but are not limited to: - Nursing: Services greater than 7 hours a da o Wound Care in Levels I-III o Ventilator Weaning o Complex Trache care o Ventilator Dependent
		Outpatient Part B	____% of the current Medicare Allowable rate upon
		Billing Deadlines	Within 150 days from date of Covered Services If Anthem is secondary, the 150 days will not begin until Provider receives notice of the primary payor's financial responsibility

Managing subsequent authorizations

- Who's responsible? Designate a set person/role
- Information needed for authorization extension requests
  - Initial auth dates approved
  - Level approved if any
  - Case Manager contact information
- Criteria that's typically requested
  - Therapy evals and most recent notes, orders, MD progress notes, nursing progress notes, vitals, wound or IV information, discharge planning and any barriers

Managing the Intake/Admissions Process

- Things to look for when running eligibility verifications
  - Medicare as Secondary Payer (MSP)
  - Medicare Advantage
  - Part A and Part B Eligibility
  - Home Health Episodes
  - Hospice Elections
  - QMB – indication the resident has Medicaid Coverage
  - QHS Dates (outside of the 1135 waiver)

Eligibility Report Examples

- Example of no Part A Entitlement, only Part B – in this case there would be no Medicare coverage for room & board, only therapy

Entitlement Information

Part A Entitlement Reason	**Part A Entitlement Date**	**Part A Termination Date**
Prior Part A Entitlement Date	**Prior Part A Termination Date**	
Part B Entitlement Reason	**Part B Entitlement Date**	**Part B Termination Date**
0-Beneficiary insured due to age OASI	08/01/2019	
Prior Part B Entitlement Date	**Prior Part B Termination Date**	

Medicare Advantage

- Medicare Advantage – look for a termination date, active coverage should match insurance verification

Effective Date	Termination Date	Administering Ins Co	Plan Name	Plan Website	Plan Phone Number	Contract Number	Plan Number	Plan Option Code Description
04/01/2019	01/31/2022	KAISER FOUNDATION HP OF CO	Senior Advantage Medicare Medicaid	kp.org/medicare	8004762167	H0630	014	C - Submit claims to the MA plan. Exception: If an MA plan enrolled beneficiary elects the Medicare hospice benefit, submit claims to NGS.
02/01/2022		HMO COLORADO, INC.	Anthem MediBlue Dual Advantage	https://shop.anthem.com/medicare	8882307338	H4346	014	C - Submit claims to the MA plan. Exception: If an MA plan enrolled beneficiary elects the

Medicare Secondary

- Medicare Secondary Payer – could be that the resident/spouse is still working, auto accident, liability, or workers comp
  - Look for a termination date and confirm with resident
  - Could be an old issue that was never updated with Medicare
  - If resident/spouse is retired obtain retirement date if possible

Medicare Secondary Examples

- If the resident or spouse is still working, they could have an alternative Insurance Plan that is the primary payer

Medicare Secondary Payer Information

Effective Date	Termination Date	Indicator	Type	Related Diagnosis Codes	Insurer Name	Address 1	Address 2	City	State	Zip
01/01/2017		Primary Payer	12 - Working aged		GROUP HEALTH INC	PO BOX 1289		MINNEAPOLIS	MN	5544

Crossover/ Supplemental

- Supplementals aren’t always listed on facesheets, its important when verifying Medicare benefits to also look for any supplemental plans the patient might have

	Medigap plans									
Benefits	**A**	**B**	**C**	**D**	**F***	**G***	**K**	**L**	**M**	**N**
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medicare Part B coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%***
Blood (first 3 pints)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A hospice care coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Skilled nursing facility care coinsurance			100%	100%	100%	100%	50%	75%	100%	100%
Part A deductible		100%	100%	100%	100%	100%	50%	75%	50%	100%

Home Health & Hospice

- Home Health information – important for Part B therapy, we won't get paid if there's an overlap. If status shows as Still patient, contact Home Health before providing therapy

- Hospice Information – if the status shows as Not Revoked, we won't get paid unless services are unrelated to the terminal condition. Check with hospice before starting therapy and adjust primary payer changes to prevent any overlap

Verification of Insurance Benefits

- Insurance verifications helps determine
  - Coverage Details
  - Subscriber Information
  - Health Benefit Plan Details
    - Deductible
    - Out of Pocket
    - Copay/Coinsurance
  - Covenant Living uses Waystar (previously known as Zirmed) as well as Availity

Verification of Insurance Benefits

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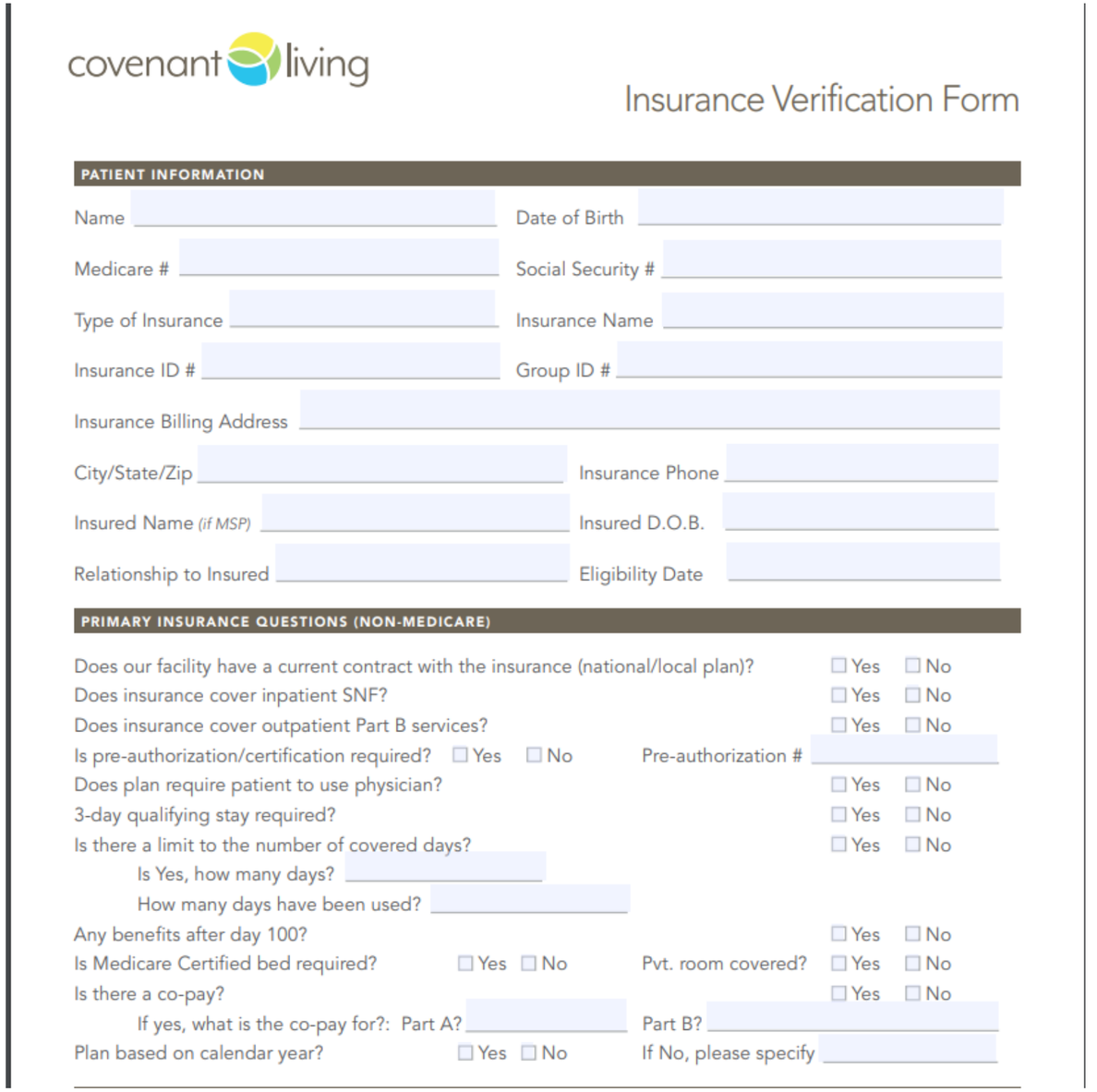

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Insurance Verification Form

PATIENT INFORMATION

Name _____ Date of Birth _____

Medicare # _____ Social Security # _____

Type of Insurance _____ Insurance Name _____

Insurance ID # _____ Group ID # _____

Insurance Billing Address _____

City/State/Zip _____ Insurance Phone _____

Insured Name *(if MSP)* _____ Insured D.O.B. _____

Relationship to Insured _____ Eligibility Date _____

PRIMARY INSURANCE QUESTIONS (NON-MEDICARE)

Does our facility have a current contract with the insurance (national/local plan)? ☐ Yes ☐ No

Does insurance cover inpatient SNF? ☐ Yes ☐ No

Does insurance cover outpatient Part B services? ☐ Yes ☐ No

Is pre-authorization/certification required? ☐ Yes ☐ No Pre-authorization # _____

Does plan require patient to use physician? ☐ Yes ☐ No

3-day qualifying stay required? ☐ Yes ☐ No

Is there a limit to the number of covered days? ☐ Yes ☐ No

Is Yes, how many days? _____

How many days have been used? _____

Any benefits after day 100? ☐ Yes ☐ No

Is Medicare Certified bed required? ☐ Yes ☐ No Pvt. room covered? ☐ Yes ☐ No

Is there a co-pay? ☐ Yes ☐ No

If yes, what is the co-pay for?: Part A? _____ Part B? _____

Plan based on calendar year? ☐ Yes ☐ No If No, please specify _____

Other Tools

- Self Audit Checklist
- Payer Sequence Guide
- Managed Care Spreadsheet

Self Audit Checklist

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Admission Record Self-Audit Checklist

DATA ENTERED INTO VISION OR PCC

Task	Completed	Initials
All Demographic Information	☐	
Billing Address	☐	
Payor and insurance information (including pre-auth/auth #)	☐	
Qualifying stay dates entered (if applicable)	☐	
Overrides and Part B utilization (if applicable)	☐	
Double check for correct spelling and numbers	☐	

UPLOADED INTO VISION OR PCC

Task	Completed	Initials
Admission agreement and ancillary paperwork	☐	
Acknowledgement of NPP or Resident Handbook	☐	
Co-insurance obligation form	☐	
Copies of insurance cards (front & back)	☐	
PASRR	☐	
Transfer records (H&P, DC Sumamry, Transfer Record, Consults, Labs/ X-Rays/Special Reports, MARS	☐	
Qualifying stay dates	☐	
SNF Nursing Admission approval	☐	
CWF (Check Connex or Zirmed)	☐	
Insurance verification form	☐	
Medi-Cal admission notification (For CA facilities only)	☐	
MSP (if necessary)	☐	

Payer Sequence Guide

- Create a document that goes over each payer sequence and what payers need to be listed first, second, third, etc
- This helps create a smooth transition with any turnover and any need for a backup up position in the event of an absence

Payer Sequence Guide Example

Payer Sequencing Guide -- SN IP / SNF Inpatient

		Payers															
		Medicare Part A DO NOT USE HSUB Days				**Medicaid/MediCAL/*MEDI** DO NOT USE HSUB Days			**HMO A**	**Private Pay** (6010, Life_X, or PR-non-contract)			**HSUB Days**		
		Day 1 – 20**	**Sequence for Days 21 – 100**			**WITH** Medicare Part B	**WITH** HMO-B	**WITHOUT** Medicare Part B or HMO-B	Be sure to select CORRECT PLAN & LEVEL	**WITH** Medicare Part B	**With** HMO-B	**WITHOUT** Medicare Part B or HMO-B	**WITH** Medicare Part B	**WITH** HMO-B	**WITHOUT** Medicare Part B or HMO-B
		Sequence by itself	**WITH** Co-insurnce	**WITHOUT** Co-Insurnce	Medicaid recipient **WITHOUT** co-insurnce										
SEQUENCE	**Primary**	Medicare Part A	Medicare Part A	Medicare Part A	Medicare Part A	Medicaid	Medicaid	Medicaid	HMO-A Plan/Level	Private Pay **Contract**	Private Pay **Contract**	Private Pay **Contract**	HSUB Days	HSUB Days	HSUB Days
	Second		Co-Insurnce Plan	Private Pay **Contract**	Medicaid	Private Pay **Contract**	Private Pay **Contract**	Private Pay **Contract**	Private Pay **Contract** OR Medicaid if recipient	Medicare Part B	HMO-B		Medicare Part B	HMO-B	Private Pay **Contract**
	Third		Private Pay **Contract**		Private Pay **Contract**	Medicare Part B	HMO-B		Private Pay Contract	Co-Ins OR Private Pay if no co-ins plan			Co-Ins OR Private Pay if no co-ins plan	Private Pay **Contract**	
	Fourth	NOTE: It is possible to have more than 20 primary or 80 secondary Medicare days. IF the resident goes on an LOA at ANYTIME during their Medicare stay the Payer Sequence Begin and End Dates must be changed to accommodate (and include) the LOA. Example: The resident (with no prior MedA days used) is admitted Jan. 1st & goes on LOA to the hospital on Jan. 17th – the date range for the 20 day sequence is: Begin: Jan. 1st and End: Jan. 22nd. Vision calculates the '#Days' as 22. The same is true for days 21 through 80.				Co-Insurance OR Medicaid if no co-ins.	Medicaid									
	Fifth					Medicaid (if 4th payer is co-ins)									

Managed Care Spreadsheet

Payor	BRAN *	CVOT *	MMCV *	SAM *	CVC *	CVI *	CVOC *	CVOF *
Insurance A	Par		Par					Par
Insurance B								Par
Insurance C								Par
Insurance D	Par - Part A Non Par - Part B	Par - Part A Non Par - Part B	Par - Part A Non Par - Part B					
Insurance E	Par		Par	Par	Par - Part A Non Par - Part B		Par - Part A Non Par - Part B	
Insurance F								
Insurance G								
Insurance H	Par	Par		Par		Par		

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