

Are skilled nursing providers leaving revenue on the table?



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The post-acute industry was less than six months into a revolutionary change in payment reform (PDPM) when COVID-19 demanded everyone's attention. But that doesn't mean that nursing providers have to leave money on the table. With the pandemic lingering on, it's easy to shift all focus to the daily necessary survival tasks. However, no matter the circumstances, taking inventory of your payer contracts and potentially re-imagining your charge master can, and should be a priority and is essential to effectively manage revenue cycle.

As an industry, even on good days margins run thin despite the intense care required to achieve positive outcomes and the heavy layer of regulation in the industry. In order to maintain quality care in the communities, it is critical to maintain a sound financial model that captures the hard work being done by your care team, despite having an underrepresented reimbursement system.

Understanding the nuances of each payer contract and effectively communicating "the rules" across the care team contributes toward ensuring SNFs are compensated appropriately for the care being delivered. Each facility should review and update their payer contract schedule to ensure changes are captured, particularly within the ever changing managed care sphere. It is especially critical for centralized multi-facility management teams to make an extra effort in educating community stakeholders as to the fine print within each payer contract.

Payer contract awareness is a fundamental element of effective revenue cycle management. Once you have this element locked down, try to take it a step further and evaluate the charge master. By and large, strategic management of the charge master has been historically left to acute care partners. However, as skilled payment systems continue to evolve and changes reverberate throughout the managed care stratosphere, money is being left on the table.

Through collaboration and analysis for multiple skilled providers, it is clear that opportunities are being missed. For example, based on contract terms and billed charges, payments are being made at the lesser of billed charges versus contracted rates. The difference becomes a contractual adjustment when cash is posted and C-Suite Executives often have no idea as to the dollar amount of legitimate-earned revenue being missed. As an industry, charge master maintenance has not necessarily kept pace in reflecting the increasing level of skilled care being provided in the industry.

Now may be the time to review your charge master and think beyond room & board. This article is not advocating for the charge of every nursing supply and grooming kit, however, there is a holistic need to review the charges being administered for care intensive services such as isolation, severe cognitive behaviors and various comorbidities and service lines being offered. Keys to effective oversight include routine case review of charge codes versus care provided, identification of rates below the Medicare allowable, and promoting effective communication and education for staff across disciplines on pricing and billing processes. Comprehensive maintenance is key to preventing leakage and driving healthy cash flow amidst these very difficult days.

Now is not the time to simply hope the revenue cycle team can succeed in this environment. It must be managed with intent, including the tracking of volumes, key performance indicators, benchmarks, and backlogs, but more importantly a well-managed plan to improve performance and deliver results. Revenue cycle leadership must be collaborative within your organization. Reviewing your payer contracts and re-examining your charge master shouldn't be a hassle. Your business has changed—so too should your expectations of revenue cycle management.

- Your hospital requires standards and protocols across its clinical service lines—are those same expectations communicated across its revenue cycle teams?
- Do departments understand what the denials are, why they occurred, and how they can be prevented?
- Does Health Information Management continuously complete its coding function within the allotted time to keep discharged not final billed (DNFB) at appropriate levels?
- Do business office staff identify underpayments, capture partial denials, and escalate patient complaints to ensure revenue and patient satisfaction scores are optimized?
- Does leadership's questions to revenue cycle stakeholders get answered with timely, confident responses?

Hospital senior leaders are dealing with myriad issues related to COVID-19 and its impact on patient volumes, patient and workforce safety, revised budgets and forecasts. Having confidence in the revenue cycle should not be compromised. Do you have operational concerns, gaps in revenue cycle leadership, transitions in high profile roles, or simply want to discuss getting your revenue cycle back on track? Our experienced healthcare team can provide short-term and long-term assistance to help ease your pain points.

ABN Update: Newly Revised From August 31, 2020

The Centers for Medicare and Medicaid Services (CMS) revised the Advanced Beneficiary Notice of Non-coverage Form (ABN), Form CMS-R-131. The notice is required to be issued to patients/residents where Medicare payment is expected to be denied. The revised ABN replaces the form that was last released in June 2017. The form and instructions for use can be accessed below. Update your forms now to ensure you don't get stuck with a technical payment denial due to administrative error.

[ABN Update](#)

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