MED-NET CONCEPTS, LLC
A Network of Healthcare Compliance & Consulting Companies

Volume 6, Issue 9 | September 2020

NEWS & VIEWS

A Complimentary Newsletter from Med-Net Concepts, LLC

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Ensuring the Integrity of a Facility's Financial Management Component Is Critical During the COVID-19 Crisis

By: Louise Lindsey

The Federal Managers' Financial Integrity Act of 1982 (FMFIA) requires that internal accounting and administrative controls of each executive agency be established in accordance with the standards prescribed by the Comptroller General. The Office of Management and Budget (OMB) under FMFIA has established guidelines for agencies to evaluate their systems of internal accounting and administrative control to determine whether those systems are in compliance with the standards established by the Comptroller General. Under those standards agencies must provide reasonable assurance to the President and Congress on an annual basis regarding the following three aspects:

1. Obligations and costs are in compliance with applicable law;
2. Funds, property, and other assets are safeguarded against waste, loss, unauthorized use, or misappropriation; and
3. Revenues and expenditures applicable to agency operations are properly recorded and accounted for to permit the preparation of accounts, reliable financial and statistical reports, and to maintain accountability over the assets.

The Centers for Medicare & Medicaid Services (CMS) is considered a contractor and is covered by the FMFIA; consequently, long-term care facilities are also required to cooperate with CMS in the development of procedures that ensure CMS compliance with FMFIA and other related standards required by the U. S. Comptroller General. The Medicare Financial Management Manual may be found at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019018.

COVID-19 Threatens the Financial Solvency of Many Long-Term Care Facilities

According to advocates for aging service providers, the struggles long-term care providers are having as they try to attain and pay costs associated with state and federally mandated COVID-19 guidelines are placing long-term care facilities at risk for financial insolvency. Mandates that must be implemented include co-horting of residents with the Coronavirus or those suspected of having it, consistent assignments for staff caring for those residents so there is no crossover to non-infected residents, frequent COVID-19 testing of staff and residents, provision of adequate supplies of personal protective equipment (PPE), and meeting overall staffing requirements despite absence of infected workers.

Long-term care facilities in North Dakota provide an example of the effect that rising costs

due to the pandemic are having. The president and CEO of the North Dakota Long Term Care Association described her state's situation to the Forum News Service. She indicated that in her state 5,300 people were in skilled nursing homes, 2,600 in assisted living settings, and 1,800 in basic care facilities.

The loss of revenue due to increases in costs poses a very real problem. For example, the daily average cost for a skilled nursing home stay prior to the pandemic was $280 per person. The CEO noted that prior to the pandemic, the wearing of masks, face shields, gowns, and gloves was atypical. While there were some instances involving a resident having an infection that required extreme isolation precautions, the expected rate increase would only average about $150 per day. Due to the COVID-19 crisis, the extremely high costs facilities have been paying for PPE orders is "mind boggling," e.g., one facility spent over $400,000 on an order of gowns. Consequently, the huge amounts facilities are forced to pay for PPE makes it difficult to quantify the additional rate increase, but it far exceeds the $430 rate ($280 + $150) per person normally expected with an infection outbreak.

Another challenge noted is that the cost of labor that has risen at least 25%.

The president and CEO of another organization with multiple sites reported that staffing costs for his company through June 2020 had increased an estimated $799,000, and projection through September indicates another $300,000 will be needed.

In addition to the increases in costs for PPE and testing, these long-term care facilities are experiencing a census decrease causing millions of dollars in losses. It was noted that due to the pandemic, people are less excited about communal living.

These financial crises serve as a red flag indicating a need for facilities to evaluate the Financial Management Components of their Compliance and Ethics Program regarding Medicare billing, risk assessments, and budgeting and resource management to determine how to be better prepared on an ongoing basis and for future healthcare crises, and how to prevent the trauma and upheaval to residents and staff that accompanies the closing of a facility.

Managing Medicare Billing is a Good First Step to Ensuring the Integrity of a Facility's Financial Management Component

Receiving reimbursement for provision of services from Medicare is a major source of revenue for a facility. Consequently, ensuring that a long-term care provider is complying with all billing policies, applicable laws, rules, and regulations is an important aspect in a healthcare organization's financial management.

In general, the company should be committed to prompt, complete, and accurate billing of all services provided to residents in preparation for reimbursement from residents, government agencies, Medicare, or other third-party payors. Billing should apply only to the services provided in accordance with government or third-party payors and be consistent with industry practice.

The following billing practices should be observed:

- Nothing false or misleading should be included on any bills or claim forms submitted by the company or any employee. Submission of claims with false or misleading information may result in an employee being disciplined or possibly terminated.
- False claims and billing fraud may involve a variety of different forms, e.g., false statements that support a claim for payment, misrepresentation or concealment of material facts, or theft of benefits or payments. The company and employees should specifically avoid the following billing practices:

○ Making claims for items or services not rendered or provided as claimed, e.g., billing for hours of therapy when only minutes were provided.
○ Submitting claims to Medicare Part A for residents who are ineligible for Part A coverage.
○ Submitting claims for services or supplies that are not medically necessary, or that were not ordered by the resident's physician or other authorized caregiver.
○ Submitting claims for items or services not provided as claimed, e.g., expensive prosthetic devices when only non-covered adult diapers were provided.

- Submitting claims for items or services that are included in the provider's per diem rate, or that may be billed as a unit and not unbundled.
- Double billing.
- Providing inaccurate or misleading information to be used in determining the Patient Driven Payment Model (PDPM) or other resident, payment, or acuity classification scale score or ranking assigned to the resident, including misrepresenting a resident's medical condition on the Minimum Data Set (MDS).
- Paying or receiving any type of financial benefit in exchange for Medicare or Medicaid referrals.
- Billing residents for services or supplies that are included in the per-diem payment from Medicare, Medicaid, a managed care plan, or other payor.

- Reporting of false billing practices. Employees who have reason to believe that false billing practices are occurring should immediately report it to his or her immediate supervisor, through the facility's Compliance Hotline, or to the Compliance Officer or another officer who has been designated to receive such a report, either verbally or in writing.

Another aspect in the management of a company's Medicare billing that should be reviewed involves specific billing procedures. It is a best practice to use a Medicare Triple Check Process prior to submitting claims. Additionally, these other billing sections should be evaluated periodically: Medicare credit balance reporting requirements and certification; monthly billing statements; demand billing; refund of overpayments; and accounts receivable, collections, and bad debt.

New NAB/NCERS Approved Privacy Series Course Now Available

The Privacy Management for Post -Acute Healthcare Professional Series is designed to provide a policy focused framework for leaders in post-acute healthcare settings.

This series will help leaders to plan, implement and evaluate privacy practices consistent with laws, regulations and best practices. It is intended for administrators, directors, officers, clinical staff, employees, contractors, consultants and others working in the post-acute care setting.

The course consists of 4 modules. Each module includes a post-test. The program is approved for 2.25 CEs from NAB/NCERS. A combined minimum passing percent of 70% for all post-tests is required to earn the 2.25 CEs.

For full details please click on this link:
https://mednetcompliance.com/store/product/nab-ncers-approved-privacy-series-course/

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