It is Never Too Early to Plan Year-End Activities!

By Jeanne Lugli, FNHIA

You don't have to have a Type-A personality to realize that it is NEVER too early to plan for year-end-related tasks in the revenue management department. This fall, I offer the following recommendations to help infusion pharmacy organizations close out 2023 and start the new year with as little impact as possible on cash flow.

Most importantly, it's helpful to create a checklist of what needs to be done and by when. This article offers suggestions and samples that can be used to develop a customized checklist. Naturally, differences in geography, organizational structure, and payors will all come into play.

MEDICARE

Medicare is typically the easiest payor to bill and collect from (once the patient qualifies for coverage) as the program has very specific guidelines for coverage and billing, set fee schedules, and so on. Year-end activities related to Medicare should focus on eligibility/plan changes and claims dates.

Most Medicare patients do not lose their eligibility. *(Note: It is possible to lose Medicare coverage if you recover from what qualified you for Medicare. For example, a patient with end-stage renal disease can lose coverage a year after they end dialysis or 3 years after a kidney transplant.)* However, the type of coverage a beneficiary chooses can change. For example, more and more Medicare beneficiaries are opting for a Medicare Advantage (MA) plan, also known as Medicare Part C. In fact, in 2023 more than one-half of Medicare beneficiaries enrolled in an MA plan.[1]

Beneficiaries can only switch between a traditional Medicare and a MA plan—or between different MA plans—ONE time per year. The Medicare annual open enrollment period for plan changes is October 15 - December 7. Changes made during the open enrollment period go into effect January 1 the following year.

It's important to note that if a patient switches plans, the new information is not available on the Medicare portal until January 1—sometimes even later. A year-end best practice is to poll patients during November and December to determine if they have made or are considering a plan change. Flag the affirmative responses for follow-up and electronic verification of eligibility in January.

Another year-end best practice is to prepare to bill claims with extended service dates for the jump in calendar years. When creating claims for Medicare, the FROM date of service must be equal to the ship date or delivery date. Although they sometimes are the same, billing by service date could result in recoupment of funds if the proof of delivery does not match your FROM date. One of the few exceptions to this rule is end-of-year billing, as Medicare expects suppliers will not cross over calendar years when billing. For these claims, split each line into 2 separate lines by calendar year. For example:

- The pharmacy provides 8 days of parenteral nutrition (PN) that is delivered on 12/26/23.
    - *Note: All lines that have a TO service date in the new year must be split. However, some items such as a pump or IV pole have the same FROM/TO date and do not need to be split.*

- The first claim would be 12/26/2023 – 12/31/2023 (a total of 6 days of service). Assuming the patient is receiving PN daily, the quantity would be 6 for the PN and each supply kit. The quantity for the lipids would depend on the prescription.
- The second claim would be 1/1/2024 – 1/2/2024. If this second claim is not billed, then the pharmacy will not be reimbursed for 2 days of service for all items (PN, lipids, and supply kits). This could amount to a loss of several hundred dollars.

Although the process of split billing over years seems rather straightforward, there are always exceptions to the rule when it comes to the home infusion billing process. The code A4221 is a good example. The billing quantity for this code is 1 per week and most therapies are billed a week at a time. Because Medicare won't allow billing supplies with fractional quantities, if the service date crosses over the calendar year, you must modify the end date to be the last day of the year.

Even if the start date of service (ship/delivery date) is on 12/31/23, it's not recommended to move the start date forward to 1/1/24 as your FROM date (to cover most days). Rather, bill 12/31/23 – 12/31/23. This recommendation is based on the fact that Medicare requires suppliers to bill by SHIP date, and you can't substantiate changing the FROM date forward with nothing billed prior.

COMMERCIAL AND OTHER PAYOR TYPES

Year-end activities for commercial payor accounts should be focused on claims dates, eligibility, and patient deductibles. Most commercial payors follow the same rules outlined above as it relates to service dates crossing over calendar years. *(Note: There are some payors that do not allow claims to cross over months or even quarters. So, be familiar with the requirements with each of the organization's contracted payors as the amount of preparation required depends on this knowledge.)*

Most commercial payors are billed with the drug plus a per diem. Claims are split (either through the billing system or manually) to bill the drug and per diem dates through year end on one claim and the balance on a separate claim for the new year. Technically, there's no need to create multiple claims. However, claims with future FROM dates cannot be submitted until the new year. Otherwise, the claim will deny for a "future start date of service."

It is worthwhile to take the time to determine the year-end billing requirements for EACH unique payor—from Medicaid to facility billing to local HMOs—prior to the end of the year to ensure your organization is prepared to comply with any other special billing requirements. This best practice will reduce unnecessary denials and maximize cash flow.

While Medicare only allows beneficiaries to change plans once a year, the same cannot be said for all other payors. If possible, it is always best to run eligibility at least 1 time per month—especially on patients who are receiving high-cost drugs. While the renewal date for commercial payors does not necessarily start on January 1, it is a common renewal time. In addition, most deductibles and co-insurance amounts reset on January 1.

Thus, it is best practice to verify eligibility on ALL patients prior to the start of a new calendar year or before the first delivery within the new calendar year. This will ensure that billers have the correct insurance documented for each patient. This also allows patient service representatives to know the patient's financial obligation before making a delivery (co-pay, deductible, etc.) and make payment arrangements in advance. If there is a change of insurance, having this information in advance can help ensure the reimbursement team has completed the necessary tasks required with the new plan, such as obtaining an authorization.

Whether your patient has a new insurance plan or not, most insurance deductibles and co-payments reset on January 1. Although the provider organization has no control over the amount of each deductible, there are steps you can take to prepare for this annual event and reduce the risk of bad debt. First, evaluate patients facing large deductible payments for possible assistance. Patients on high-cost drugs may qualify for co-pay assistance—while some programs are based on income, many are not. Patients who don't qualify for state Medicaid but have a catastrophic illness may be eligible for co-pay guarantee programs that can offset patient expenses.

Be sure to ask about health saving accounts (HSAs) for patients with high-deductible health plans through an employer. Surprisingly, many are unaware that they have funds in an HSA account established by their employer, especially if they are not personally contributing to the HSA.

Consider sending a letter to patients who don't have full coverage asking them to contact the financial office to make payment arrangements for the upcoming year. And consider offering Care Credit to patients versus carrying the payment plan internally over several months.

PATIENT CENSUS

It's great to start the new year with a "clean slate." Take the time to review any patients on census who have not been closed out/made inactive and have not had a delivery in 45-60 days. Please note that it may be preferable to exclude patients on intermittent specialty drugs, such as zoledronic acid (Reclast®, Novartis) which is given once a year, from an inactivity report.

ACCOUNTS RECEIVABLE

Lastly, don't forget about the AR already on the books. There are reports, reminders, system triggers, etc. to ensure that each claim is "touched" by the right person. However, even the best system is only as good as the sum of the users working in it! Taking the time to review all remaining claims to ensure they are properly worked can provide a cash boost in January and allow you to head into the new year with momentum. Act on any claims that haven't been properly worked to continue the momentum.

So, about that checklist. Have I given you some ideas on how you should prepare for the upcoming year end? Has reading this article triggered you to think of additional tasks to help you prepare? Feel free to share your ideas on the NHIA Community. The home and alternate site infusion therapy community is quite small compared to other areas of health care. Additionally, home infusion reimbursement is by far the most complex in health care. The more we can help each other to be compliant and successful, the better it is for the entire industry. Good luck and happy (early) new year!

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References

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