



THE SKILLED NURSING FACILITY

REVENUE CYCLE PLAYBOOK

*Practical Strategies for Billing, Reimbursement,
Denials & Collections*

2026 EDITION

INCLUDES
2026
REGULATORY
UPDATES +
PRACTICAL
WORKLISTS



Mary-Jo Wilson

Director, Long-Term Care Services

With contributions from

Hariharasudan Neelarathinam & Brian Reese

COMPLIMENTARY LEADINGAGE 2026 EDITION



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Published by 24/7 Medical Billing Services LLC

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Publication Information

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Educational-use notice

This handbook contains general educational and operational information. It is not legal, clinical, coding, payer-contract, tax, or reimbursement advice. Requirements and deadlines differ across payers, states, contracts, and time periods. Readers should verify applicable laws and official guidance before applying any procedure to actual residents, claims, or financial accounts.

Mary-Jo Wilson authored the foundational operational content of this playbook, drawing on nearly 30 years of experience in the skilled nursing community. Additional editorial material, practical worksheets, and official source references were prepared for the 2026 conference edition. Illustrative examples and amounts are fictional and do not represent actual client results.

WRITTEN FOR THE WHOLE TEAM



Who this playbook is for



Administrators

Oversee one facility or many



Business office managers

Own billing, posting and collections



Nurses & DONs

Shape level of care and documentation



MDS coordinators

Drive PDPM accuracy



Admissions teams

Verify payers before the stay starts



Therapy leaders

Support medical necessity



Finance leaders

Watch cash, A/R and month-end close



Compliance reviewers

Protect resident rights and funds



Use this playbook alongside current CMS, Medicaid, state and payer instructions. Official guidance always controls actual billing and resident-account decisions.

A Message From Our Founder



Hariharasudan Neelarathinam

Founder & CEO

24/7 Medical Billing Services LLC

20+ YEARS IN HEALTHCARE REVENUE CYCLE MANAGEMENT

For more than 20 years, I have worked in healthcare revenue cycle management, helping healthcare organizations strengthen collections, reduce denials, improve operational performance, and navigate an increasingly complex reimbursement environment.

I founded 24/7 Medical Billing Services in 2015 with a simple belief: strong revenue cycle performance comes from combining knowledgeable people, disciplined processes, and the right technology.

Over the years, I have had the opportunity to lead more than 100 client transitions across 12+ healthcare specialties, working across Medicare, Medicare Advantage, Medicaid, VA/TRICARE, and commercial payers.

Skilled nursing facilities face a particularly complex revenue cycle. Admissions, authorizations, clinical documentation, PDPM, payer requirements, billing, denials, collections, and accounts receivable are deeply interconnected. A problem early in that journey can become a financial challenge months later.

We created The Skilled Nursing Facility Revenue Cycle Playbook to share practical knowledge from people who understand these challenges firsthand. Our goal is not simply to describe revenue cycle processes, but to provide ideas and practical guidance that SNF teams can discuss, evaluate, and put into practice.

I hope this playbook becomes a useful resource for your organization and, most importantly, helps your team ask better questions about where revenue is getting stuck and how those challenges can be addressed.

Hariharasudan Neelarathinam

Founder & CEO

24/7 Medical Billing Services LLC

20+

years in healthcare
revenue cycle
management

2015

24/7 Medical Billing
Services founded

100+

client transitions led

12+

healthcare specialties
supported

A Note From the Author



Mary-Jo Wilson

Director, Long-Term Care Services
24/7 Medical Billing Services LLC

NEARLY 30 YEARS IN THE SNF COMMUNITY

I have been part of the long-term skilled nursing facility community for almost 30 years. My journey began as a temporary front desk employee for a small skilled nursing facility management company in Easley, South Carolina.

With a background in accounting and experience using Excel, Word, and PowerPoint, I was hired full-time as a payroll and accounts payable clerk. About a year later, as the company expanded, I moved into an accounts receivable billing role. That is where my passion for skilled nursing facility billing began, and I have never looked back.

My career has taken me to many organizations and different roles. Along the way, I have learned from generous teachers, colleagues, and mentors. I also learned that our industry requires us to adapt, continue learning, and grow as the needs of residents and facilities change. One lesson stands out: working in a skilled nursing facility or a management organization is never about just one person. It is always about the team. Success requires coordination, understanding, and clear communication.

Sharing what I have learned with people who are beginning their own journey, as well as with those who have dedicated many years to this work, has been one of my greatest rewards. If a question in this playbook helps you improve a process, strengthen a skill, or discover something you did not know to ask, then I will consider it worthwhile.

Above all, I have learned that this work is not ultimately about us. It is about the people and communities we are privileged to serve, often during some of the most challenging moments of their lives.

My hope is that this playbook helps SNF teams strengthen communication across departments, identify revenue-cycle issues earlier, and create processes that support both financial performance and the residents they serve.

Mary-Jo Wilson

Director, Long-Term Care Services
24/7 Medical Billing Services LLC

A Message From Brian Reese



Brian Reese

Director of Sales
24/7 Medical Billing Services LLC

30+ YEARS IN HEALTHCARE & REVENUE CYCLE MANAGEMENT

Revenue Cycle Performance Starts With the Right Process

Throughout more than 30 years in healthcare and revenue cycle management, I have seen one principle remain consistent: strong financial performance rarely comes from fixing one isolated part of the revenue cycle.

It comes from understanding how people, processes, technology, payer requirements, and financial workflows work together.

Over the course of my career, I have had the opportunity to work with hundreds of healthcare businesses and practices, helping strengthen workflows and identify opportunities to improve revenue-cycle performance. My experience has included financial leadership, strategic planning, workflow design, business development, profit growth, and team building.

For skilled nursing facilities, this interconnected approach is particularly important. An issue with payer identification, authorization, documentation, billing, or follow-up can eventually appear as a denial or an aging accounts-receivable problem.

That is why this playbook looks beyond individual billing tasks and considers the broader revenue-cycle journey.

As you read it, I encourage you to ask one simple question:

“Where in our revenue cycle are we losing time, information, or revenue?”

Often, answering that question is the beginning of meaningful improvement.

Brian Reese

Director of Sales
24/7 Medical Billing Services LLC

Contents

BEFORE YOU BEGIN

A Message From Our Founder	4
A Note From the Author	5
A Message From Brian Reese	6
Introduction	8

THE 15 CHAPTERS

Chapter 1. Referral Team – Who Should Be Involved	10
Chapter 2. Billing Software Systems	12
Chapter 3. Admissions	14
Chapter 4. Payer Identification	15
Chapter 5. Authorizations	17
Chapter 6. Credentialing	19
Chapter 7. Month End Close/Triple Check	20
Chapter 8. PDPM	23
Chapter 9. Diagnosis Codes	26
Chapter 10. Private Pay	28
Chapter 11. Return to Provider vs Denials	31
Chapter 12. Additional Documentation Requests (ADR) & Appeals	33
Chapter 13. Payments, Adjustments, Write-Offs	36
Chapter 14. Accounts Receivable	39
Chapter 15. Resident Trust Fund Management	44

CLOSING, TOOLS & RESOURCES

Closing Summary	49
Practical Working Templates	51
Official Resources and References	52
5 Questions to Ask Your Revenue Cycle Team	54
About 24/7 Medical Billing Services	55
Complimentary SNF Revenue Cycle Assessment	56

How to use this playbook

1 Start where it hurts

Read in order, or go straight to the chapter behind the issue keeping your team busy today.

2 Turn questions into owners

Each chapter asks questions. Give every weak handoff an owner, a record and a review date.

3 Check the 2026 updates

Regulatory clarification boxes and [R#] references point to the official source to verify.

SUGGESTED STARTING POINTS

Administrators

Ch. 1, 3, 7, 14

Business office

Ch. 4, 10–13

MDS & nursing

Ch. 1, 5, 8, 9

Finance & compliance

Ch. 7, 14, 15

Introduction

Why this book matters

Every skilled nursing facility has days when the clinical work is moving forward, the building is busy, and everyone is doing their best, yet the financial report tells an entirely different story. Claims are waiting for a missing document. A resident's coverage has changed without reaching the business office. A vendor invoice is late. An authorization has expired. None of those problems begins with the person who presses the button to submit a claim, but all of them eventually reach that person's desk.

This book is written for the people who recognize those days: administrators, business office managers, nurses, MDS coordinators, admissions teams, therapy leaders, and the people who oversee the financial health of one facility or many. It reflects the practical view that collections improve when departments communicate early, document well, and understand where their responsibilities meet.

The chapters follow the work in much the same order that a facility experiences it. We begin with referral decisions, billing systems, admissions, and insurance verification. We move into authorizations, credentialing, month-end review, PDPM, and diagnosis coding. We then address resident balances, returned and denied claims, appeals, payment posting, and accounts receivable. We finish with a responsibility that is distinct from facility revenue but every bit as important: safeguarding resident trust funds.

Readers will notice that many sections ask questions rather than offering one-size-fits-all answers. That is intentional. A process that works for a 60-bed standalone building may not fit a multi-facility organization. Medicare fee-for-service requirements differ from Medicare Advantage plan terms, while Medicaid coverage, rate setting, and resident liability can differ by state. The questions invite readers to compare the practices described with their own agreements, policies, and current official guidance.

A practical way to use the book

Read the chapters from the beginning, or start with the issue keeping your team busy today. When a chapter identifies a weak handoff, turn the discussion into an assigned action: who verifies it, where is the result documented, who receives the exception, and when is it reviewed again? A checklist without an owner is only a list. An accurate, consistently followed policy is an operating control.

The two final chapters, developed for this edition to complete the updated table of contents, include sample worklists, reconciliations, and illustrative scenarios. The examples use invented amounts and situations for teaching purposes; they are not reported outcomes for clients of 24/7 Medical Billing Services LLC.

This publication is an educational resource, not legal, clinical, tax, or reimbursement advice. Requirements can change, and official Medicare, Medicaid, state, and payer instructions should

control any actual billing or resident-account decision. The official resources at the back of the book will help readers locate the guidance applicable to their facility.

At its heart, sound SNF billing is an exercise in stewardship: of accurate records, of staff time, of a facility's financial stability, and ultimately of the resources entrusted to the people caring for residents.

HOW THIS PLAYBOOK IS ORGANIZED



The SNF revenue journey, chapter by chapter

1

Before & at admission

Set the stay up correctly

1

Referral team

2

Billing systems

3

Admissions

4

Payer identification

5

Authorizations

6

Credentialing

2

During the stay

Capture care accurately

7

Month-end & triple check

8

PDPM

9

Diagnosis codes

3

After the claim

Turn claims into cash

10

Private pay

11

RTPs vs denials

12

ADRs & appeals

13

Payment posting

14

Accounts receivable

4

Stewardship

Protect what residents entrust

15

Resident trust funds

Read from the beginning, or start with the issue keeping your team busy today. Turn each weak handoff into an owner, a record and a review date.

Chapter 1 – Referral Team – Who Should Be Involved

Skilled nursing facility (SNF) billing does not rely only on the business office. Revenue and collections should be based on a whole-team approach.

CH
1

The Departments and Department Heads that have a direct impact on Revenue and Collections are:

- Admissions
- Nursing – Director of Nursing
- MDS – MDS Coordinator
- Administrator/Executive Director
- Physician – Medical Director/Referring
- Therapy – Therapy Director
- Medical Records

To a smaller extent the following individuals that participate in the MDS Assessment; Social Services, Dietary and Activities. The role each of these individuals plays and the departments under them are critical in terms of determining the referrals and patients/residents who are admitted to the facility.

Admissions/Marketing is often the primary contact with any affiliated Hospitals, Physician Offices, and Other Nursing Homes from which the SNF receives referrals. They need to be knowledgeable regarding the current bed status, bed certifications, case mix (Medicare, Medicaid, Managed Care, Private Pay, or Private Insurance). Knowing which payers the facility is certified, enrolled and contracted with as a Provider is crucial to admitting the correct referral.

DON is the clinical specialist who understands and is cognizant related to the Level of Care and Case Mix that his/her nursing staff are able to treat and care for. Can the staff sustain High Level Care needs, address all Comorbidities a resident might have and any additional special needs (Wound Care, Trachs, Vents, Enteral Tube Feeding or catheters). Also staffing levels and current case mix already within the building need to be considered.

MDS Coordinator is the specialist who will be assessing residents related to the MDS Assessment ensuring that accurate nursing, therapy, medication, treatments, comorbidities, diagnosis, physician orders etc.... are captured and recorded accurately in the assessment to generate the highest PDPM Assessment score. Reviewing the hospital documentation received as part of the referral and discharge planning from the hospital will assist in identifying critical look back period data and treatments received. If the referral is for a Medicare, Medicaid or Managed Care Plan they need to understand their current census and caseload to ensure timely and accurate entry and submission of the MDS Assessments. Does the State currently require an MDS Assessment to be performed for Medicaid? Does the Managed Care Plans for which the facility is a provider and has a contract reimburse based on PDPM or Levels, is the correct options being addressed as part of the MDS Assessment being completed and does it require submission or just completion?

Administrator has the final say on who is accepted for admission and needs the department heads to provide them with the correct and accurate information to ensure successful treatment and

continued care for the admissions accepted. If there are any issues that might contribute to an unsuccessful admission these need to be communicated clearly, logically and sometimes in contradiction to what another department head may say. If not fully informed, a decision that could have clearly unfavorable outcomes could be made.

Physician/Medical Director should always review the referral to validate and sign off on the Certification of Medical Necessity, Medicine changes/updates, Therapy orders, Specialty Treatment orders, Diagnosis and complete an initial physical within 24 hours of admission. If changes in condition would necessitate an increase in care needs or a reduction in care needs this needs to be communicated timely to the staff in the facility so that any necessary IPA or OBRA assessments can be completed timely and accurately.

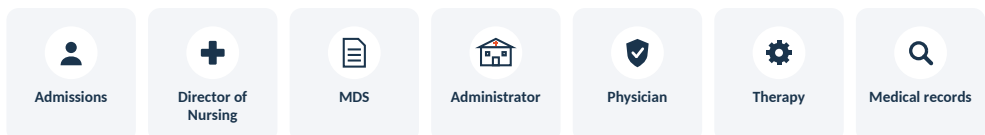
Therapy Director involvement is in relation to any previous therapy received during the hospital stay. A review of this information will allow the therapy team a starting point for determining additional therapy needs to ensure that the resident has an opportunity to return to their baseline activities or even possibly improve on their baseline to provide a better quality of life. The director will also need to verify that the proper evaluations and therapy notes are completed and signed by the physician and therapist timely and accurately to support any Medical Necessity reviews or denials that may result.

Business Office Staff are the gatekeepers, they are the ones who are responsible for ensuring all the other departments have completed their roles, and the data has been entered so that when claims are generated the data is reflected and supported on the claim. They should also best understand the payers that a facility can or cannot accept. Depending on the payer or payers involved should be completing a payer verification to validate the correct Primary, Secondary and possibly Tertiary payer a referral might have. They will also be responsible for verifying if any initial admitting authorization is required and has been obtained. They are responsible for knowing the Current Census and bed availability and verifying that accurate resident critical information is entered into the system timely.

2026 regulatory clarification | Physician-visit timing

The source text recommends an initial physical examination within 24 hours. This should be treated as a facility workflow preference or patient-specific clinical need, not as the general federal SNF initial comprehensive visit deadline. Applicable physician-visit timing must be verified under 42 CFR § 483.30 and current CMS interpretive guidance.

THE REFERRAL TEAM AT A GLANCE



Business office: the gatekeeper that confirms every role is complete before a claim is built

Chapter 2 – Billing Software Systems

There are several good to excellent billing software systems available for SNFs in the industry today (PCC, Matrix Care, My Unity, Netsmart, AHT), which one is your facility using?

Is your current software system a comprehensive Clinical and Billing Software system? Does it incorporate a built-in billing submission interface system, or do you also have a contract with a clearinghouse such as e-Solutions, Waystar, or Inovalon?

CH
2

Does it allow for import of ancillary charges from various outside contracted vendors such as:

- Pharmacy
- Therapy
- X-Ray
- Medical Supplies
- Durable Medical Supplies (DME)
- Oxygen

All of these are considered billable and should be being captured on your Medicare, Managed Care, Insurance A & B Claims and even some, depending on your state could be covered under Medicaid.

For part B claims typically these vendors may or may not submit the claims themselves. This of course depends on the contracts you have established with the Vendors who provide these services or supplies to the SNF. Knowing what is billable by the SNF as Part B claim, what might be considered Consolidated Billing, or what requires a DME License is something every SNF should be aware of.

Has your staff been properly and completely trained in the use of all aspects of the Software System your facility uses? Are you utilizing the software to its full potential? Do you have policies and procedures written down or training software available in the event of turnover or new hires?

Do you have an assigned staff member as a Super User or Administrative User who knows how to add or update Payers, Charge Codes, Rate Templates each time they are updated? Do they know where to find the updates to Medicare, Medicaid and Managed Care Payer rates?

If you are using a clearinghouse to submit your claims, does it provide the ability to review claim denials, make corrections, submit corrected claims, create and submit secondary claims, submit appeal documentation?

Is the clearinghouse able to provide and submit claims to the various Managed Care and Insurance plans that you are enrolled in as a provider? Does it provide you with the ability to enroll for access to various plans?

If your billing software system and clearinghouse do not provide these services do the facility staff, Super User, or Administrator know how to access and enroll in the various online insurance/payer portals? Do they know how to provide or add additional users as necessary?

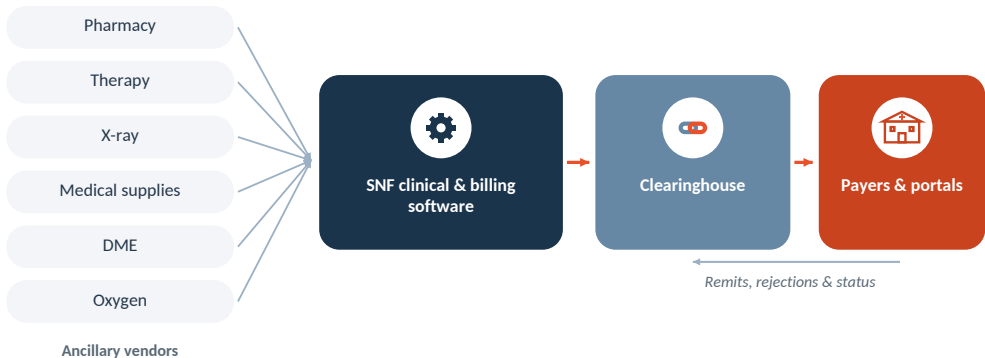
Is management able to pull together the necessary reports and data it needs for Month End Close, Quarterly Reporting, Financial Yearly Audits, Annual Survey, Cost Reports, and Annual Tax Reporting easily and accurately?

Most Billing Software Systems will provide basic initial setup and training when the SNF purchases the system. Do you know if you provided them with everything you needed at that time or are you now finding out that you missed some vital aspects? Were you provided the option to add additional modules, set up and training for future needs or is this an add-on cost? If the process for reporting and resolving software issues is easy and do you get the results you are expecting? Is the support access staff available and helpful?

2026 regulatory clarification | Consolidated billing

Whether a vendor or the SNF bills for an ancillary item depends on the resident's coverage, the service, and the current consolidated-billing exclusions. The lists in the chapter are a practical discussion, not an automatic authorization to bill every listed item separately. See [R4].

TECHNOLOGY AT A GLANCE How charges and claims move through your systems



QUICK READINESS CHECK

- ✓ A trained super user updates payers, charge codes and rates
- ✓ Written procedures survive turnover and new hires
- ✓ Staff can work denials and corrected claims electronically
- ✓ Month-end, cost report and audit reports pull easily

Chapter 3 – Admissions

Everything starts with Admissions!

Is your Admissions Team Properly Trained? Do they understand the Facility Case Mix needs and monthly plan? Are they knowledgeable about Demographics for your SNF location?

Are admissions to the facility Payor or Case Mix Driven?

Are they checking referrals for Primary Payer only or do they verify Secondary Payer or possibly Tertiary Payers?

Are they knowledgeable about the difference between Medicare, Managed Care Replacement Plans, Managed Care PPO Plans, Straight Insurance Plans, Retirement Plans, Long Term Care Plans, Medicaid, Veterans Administration or Hospice?

Can they identify the correct primary payer based on the referrals received? Do they check to see if the referring organization has an initial or ongoing authorization that can be used by the facility or if submission of a new authorization request is required?

Do they validate the primary payer is accurate for the resident or referral being provided?

Does the admissions team have a Medicare Secondary Payer Questionnaire Form that they utilize to verify that the resident is not covered under a situation or plan that supersedes Medicare Part A?

Does a written policy and procedure for Admissions exist? Does the facility utilize an Admissions Packet that provides the resident, responsible party or Power of Attorney with accurate admissions information and includes the proper required notifications with acknowledging signature or initial requirements? Is the Admissions Packet completed prior to or upon Admission to the facility and the proper authorization to medically treat the patient or resident signed and dated accurately?

Are the various payers that the resident might be entitled to and their coverage information explained in detail? Especially related to Medicare, Managed Care Replacement Plans, Medicaid, Medicaid Pending or Private Pay?

Is the resident, responsible party or Power of Attorney provided a copy of the signed Admissions Packet?

Does admissions ask for and obtain copies of all insurance cards upon admission? If not, is this communicated to the Business Office so that it can be followed up on immediately? Do they ask for copies of Power of Attorney documentation or obtain responsible party signatures as part of the admissions process?

Is all the residents' demographic information obtained upon admission or is this followed up on and obtained by Social Services or Business Office Staff after admissions?

Is a Health Care emergency contact obtained and recorded prior to or upon admission to the facility?

Chapter 4 – Payer Identification

Obtaining proper payer identification is critical to billing and collections.

We have already discussed how this process starts with Admissions. However, it does not end there. With the annual and sometimes semi-annual or quarterly changes to Medicare, Medicaid, and the availability of Managed Care Replacement Plans, Working Aged Employer Plans, Long Term Care Insurance Plans, and Veterans Administration it is critical that a resident's primary payer be verified monthly or upon each admission or readmission to a skilled nursing facility.

This is especially important for all residents during the Open Enrollment period for Managed Care Plans and Private Insurance Employment Plans. Residents, Families, Responsible Parties and Power of Attorney appointees will be subjected to a bombardment of advertisements on television, radio, mail and visits to Walmart, Costco, Target, Sam's Club, or other easily accessible marketplaces during this period. It is not unheard of for any of these individuals to change a current resident's enrollment and forget to notify or update the Skilled Nursing Facility staff. Such changes can cause havoc in claims submissions and collection efforts.

Best practice is to implement a policy and procedure of performing payer eligibility checks annually on all residents currently residing in your facility on Primary and Secondary Payers. We also recommend that these eligibility checks be performed Monthly during the open enrollment period of November 1st through January 31st of each year.

Additionally, if your facility accepts Medicaid Disabled Residents under retirement age, they are eligible to add Medicare Part B coverage once they have been Medicaid Disabled for 2 years.

Any Medicare Part A eligible person is offered the ability to enroll into Medicare Part A & B upon reaching age 65. If they opt out of enrolling in Part B at that time they can subsequently choose to enroll at a later date by submitting a request and paying a penalty for the time that they would have been eligible to the date that they actually enroll. So, checking for Medicare Part B enrollment annually or upon someone reaching their 65th birthday is also a best practice.

A facility business office cannot rely on a resident, resident responsible party or resident's power of attorney to communicate these changes but needs to be proactive to validate payers or payer changes.

Of note to some SNF staff, admission to a skilled nursing facility is considered a qualifying event when it comes to Managed Medicare Replacement Plans. A resident, resident's responsible party or resident's power of attorney should be informed about this option at that time and all relevant reasons as to how this could or could not be impactful for them should be discussed.

In addition to this the coverage that is provided under Managed Care Replacement Plans vs Medicare Part A especially in consideration of copays, coinsurance and Deductibles should be provided and discussed upon admission. Understanding that most Managed Care Replacement Plans work well when a resident is in an at home situation but may not cover everything or often does not cover a complete 100 Day SNF Stay is something that every business office staff member should be able to explain and clarify for any resident, resident's responsible party or resident's power of attorney.

Informing these same individuals regarding the difference between Primary Payer, Secondary Payer and possible Tertiary or Specialty Payers should be part of the Admissions, Readmissions, and Annual reviews.

If a facility accepts straight Medicaid residents or Pending Medicaid residents the responsibility for Private Pay Portions must be clearly and concisely explained. Also, the responsibility for completing and responding to requests for Financial Information from the state Medicaid bureau should be clearly explained.

Identifying a resident's payers and obtaining correct valid ID numbers, plan details, copies of insurance cards, and any authorizations will ensure timely accurate claim generation, submission and collections.

2026 regulatory clarification | Enrollment and coverage changes

The monthly verification recommendation is an internal control. Medicare open-enrollment periods, institutional special enrollment opportunities, and Medicaid eligibility rules should be verified individually rather than inferred from a single November-through-January window. See [R6] and the plan's current guidance.

PAYER IDENTIFICATION



Know who pays, in what order, and check again

PRIMARY

Pays first: Medicare, Medicare Advantage, employer plan, Medicaid or other

SECONDARY

Picks up eligible balances after the primary processes the claim

TERTIARY / SPECIALTY

Any remaining eligible coverage, such as VA or a specialty plan

WHEN TO VERIFY



Every admission & readmission



Monthly, as an internal control



At least annually for all residents



At 65: confirm Part B enrollment

Collect at admission



Valid ID numbers



Copies of every insurance card



Plan details & authorizations



POA or responsible-party documents

Enrollment periods and Medicaid eligibility rules vary; verify each resident individually against current official guidance.

Chapter 5 – Authorizations

With the prevalence of Managed Care Replacement Plans, Employer Retirement Medical Plans, Auto Liability Plans, Veterans Administration Plans, etc., a key component to consider and understand is authorization requirements.

Most Insurance Plans will require an initial authorization upon admission to a skilled nursing facility. Typically, this needs to be requested prior to, upon admission or within 24 hours of admission to a SNF.

Initial authorizations are generally valid for a period of 7-10 days. Follow-up authorizations will need to be obtained before the end of the current authorization and will authorize anywhere from an additional 7-21 days.

Veteran's authorizations typically will cover a term of 365 days, however if a resident discharges to the hospital the VA will require notification of the discharge and either a bed hold authorization will be provided or a new authorization will be required upon readmission. This is dependent often on the Local Community VA plan.

Items typically requested to be submitted or provided to the Insurance Company for authorizations is dependent on the type of authorization being requested:

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5

Initial Authorization

- Hospital Discharge Record
- Hospital MAR/TAR
- Hospital Nursing Notes for last 7 days
- Hospital Physician Notes/Orders for last 7 days
- Physician Certification of Medical Necessity
- Orders for Therapy

Ongoing/Continuing Authorization

- Physician Certification of Medical Necessity
- MDS Assessment – 5 Day Assessment – Any OBRA Assessment
- Copy of Physician or Physician Assistant Notes
- MAR/TAR
- Therapy Evals/Therapy Grids
- Nurses Notes
- Sometimes a Copy of the Care Plan

In most cases the Initial Authorization is obtained by Admissions or Marketing staff prior to admission to the SNF. Sometimes these can be a carryover authorization from the admission/discharge from the hospital but if this is what is used it is best to verify with the Insurance Company that this will cover the initial authorization and admission to the SNF.

Follow-up or Ongoing Authorizations should be the responsibility of Nursing, MDS or Medical Records as it requires the submission of clinical documentation that the business office staff does not always have access to.

A reminder should be auto generated in the responsible parties' calendar, software dashboards, or medical notes so that the required information is submitted timely and accurately.

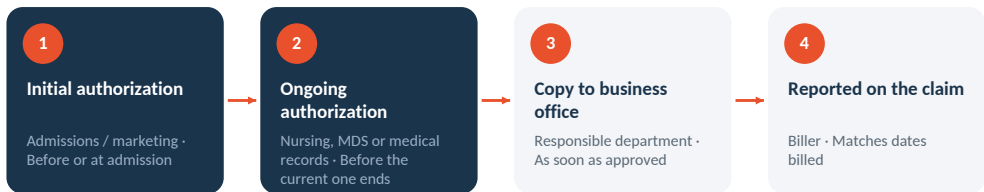
Once the valid authorization is received copies should be provided to the business office, biller to ensure accurate reporting on claims to be submitted.

2026 regulatory clarification | Authorization periods

The example authorization lengths described above are common operational experiences, not universal coverage or notification deadlines. Confirm the actual plan contract, authorization notice, admission requirements, and applicable appeal rights.

CH
5

AUTHORIZATIONS Who owns each step of an authorization



Initial request often includes

- Hospital discharge record
- Hospital MAR / TAR
- Last 7 days of nursing notes
- Physician notes & orders
- Certification of medical necessity
- Therapy orders



Ongoing request often includes

- Certification of medical necessity
- MDS 5-day or OBRA assessment
- Physician or PA notes
- MAR / TAR and nurses notes
- Therapy evals & grids
- Sometimes the care plan

Authorization lengths and required documents vary by plan and contract. Set calendar or dashboard reminders before each end date.

Chapter 6 – Credentialing

In order for a Skilled Nursing Facility to bill Medicare or Medicaid they must be credentialed or enrolled as a certified provider. Additionally, most insurance plans will require an annual recredential be provided.

There is an entire process that needs to be completed and requires multiple steps as well as access to specific online portals.

Besides Medicare and Medicaid, most Managed Care Plans or Insurance networks require a SNF to be registered as an in-network provider and often require a negotiated contract.

It is important to carefully negotiate your contract terms with these insurance plans to be beneficial to your SNF. Most insurance companies' goal is to pay the SNF as little as possible, so they determine a national average reimbursement rate for room and board and establish care level rates based on a need to meet additional medical necessity comorbidities or care treatments to receive a higher rate.

If your facility is in an urban setting the national base rate, they are willing to provide could be sufficient but if your facility is in a rural setting and they provide a lower rate as a result you may or may not be making any money. Some plans will base the reimbursement on the State Medicaid Average reimbursement.

If you typically have or take higher rated case mix resident's it may be beneficial to include a clause for one-off negotiated contracts. This will allow you to negotiate with the Insurance Company to obtain a higher rate based on the individual resident needs.

Failure to obtain the proper contract or in-network status can result in a denial of payment, out-of-network reimbursement payment, which is often less than 50% of allowed in network amounts, or a percentage of actual charges reported on the claim. If you are not capturing all allowed charges and only reporting room and board this means a much-reduced payment amount.

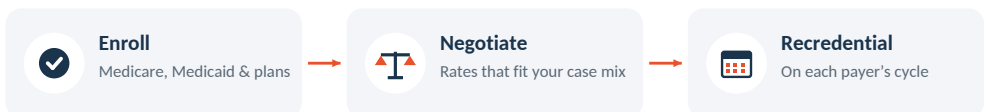
Additionally claims submitted by out-of-network providers often face extended processing time taken by the Insurance company resulting in multiple months with no payment and no recourse for private pay payment due to improper identification of payer and to income limits of elderly patients.

Resulting in BAD DEBT WRITE OFFS.

2026 regulatory clarification | Contract terms and network status

Recredentialing cycles and out-of-network reimbursement formulas depend on the contract and payer. Statements about typical payment percentages should not be treated as validated national benchmarks.

IN-NETWORK STATUS PROTECTS REIMBURSEMENT



Chapter 7 – Month End Close/Triple Check

Does your SNF possess a clearly defined and detailed policy and procedure for Month End Close?

Does it include a claims Triple Check meeting or process?

Both items are Critical Best Practice for any SNF to incorporate or possess. These policies and procedures ensure timely accurate financial accounting information and timely accurate and clean claim submission resulting in prompt payments.

A Month End Close policy and procedure should include a timeline for completion of no more than 3-5 business days at the beginning of each month for the prior month actions.

The key component of a Month End Close Stay are that certain reports need to be reconciled during the first two business days of each month. These reports include the following:

- Daily/Monthly Census
 - Admissions
 - Hospital Stays
 - Readmissions
 - Room/Bed Changes
 - Payer Changes
 - Discharges- Home-Hospital-Other SNF/ALF-Death
- Resident Payer Setups
- Posted Cash Receipts to Bank Statements
- Payer Days Count
- MDS Completion/PDPM Rate
- Private Pay Statements
- Revenue Reconciliation
- Journal Entry Reconciliation

If the reconciliation results in any updates or changes to the data previously entered, then a final reconciliation should be completed for these same reports prior to a SNF completing and finalizing Month End Close.

Some billing software systems have been updated to incorporate a Month End Close module that completes this reconciliation process electronically and provides reports identifying when an error exists that assists and allows a more cohesive and timely reconciliation process. If your SNF does not have one of those billing software systems, you should have detailed item by item policy and procedure that incorporates a checklist to ensure these processes are completed each month.

One absolutely set in stone component of this policy and procedure should include a deadline of no more than 2-3 business days which clearly communicates receipt of all invoices from any outside vendors you may have contracts with that supply ancillary services to your residents/patients.

These receipts need to include a breakdown of the services that were provided to residents/patients by payer type. Specifically for any residents that are currently in a Skilled Services Medicare or

Managed Care Part A stay. Any Ancillary Services provided to a resident in a Skilled Services Medicare A or Managed Care Part A stay are considered Consolidated Services. These ancillary services are required to be included on the claim for the stay dates and are considered to be supportive and inclusive of the PDPM Reimbursement Code and rate reported on the claim.

For payers currently being covered by primary payers other than Medicare or Managed Care Replacement plans not considered to be in a Skilled Part A stay, it will depend on the vendor type and contract negotiated as to whether the facility can or should file a Medicare or Managed Care Part B claim. Often the following type of vendors bills for and receives reimbursement for any Part B Ancillary Services separately from the SNF. Those Vendors are:

- Pharmacy Charges
- Durable Medical Equipment Supplies (DME)
- Ambulance/Transport
- Billable Medical Supplies (including wound care, ventilators, tracheostomy supplies, ostomy supplies, enteral feeding, incontinence supplies, oxygen, and rental equipment)

These vendors will typically only provide an invoice to the facility for the Services and Charges that were provided to residents in a Skilled Medicare or Managed Care Part A Stay.

Vendor services considered billable by the SNF as Medicare Part B claims include the following:

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- Therapy Services
- Billable Medical Supplies (including wound care, ventilators, tracheostomy supplies, ostomy supplies, enteral feeding, incontinence supplies, oxygen, and certain rental equipment)
- Transport Services (If the facility has its own Medically Licensed Van)
- X-rays

You may ask why I included Billable Medical Supplies, if a SNF were to include a Medical Supply Inventory System either one under contract or a semi-manual system that incorporates a secure and accurate method for tracking the use of and assignment to a specific resident for the allowed billable medical supplies these in a similar manner to billing for Vaccines can be billed and reimbursed to the facility at the allowed amounts. Which is why it is so critical for SNF to have a contract with all Vendors to receive the invoice related to these services and items within the first 2-3 Business Days of the month and for those invoices to be broken down by Payer.

The facility will then reconcile the invoices received to the Census for the prior month to verify that the charges and dates of service are being accurately reported for billing under the correct type of Payer. Once the charges and dates of service have been verified then it is the responsibility of the assigned Business Office personnel to enter and record the charges and services into an Ancillary Batch.

Depending on the type of Billing software system your SNF currently uses it may or may not incorporate the ability to allow for these charges/services to be provided in a separate import file which will save time and effort in creating the appropriate Ancillary Batch. Some SNFs will work with the billing software system to design such a module or have a programming design team that can design this and provide it to the Vendor as part of the negotiated contract.

Once the charges have been received, verified and the Ancillary Batches created and all reports have been reconciled, it is time to generate/create your claims. Most billing software systems will generate the claims in a Trial Format to provide a final opportunity for the Billing Team or Business Office to review the claims for accuracy.

This opportunity is where the policy and procedure related to the process we identified as Triple Check should be implemented. The process should incorporate an interdepartmental meeting or review, whereby the following assigned department staff complete review of the claim form prior to the claims being finalized and submitted to the Payers.

The department manager or designated representatives that should be included in this process should be from these departments:

- Business Office Manager
- MDS Coordinator
- Nursing
- Therapy
- Medical Records

Each of these representatives has critical insight into the information that should be included on the claim and should be verifying that information is accurate and that each department agrees on the data that has been included. The goal is that the SNF is submitting a totally error free clean claim the first time and reduce the number of Return to Provider or Denials received from the payers.

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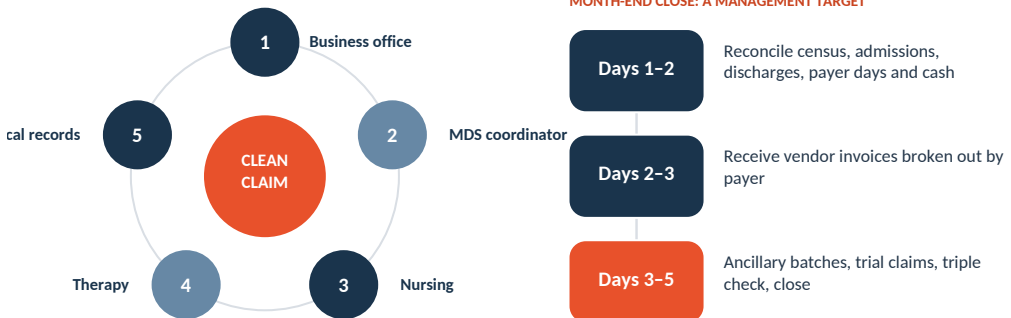
2026 regulatory clarification | Consolidated billing and month-end deadlines

The proposed 3–5-business-day close is a management target, not a general CMS mandate. Services excluded from SNF consolidated billing, and rules for separately billable services, must be checked under the current CMS guidance. See [R4].

TRIPLE CHECK



Five departments, one clean claim



Chapter 8 – PDPM

It has been eight years since the PDPM Model was introduced to our industry. During those eight years we have seen multiple changes occur each year as updates are proposed and finalized for release on October 1st each year.

Each year every SNF should have designated staff review the proposed rule changes and the final rule so that they understand what is expected of them each year.

These annual updates will require changes to current policies and procedures that are the backbone of the facility staff's ability to incorporate those changes into their daily tasks and routines.

Often these changes will impact the Billing and Clinical Software System your SNF is currently utilizing. Does your contract with your current software system include these updates that are received automatically in a new release version or do they require an individual or multiple individuals to make manual updates.

Do these individuals have the appropriate training and technical knowledge needed to make those updates?

Do they completely understand the PDPM module and the components that make up and the data that contributes to each component's designation and its impact on the reimbursement received. Often SNFs do not take into consideration turnover in critical staff positions and if the new hire has been truly trained or understands this process completely.

The components within the PDPM designated rate and how they coordinate together to determine the reimbursement received need to be fully grasped by certain staff within your SNF organization or you may be leaving revenue on the table.

In this book we have discussed previously the importance of incorporating a Referral Team that reviews and discusses each referral received. That team's understanding of the PDPM module and its components is the most important aspect of that review.

Four of the components of the PDPM rate contribute to the overall reimbursement that will be generated. The fifth component is an indicator only. The five components consist of:

1st Component Physical/Occupational Therapy Combined

2nd Component Speech Therapy

3rd Component Nursing RUG

4th Component Non-Therapy Ancillaries

5th Component MDS Assessment Type

Understanding where in the MDS Assessment these components are recorded is the responsibility of the MDS Coordinator and the departments that enter respective data related to the resident's current capabilities and daily activities.

The PDPM Model was designed to replace the old Resource Utilization Group IV (RUG IV) system which mainly focused on a Primary Diagnosis and Therapy Services to determine the reimbursement rate achieved.

Medicare designed the new system to consider not only the Primary Diagnosis for which a resident had a 3-Day Qualifying Hospital Stay and the need for Skilled Therapy Services, but instead to review all aspects of a resident's current health needs that require a SNF stay.

A SNF is now forced to review and address the complete healthcare picture of the patient/resident and if this done accurately and with proper due diligence can provide better outcomes for the patient and also possible higher revenue/reimbursement for the SNF.

Understanding and capturing all the necessary data related to achieving the highest reimbursement rate requires staff knowledge and understanding of the various component requirements, calculations and impacts of the PDPM rate generations.

Medicare provided a basic component rate calculation cheat sheet when PDPM first was released. Does your current policy and procedure incorporate this system or is your software system designed to incorporate that information automatically. This document is still available for download and review from the [medicare.gov](https://www.medicare.gov) website.

Medicare also provides an updated rate table in the Finalized Ruling that details the reimbursement rates for each component designation received from the PDPM Rate produced from the MDS system. Most SNF Software Systems have incorporated this rate template as part of their reimbursement revenue calculation. They also utilize it to design a report that will provide you with the Daily Reimbursement Rate to be expected based on the rate produced. This is a simple report that can assist your Management Staff in planning monthly budgets, case mix goals and trends.

Keep in mind that your location demographic also plays a part in your referrals and the rates that your SNF receives. The PDPM System is designed to consider your facility's location, are you Urban or Rural? It also factors in your staffing requirements, and the current national hourly rates for staffing of all the various departments within your facility.

Finally beginning October 1st, 2025, the PDPM Module is being utilized to assist States in determining Medicaid Reimbursement Rates. Keeping up with these state updates and changes is important to a SNF as it may or may not require hiring additional MDS assessment staff based on your current case mix and the requirements of the State for completing and possibly submitting Medicaid OBRA MDS Assessments using the PDPM Model.

Some states also have incorporated utilizing Managed Medicaid Insurance Plans that require enrollment by the SNF to that state plan. Depending on the size of the state certain counties may be limited as to the residents they can admit under Medicaid by the type of Managed Medicaid Plan assigned to that county.

Staying updated and informed and incorporating these changes is the only way a SNF continues to succeed in the future.

2026 regulatory clarification | PDPM components and date

PDPM took effect October 1, 2019. The Medicare PDPM per diem comprises five case-mix adjusted payment components (PT, OT, SLP, nursing, and NTA) plus a non-case-mix component. The assessment type is not itself a fifth payment component. The FY 2027 SNF PPS rule and the current MDS manual should govern 2026-era coding and payment work. See [R1], [R2], and [R3].



PDPM AT A GLANCE

What makes up the Medicare PDPM per diem

PT

Physical therapy

OT

Occupational therapy

SLP

 Speech-language
pathology

Nursing

Nursing component

NTA

Non-therapy ancillaries

Five case-mix adjusted components

+ Non-case-mix component

A flat amount that applies to every day of the stay


Daily PDPM payment

Driven by accurate MDS coding

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KEY DATES

Oct 1, 2019

PDPM takes effect

Every Oct 1

Annual final rule updates

2026-era work

 Follow the FY 2027 SNF PPS rule &
current MDS manual

Revenue left on the table usually starts with:

- Untrained staff after turnover
- Missed comorbidities in hospital records
- Software rate tables not updated
- Diagnosis codes that don't support the MDS

The MDS assessment type is an indicator, not a payment component. See references [R1]–[R3].

Chapter 9 – Diagnosis Codes

Incorrect diagnosis codes on a claim are becoming one of the most reported rejection reasons we as billers are seeing.

If the primary and admitting diagnosis codes are not appropriate and supporting of the PDPM Code generated from the MDS Assessment, or the Therapies and Services being reported on the claim then the claim is going to be rejected or returned to the provider.

Is your team reviewing the documentation received as part of the referral process to determine the correct admitting and comorbidity diagnosis that should be being captured and reported.

Remember any new admission requires that the Admitting and Primary diagnosis must be for an illness that was treated while the patient/resident was in the hospital for their 3-Day qualifying. If a resident is sent to the hospital and has a new 3-day qualifying stay the referral team should review the hospital discharge documentation to determine if a new 5-Day Admitting MDS Assessment should be completed.

If the patient/resident is being readmitted after less than a 72 hour stay, then the diagnosis for that stay can be utilized as a new diagnosis in a location other than Admitting or Primary. The original Admitting and Primary Diagnosis from the MDS 5-Day Assessment submitted can still be used if the ongoing stay is still treating or related to that initial Admitting or Primary Diagnosis. The facility referral team must closely review the new hospital documentation and prior look back period of facility documentation to determine if it still supports use of the original Admitting and Primary diagnosis.

If the original Admitting or Primary Diagnosis has been resolved prior to the less than 72 hours stay or the look back period of current facility documentation does not support the original Admitting and Primary Diagnosis then an IPA MDS Assessment should be completed, submitted and the Admitting and Primary Diagnosis should be updated and tied to treatments provided during the Hospital Stay.

With the changes to state Medicaid systems now incorporating and following the PDPM Module and MDS Assessment Schedule this has become a factor that must be considered as well. Keep in mind that discharges to the hospital while a resident is in a Medicaid Stay does not necessarily rely only on if the resident had a new 3-Day Qualifying Hospital Stay.

If the reason for the visit to the hospital changes or impacts the care level for the resident but not to the extent that it would qualify for a New Medicare stay, it may still be necessary to complete an IPA or OBRA Assessment to reflect the new level of care being received.

Besides determining the timing and need for new MDS Assessments other considerations related to Diagnosis codes needed on a claim are tied to the care and services being reported. If the claim is a Medicare Part B Claim, then consideration of the services being reported needs to ensure that the correct Admitting Code is tied to the continuing stay for admission. If the resident's Primary Payer changed from Medicare to Medicaid and an OBRA or Discharge Assessment resulted in a change to

the Admitting Diagnosis this needs to be reported on the claim. Or if an updated OBRA Level of Care Change Assessment was completed then the new Admitting Assessment needs to be reported.

On Medicaid and Medicare Part B claims it is not always necessary for the Admitting and Primary Diagnosis to match. Often if the claim is for Therapy, or Medical Supplies related to a specific illness such as Wound Care, Ostomy Care, Vent Care, Trach Care etc. then the Primary Diagnosis should be tied to that illness or care with supporting additional diagnosis if needed.

Any changes or updates to diagnosis codes must also be recorded and documented in the Diagnosis Sheet, the Physician Notes, Therapy Evals, Therapy Grids and Care Plan all these documents should have the appropriate signatures and dates recorded on them as well.

A licensed, registered coder should review the diagnosis codes in all documentation to confirm that they meet the required level of specificity and accurately support the services reported on the claim. Billers are seeing more claims rejected, denied, or returned to providers because they do not meet these requirements.

Choosing the easiest general generic diagnosis is not always acceptable any longer. Continuous use of the diagnosis' that include the wording of Unspecified are being reviewed and may result in a facility being placed under a post- or prepayment Review Audit.

2026 regulatory clarification | Diagnoses and interrupted stays

Hospital stay requirements, the PDPM interrupted-stay policy, ICD-10-CM selection, and the appropriate MDS schedule involve fact-specific rules and possible waivers. A three-day hospitalization is not a universal prerequisite in every Medicare-covered scenario; diagnosis and assessment decisions should follow current CMS guidance and the clinical record. See [R2], [R3], and [R6].

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DIAGNOSIS CODES



Every record has to tell the same story



Heavy reliance on "unspecified" codes draws scrutiny and can lead to pre- or post-payment review. A licensed coder should confirm specificity.

Chapter 10 – Private Pay

This payer is the one SNFs will tell you is the Hardest or the Easiest to manage, collect, or see remain on the facilities Accounts Receivable Aging report.

It all depends on the policies and procedures that have been defined for the various Payers that fall into this category. The payer designated and assigned as Private Pay and is listed in a resident's documentation as the Primary Payer to capture the charges related to Room & Board for residents is not the only payer to contribute to this category.

The other payers often assigned to this category of Private Pay include the following:

- Medicaid Pending
- Private Pay Medicare A coinsurance
- Private Pay Medicare B coinsurance
- Private Pay Managed Care A coinsurance
- Private Pay Managed Care B coinsurance
- Private Pay Deductible
- Resident Responsibility/Portion (Medicaid Assigned)

Additionally, any ancillary charges that may not be covered by a Primary or Secondary Payer under Medicare, Medicaid or Managed Care carve-out Plans could be recorded under Private Pay.

These charges should all show up as different and detailed on the residents' Private Pay Statement to avoid confusion. They also should be included on a list of Services/Charges that can be billed as Private Pay Services and charges. Some of these Ancillary Services might include:

- Beauty & Barber Shop Charges
- Facility Provided Laundry Services
- Television/Cable Services
- Telephone Services
- Incontinent Supplies
- Billable Medical Supplies
- Non-Formulary Pharmacy Prescriptions
- Durable Medical Supplies (DME)
- Therapy Charges

Basically, if the Ancillary Service or Charge is billable to Medicare, Managed Care, Insurance, or Medicaid it must be included in the list of charges that can be billed to Private Pay residents who do not have these other payers as an option.

Keep in mind that if you decide not to bill or to waive these services or charges for your Private Pay residents then you must clearly state this in the Admissions Packet and it must require a signature for all Admissions.

However, keep in mind that by including such documentation in your admission packet does not always protect the SNF from any follow up action or review and scrutiny during Annual Medicare or Medicaid Surveys.

Best Practice if you include it and bill for it for other payers include it and bill for it to Private Pay.

Related to the Medicaid Pending payer, make sure that this payer is explained in full detail to a resident, a resident's responsible party or a resident's financial Power of Attorney upon admission. Failure to explain that if the resident is denied or not approved for Medicaid could result in them being Liable Privately for the months that the resident was considered Medicaid Pending at the Private Pay Rate and them signing documentation to acknowledge the same could impact the SNFs ability to collect for these charges.

Most states will allow for the facility to collect a portion of the residents' current liquid assets (Social Security, Retirement Income, Stock Dividends, 401K Payments, Rental Income etc.). Being knowledgeable regarding the allowed income limits, allowed assets, allowed deductions, and the look-back period will enable your staff to be able to clearly explain and inform responsible individuals upon admission of these requirements.

They should also be informed that as the Financial Representative it is their responsibility to manage prompt timely payment for these charges and to complete the Medicaid Application and provide any required or requested documentation to the State Medicaid employee assigned to the resident's case.

We recommend having this documented as part of the Admissions Packet or as a separate Medicaid Pending Packet that requires their signature and date acknowledging this has been explained and they understand and accept responsibility.

As part of the Admissions Packet and Admissions process the copay, coinsurance and Deductibles that may be applied by Primary Payers should be documented and clearly explained. This should be clearly explained and documented that if it is determined that these particular categories are received on an Explanation of Benefits as allowable to be passed on to the resident as a Private Pay charge, they will subsequently show up on a Private Pay Statement as such and are due and payable upon receipt.

To assist billers and business office staff with collections of Private Pay balances there should be in place a clearly defined and detailed policy and procedure for Private Pay collections. This policy and procedure should include a check list for each of the collection efforts to be followed and a timeline for completing them.

This becomes especially important related to Medicare Part A coinsurance charged to Private Pay. If the proper steps and collection efforts are properly documented and recorded, then this can be submitted as Reimbursable Bad Debt on the Medicare Cost Report.

This same principle holds true for Medicare Part A coinsurance billable to Medicaid that may be approved as a Zero Payment or Partial Payment if the appropriate documentation is retained these unpaid coinsurance Balances can be submitted as Reimbursable Bad Debt on the Medicare or Medicaid Cost Reports.

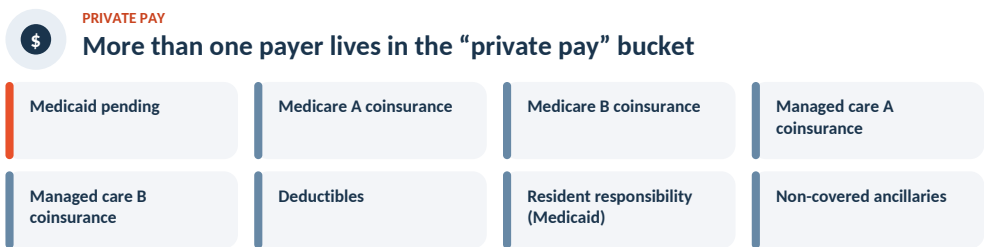
Proper policies and procedures related to these processes and a detailed check list make this process easier and trackable.

Keep in mind utilization of and incorporation of documenting collection efforts is often included as part of a Collection Module in most SNF Software Systems. Detailing proper use of these modules as a policy and procedure is easy as most systems include a training module or screen shot capabilities.

Finally, besides the business office or billing staff it is important that the Administrator or Executive Director be a part of the Collections Effort. Sometimes a phone call from them or a meeting with them can make all the difference in achieving payment for balances due.

2026 regulatory clarification | Charges to residents and Medicare bad debt

The list of potential private-pay items does not itself make every item separately chargeable. Federal law prohibits charges for services included in covered Medicare or Medicaid payment, with limited exceptions. Medicare bad-debt treatment also requires specific eligibility and documentation criteria. See [R7] and [R8].



A COLLECTIONS LADDER THAT HOLDS UP

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- 1 Explain obligations at admission and get signatures
- 2 Send clear, itemized private-pay statements
- 3 Follow a written timeline of collection efforts
- 4 Involve the administrator when balances stall
- 5 Document every effort before any bad-debt claim

Charges must not duplicate services already covered by Medicare or Medicaid. Medicare bad debt has its own criteria. See [R7] and [R8].

Chapter 11 – Return to Provider vs Denials

As part of the claims policy and procedure does your SNF incorporate a timeline for generation, review, submission and follow-up?

Does your billing staff understand and follow that policy and procedure?

When following up on a claim do they understand the difference between Paid vs Suspended vs Return to Provider vs Denied Claim?

Are they set up with access to the Medicare Administrative Contractor (MAC) web portal and the Direct Data Entry (DDE) system or does the electronic claims submission clearinghouse software system your facility uses provide access to track claim status, correct claims and resubmit claims?

Understanding the various claim status codes, as well as the rejection or denial reason codes is critical to being able to timely correct and resubmit claims for a quicker payment decision and receipt.

If the SNF Business Office Staff and billers have access to electronically review claims without having to wait on an actual Explanation of Benefit (EOB) or Remittance Advice (RA) to follow up on a claim it saves time and results in a quicker resolution to final payment.

Return to Provider claims are placed in a T B9000 status to begin with if a biller notes this claim in collections module, they can follow it until it reaches its final status of T B9996. Once the claim is in that final status of T B9996 the claim can be reworked, corrections made and the claim can be resubmitted. It does not require a type of bill change, only a Condition Code of D9 with remarks stating what data was corrected. It will not have a Claim ID/Control Number as the claim did not reach a Paid or Denied Status.

Being able to identify the Return to Provider Claim sooner rather than later can be the difference between receiving payment in the same month as the claim was submitted and having the claim age out to your 60-Day Bucket.

If a claim is placed in a Denied Status it will start with a D B9000 Status and will eventually reach a D B9996 Status, that claim has to be either appealed or resubmitted as a Corrected Claims with a type of Bill Code of 217, 227, 327 entered in field location 4, a specific Condition Code in field location 18-28, corrections made to the data that was incorrect on the claim the Document Control Number that will need to be entered into field location number 64-Documents Control Number this is so that it will reference the denied claim and finally supporting remarks that indicate the corrections made. Often these remarks and format are specific to the MACs and if incorrect remarks or format are used the claim can be rejected or denied again.

Sometimes a SNF may have to wait until a claims EOB or RA is received to rework/correct denied claims. However, if you provide your staff with the correct electronic access, training and knowledge then reworking and correcting claims can be completed in a much faster timeframe resulting in more prompt payment.

It needs to be understood each time a claim is denied it will generate a new Document Control Number accurate notes added to the Collections Module of the billing software need to record the date of denial and each Document Control Number so that proper tracking of claims is achieved.

The Denial Codes or Error Codes on a claim whether it is a Return to Provider claim or a Denied Claim are standard throughout the industry for Medicare and Medicaid. A copy of the list of denial/error codes can be obtained through Medicare.gov website and are easily looked up by searching for CARC Codes in the search bar.

However, depending on the Managed Care Insurance Provider they may incorporate a series of specialty or provider only Denial/Error codes. As you negotiate your contracts and enrollment with these providers and enroll in their individual web portals there should be a location for downloading claims processing manuals. The manuals should include a list of possible denial/error code reasons and whether the corrected claims can be submitted through a clearinghouse or must be submitted through the Insurance Company web portal.

We recommend that if you have not already done so that your SNF make sure to enroll in your States Medicaid Web Portal as it will provide the ability to check resident benefits as well as claim status and may require that corrected or secondary payer claims be submitted through that web portal and not through an electronic claims clearinghouse.

2026 regulatory clarification | Claims correction methods

Specific RTP and denial status codes and the bill type or condition codes needed for a corrected claim vary with the transaction, payer, and MAC workflow. Do not automatically use one set of codes for all returned or denied claims; follow the applicable MAC or payer instructions.

KNOW THE DIFFERENCE

Return to provider vs. denied claim

Return to provider (RTP)	VS	Denied claim
✓ Never reached a paid or denied status ✓ No claim control number is issued ✓ Correct the data and resubmit ✓ Catch it early to keep cash in the same month		✓ Payer made an adverse decision ✓ A document control number is issued ✓ Appeal, or send a corrected claim that references it ✓ Log every DCN and date in collections notes

Status codes, bill types and condition codes vary by transaction, payer and MAC. Follow the applicable instructions.

Chapter 12 – Additional Documentation Request (ADR)-Appeals

As part of claims processing a SNF should embrace a policy and procedure that includes follow-up after claims have been submitted. This should be true for all payers but especially for Medicare and Managed Care Replacement Part A & Part B claims. If your SNF is utilizing a clearinghouse electronic claims submission software, then it often will include the ability to view and check claims status processing.

If your SNF does not utilize a clearinghouse electronic claims submission software and instead relies on enrollment in the various Medicare Administrative Contractor (MAC) web portals and access to Direct Data Entry (DDE) or a Managed Care Insurance web portal to access claims this will work as well. Either way it is important that claims are reviewed and checked timely after submission instead of relying on just the receipt of an Explanation of Benefits (EOB) or Remittance Advice (RA).

The reason we stress this is that there is one type of claim status which, if a claim is placed in requires immediate timely response as it includes a time limit to respond and requires the SNF to compile and submit additional documentation to appeal. This status is S B6000 or S B6001 or the Additional Documentation Request (ADR) claim. If a claim is placed in this status a SNF only has an initial 120 Days from the date of the ADR Status Notification. The MAC is required to update claims status in DDE daily and this information is also communicated to the various clearinghouse software systems as well. At that time a letter is attached to the notification, and your count down begins.

They will also issue a letter to the facility through the mail as notification of a claim placed in this status. A SNF can set up while completing enrollment where and who these letter notifications are sent to. We recommend that they be sent to at least two different individuals within the facility Management Structure to ensure that an ADR Notification is not missed.

This type of claim status immediately requires manual retrieval of documentation to support the denial reason; the reason and dates of service (DOS) will be detailed in the letter that is attached or sent.

A SNF should have a policy and procedure that incorporates a check list for the necessary documentation that should be gathered and a file created to keep all the documentation together until it can be reviewed by the Management Team. The Management Team will validate that the documentation supports the appeal, includes all the necessary requested documentation and that it is in the format requested.

CMS Electronic Submission of Medical Documentation (esMD)

<https://www.cms.gov/data-research/computer-data-systems/esmdual>

Available submission methods may include: U.S. Mail, a designated MAC portal, esMD, fax, or approved electronic media, subject to the reviewer's current instructions.

There are 5 Levels of Appeal that a claim can be escalated through to try to achieve payment. They are:

1st Level – Redetermination – Conducted at the MAC or Medicare Intermediary – must be submitted within 120 Days of receipt of Letter – MAC will usually respond within 60 Days

2nd Level – Reconsideration – Conducted by Qualified Independent Contractor (QIC) – Has to be submitted within 180 Days of Receipt of the Letter – QIC will respond within 60 Days

3rd Level – Hearing by Administrative Law Judge (ALJ) – must be submitted within 60 Days of denial by QIC and claim dispute amount must be \$190.00 or greater – ALJ will respond within 60 Days, if ALJ fails to respond within 60 days an appeal can be submitted to the next level

4th Level – Medicare Appeals Council – must be submitted within 60 days after the receipt of denial by ALJ or after 60 Days without response from ALJ – Medicare Appeals Council will respond within 90 Days (again the dispute amount must be \$190.00 or greater.)

5th Level – Judicial Review in US District Court – must be submitted within 60 Days of denial by Medicare Appeals Council – There is no time limit for a response – The amount in dispute must be \$1900.00 or greater.

As the SNF ADR Team submits an appealed claim through the various levels the submission dates and response dates should be recorded in the SNFs billing software collections module for tracking purposes.

If a claim is at any time paid in full the appeal process stops. If a partial payment is received it is up to the SNF if they choose to accept this and stop the appeal process or dispute the remaining amount and continue appealing the disputed portion.

A SNF can decide at any time whether to continue the appeal process or accept the denial of the claim. If the decision is to stop the appeal process this means that the facility is accepting the denial of claim payment and that means the amount cannot be passed onto the patient/resident as Private Pay but instead must be recorded as a Bad Debt Write Off.

If the decision is to accept this as Bad Debt the facility should at this time begin to follow their policy and procedure for Bad Debt Write Off process. This policy and procedure should incorporate a check list that includes the documentation to be retained, the collection or appeal process followed, and the Management Levels required to approve and sign off on the Bad Debt amount.

Additionally, at times an Insurance Company payer involved in an ADR request or denied claim appeal may reach out to independent claims dispute agencies and offer a SNF a partial settlement amount to the claim. It is totally up to the SNF if they chose to accept this amount, but they must understand that this constitutes payment in full and they are not able or allowed to pass on the remaining balance to the patient/resident as private pay responsibility.

In this chapter we have discussed this status as it applies to an individual claim, however it is important to note that if a SNF is consistently receiving these requests or is demonstrating a repeated questionable denial pattern the MAC can place the facility in either a pre-payment or post-payment audit review.

These audits usually include more than one claim and possibly all claims for that month submitted will be placed in an ADR status and the facility will be required to provide the requested additional documentation. Some claims may be resolved through the first level of appeal however; it may be necessary for the claims to go through all levels of appeal before being paid.

For this type of audit to be lifted there is often a requirement that the facility reach a percentage of 93% or better of the claims submitted be considered clean claims and receive payment without having more than 7% of the claims be chosen for ADR, for two consecutive months.

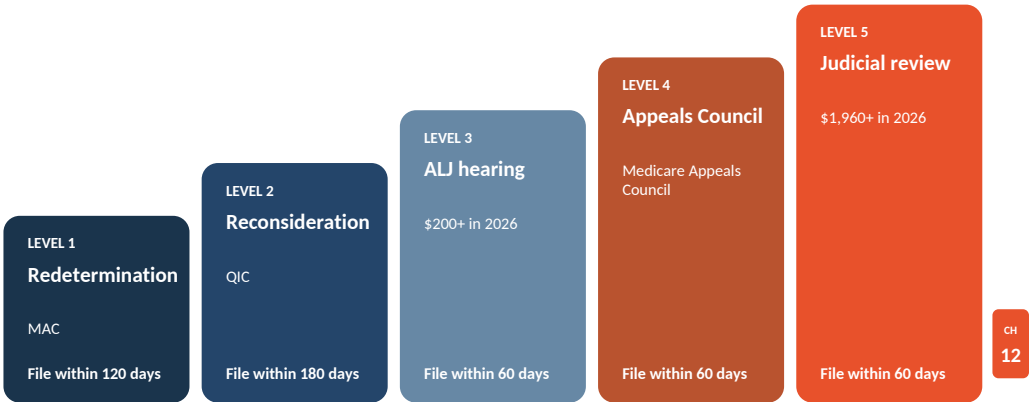
2026 regulatory clarification | ADR response versus appeal deadline

An ADR requests documentation before or after payment. CMS generally provides 45 calendar days for MAC, SMRC, and RAC ADR responses, or 30 calendar days for UPIC requests. A first-level Original Medicare redetermination is a different process, usually requested within 120 days after receipt of the initial determination. For calendar year 2026, the ALJ and judicial review amount-in-controversy thresholds are \$200 and \$1,960, respectively. Do not use the 93% figure as a universal audit release threshold. See [R5], [R9], and [R10].



MEDICARE APPEALS

Five levels of appeal, one step at a time



An ADR is not an appeal

CMS generally allows 45 days to answer MAC, SMRC and RAC documentation requests, or 30 days for UPIC requests. Route ADR letters to at least two managers.

Filing windows run from receipt of each decision. Thresholds shown are the CY 2026 amounts in controversy. See [R5], [R9], [R10].

Chapter 13 – Payments, Adjustments, Write-Offs

Once the SNF Business Office receives a payment notification, either Explanation of Benefits (EOB) or Remittance Advice (RA) the staff member assigned should first determine if the payment has reached the facilities bank account and then post the payment in their Billing Software System Module that day.

Cash receipts or payments should be posted daily, and the facility should have a written policy and procedure that details the complete process.

Ensuring payments are posted to the correct payer is crucial to managing the SNFs Accounts Receivables. Most facilities will have multiple payers to cover the difference between Primary, Secondary and Tertiary payers it is not uncommon for more than one payer to be associated with the same Insurance Company or Provider. This can result in different claim types being paid on the same EOB/RA. Being able to correctly identify the payer the payment belongs to is critical.

Most Billing Software Systems provide the ability for the facility to accept Electronic Remittance Advice payments and import them via an electronic 835-File Format. However, this service is one that the facility will need to enroll in when setting up the Insurance Company within the billing software or clearinghouse software.

If this option is available and is utilized the review of the batch created still needs to occur to ensure accurate posting of the payments to the correct payers. It should be compared to the EOB/RA to validate.

Once payment is posted it is not unusual for there to still be minor balances remaining. This will depend on the facility and how the various payers were set up. Were the payers set up to automatically adjust certain easily identifiable reductions that are commonly applied to payments. These commonly applied reductions include:

- coinsurance
- copays
- Deductibles
- Percentage Rate Reductions
- Care Level Set Rates
- 2% Medicare Reduction
- Medicaid Resident Private Pay Portion
- Penny Adjustments – due to Rounding of Payment Calculations

These commonly applied reductions are usually communicated when a residents payer source eligibility is verified or if a Managed Care Plan contract has been established.

However, it is often that even with these commonly applied reductions are factored into the payer revenue calculations and are deducted and passed on to the next or Secondary payer automatically that a payment may have additional credit or debit balances that remain.

It is imperative that a biller be able to read and understand an EOB or RA accurately to determine whether the remaining balance is something that should be passed on to a Secondary Payer, the resident as Private Pay, as an Adjustment (facility responsibility) or is this a balance that should be pursued/appealed and possibly eventually submitted as Bad Debt Write Off.

Understanding the various coding of the EOB or RA is dependent on identifying the type of adjustment being made and then identifying the adjustment reason code. As mentioned previously the industry utilizes a standard claims adjustment reason code (CARC) code list and system that most all payers follow.

The first component of a CARC code is the type of adjustment being made. There are five different adjustment type codes that can be applied. They are:

- CO – Contractual Obligation – Provider Adjustment/Write Off
- PR – Patient Responsibility – Amount Billed to Patient
- OA – Other Adjustment- Miscellaneous
- PI – Payer Initiated – Adjustments Initiated by Payer
- CR – Corrections & Reversals – Corrections to Prior Payments

These adjustment type codes will be followed by up to a 1–4-digit number, this number is tied to a reason for the adjustment and assists the biller in determining the reason for the adjustment and the next action required.

To obtain a copy of the CARC Code list you can do a web search.

The first adjustment type CO is self-explanatory and most SNFs allow a biller to immediately enter an Adjustment Batch and apply this to any remaining balance on the account.

The second adjustment type PR is also self-explanatory and has often already been addressed in the automatic payer adjustment set ups, so a biller needs to carefully review the reason code to determine if this amount has already been applied prior to the payment being received.

The next two adjustment types are ones that require the biller to look up the specific reason code to accurately determine if this is an additional adjustment that has been applied that was not previously considered in the Payer Setup to adjust off automatically or if it is an additional adjustment is required to be entered.

Finally, the last adjustment type is one that we often will see when the facility has reported a credit balance for recoupment or has submitted a corrected claim for an unpaid portion of a previously paid claim. This code will usually show up on a credit or negative payment indicated on the remittance advice and may or may not have a similar DOS claim being paid right below it.

This type of claim adjustment and negative recoupment may also result in what we call a zero-remittance payment, or the RA will have a Remit Number instead of an EFT Number. Even though there are actual payments on a RA of this nature this RA and the payments associated with it need to be held until the next actual positive payment remit is received. They will often at the end of the RA show a list of claims that were being recouped and a biller should be able to determine how this recoupment payment should be applied to clear the credit balance.

The policy and procedure for posting payments should include a detailed process for how these zero-remittance payments are identified, how they are held and how they should finally all be documented and recorded as part of a Cash Receipt Batch and payment.

Once all the payment batch has been posted the biller should review the accounts to determine if there is any remaining balance on the account for those DOS and if that balance is related to any of the adjustments indicated on the claim.

If the remaining balance is a credit balance (negative) the biller needs to determine if at some point after the claim was submitted was a correction to the claims submitted or possibly was a corrected MDS Assessment submitted and a new claim was never generated or a corrected claim needs to be submitted. This type of correction can be tricky as there is a time limit to when corrected claims due to MDS Assessment or PDPM Code changes can be submitted.

If the remaining balance is a debit balance (positive) the biller needs to compare the payment details to the claim itself to determine if a particular line item may have been denied or the various CARC codes on the remittance advice to determine what reduction might have contributed to the outstanding balance. This may or may not be solvable by an adjustment or it may require a corrected claim to be submitted, or an appeal based on the reason code to be attempted.

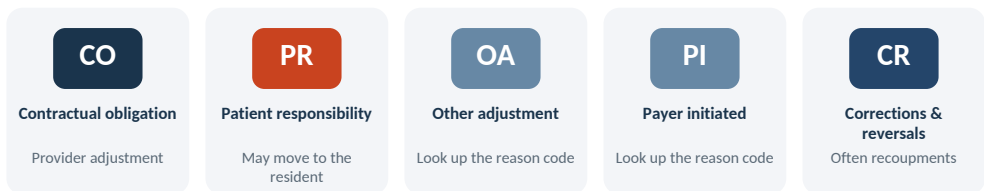
2026 regulatory clarification | Posting and adjustment classifications

Daily posting is a useful internal target, not a general federal posting deadline. A remittance adjustment group code or CARC alone does not authorize patient billing or a contractual write-off; confirm payer contract terms, remittance context, and covered-resident protections. See [R7].

READING THE REMITTANCE



Claim adjustment group codes at a glance



POSTING FLOW



A group code or CARC alone does not authorize resident billing or a write-off. Confirm payer terms and resident protections. See [R7].

Chapter 14 – Accounts Receivable

Accounts Receivable – Identifying Trends – Is Help Needed?

At the monthly financial meeting, the administrator sees that the facility's census has remained steady, but collections have not kept pace. The aging report shows more unpaid balances over 90 days. One biller says those claims are pending. Another is waiting on medical records. A third has been calling a payer but cannot find the last follow-up note. It is tempting to conclude that the facility simply needs someone to make more phone calls. The better starting point is to understand why each dollar is still open.

Accounts Receivable (A/R) is not one problem. It is a collection of different issues that need different responses. Some balances are recent claims still moving through routine adjudication. Others are unsubmitted claims, returned claims, denials, payment variances, secondary balances, Medicaid pending accounts, or private-pay obligations. If all of these are treated as one large list, staff may spend hours on easy accounts while the accounts most at risk continue to age.

Begin with a reliable A/R report

The business office should be able to produce a current A/R report that agrees, as reasonably possible, with the facility's general ledger and posted transactions. Before drawing conclusions, confirm the report date, the aging basis, the treatment of unapplied payments, and whether credits are shown separately. Aging by date of service can tell a different story from aging by the last bill date or due date. The organization should define one primary reporting basis and use it consistently over time.

The report should show at minimum the resident account or approved identifier, payer, claim or invoice reference, dates of service, original billed amount, payments, adjustments, open balance, aging bucket, claim status, last action, next action, and responsible staff member. Protected information should be limited to what the reviewer needs. Payer-level totals help the administrator see whether a delay is concentrated in Original Medicare, Medicare Advantage, Medicaid, commercial insurance, or resident responsibility.

A familiar set of age ranges is 0–30, 31–60, 61–90, and over 90 days. Some facilities break the last group into 91–120 and over 120 days. Both are useful, but the reporting standard should not change in the middle of a trend comparison. A 90-day balance is not automatically uncollectible; it signals the need to examine the reason and the remaining filing or appeal rights.

Five questions to ask before working an aged balance

1. **Was the claim actually accepted?** A claim transmitted from a billing system can be rejected by the clearinghouse or returned for correction without reaching payer adjudication. Save the acknowledgement, not merely the transmission date.
2. **Who is responsible for payment today?** Recheck eligibility, the order of primary and secondary coverage, authorization, and any resident liability. A coverage change during the stay may explain a growing balance.

3. **What is the most recent documented status?** Distinguish accepted and pending claims from denied claims, requests for additional documentation, and payments awaiting posting. Record the source and date of the information.
4. **Is a deadline approaching?** Timely filing, corrected-claim windows, request-for-information dates, appeal deadlines, and contract dispute periods should determine urgency. Never assume every payer uses Medicare's timeframes.
5. **What specific action will resolve the issue?** Examples include obtaining a missing assessment, correcting a payer ID, supplying a clinical record, filing an appeal, reconciling a remit, or contacting the resident about a legally valid obligation.

The result should be a work queue with an action owner and due date. Avoid vague notes such as 'followed up' or 'will check later.' A useful note explains what was learned, from whom, the reference number if available, the next step, and when it will be completed.

Work by risk, not simply by oldest balance

An effective follow-up sequence balances age with financial exposure and the risk of losing appeal or filing rights. A large balance awaiting a document due tomorrow should move ahead of a small, newly submitted balance. A denied claim approaching a deadline may take priority over a much older account that is waiting on an approved payment schedule.

A simple management method is to classify open items into four work queues. **Submission exceptions** are claims not yet accepted. **Payer processing and denials** are accepted claims requiring status review, correction, documentation, or appeal. **Reconciliation exceptions** are credits, missing remittances, offsets, or apparent underpayments. **Resident and other balances** are coinsurance, permitted private-pay charges, and state-specific patient-liability amounts. Within each queue, flag deadline risk, high-dollar balances, and accounts requiring a cross-department decision.

To prevent forgotten work, choose a cadence appropriate to the payer and the issue. Staff can review urgent deadlines every business day, denial queues at least weekly, and overall payer aging with the administrator monthly. These are proposed operating practices, not federal billing deadlines. A/R work should be documented in the same system used to track claims whenever possible, with secure access and consistent status definitions.

Trend analysis that tells management something useful

Look beyond the grand total. Compare aging by payer, facility, reason code, claim type, and admission cohort. Ask whether the same payer repeatedly delays authorization reviews, whether claims from one month were held for MDS data, or whether changes in staffing coincided with a rise in unresolved items. Compare the trend with cash collections and unbilled A/R. A falling A/R balance can reflect real collections, but it can also reflect write-offs that hide the underlying issue.

A good monthly A/R review separates three movements: the opening balance, new charges, and reductions through cash, allowable adjustments, and authorized write-offs. Reconcile these movements to the closing balance. Then drill into the remaining items that management can still

influence. Confirm that contractual adjustments were based on correct payer terms and that payer underpayments have not been written off automatically.

Illustrative A/R aging example

The following figures are fictional and are included only to demonstrate a dashboard. They do not represent a facility, a 24/7 Medical Billing Services LLC client, or an industry benchmark.

Age of outstanding balance	Amount	Share of total
0–30 days	\$180,000	36%
31–60 days	\$125,000	25%
61–90 days	\$80,000	16%
Over 90 days	\$115,000	23%
Total	\$500,000	100%

In this example, \$195,000 is older than 60 days. The next step is not to issue a generic collection target. It is to segment that \$195,000 by payer, status, deadline, and action required. If \$70,000 relates to documentation requests, the nursing and MDS teams belong in the resolution meeting. If \$45,000 represents secondary claims that were never submitted, the submission workflow needs attention. If the balances reflect payment offsets, posting and reconciliation may be the immediate issue.

A small but useful KPI set

Days in A/R can be estimated as ending net A/R divided by average daily net revenue over a defined period. State the numerator, the revenue definition, the period, and whether credit balances are netted. **A/R over 90 days percentage** is the open balance aged over 90 days divided by total open A/R using the same aging basis. **Unbilled A/R** is the value of charges or services not yet released in accepted claims as of the reporting date. **Initial claim rejection rate** measures claims rejected before payer adjudication divided by submitted claims over a defined period. **Initial denial rate** measures claims receiving an initial adverse payer determination divided by adjudicated claims, with a clearly specified claim- or dollar-based denominator.

Track these indicators consistently rather than treating any single percentage as a universal target. Compare your facility's own performance over time, investigate changes, and use outside benchmarks only when their definitions truly match yours. Staff productivity must be considered alongside accuracy; measuring phone calls alone does not show that outstanding claims were resolved.

When is outside billing assistance appropriate?

Sometimes the problem is a short-term workload spike: a vacant billing position, a system conversion, a backlog after a payer change, or an unusual audit. At other times, leadership discovers that the billing process has no consistent assignment of responsibilities. Either situation may warrant focused

outside support, but outsourcing is not a substitute for accurate resident registration, sound clinical documentation, facility oversight, or timely authorization decisions.

Before selecting additional resources, define the work that must be performed. Is the need claim follow-up, corrected claims, denial appeals, payment reconciliation, Medicaid pending accounts, or a full A/R cleanup? Agree on secure system access, documentation standards, payer escalation rules, quality review, reporting frequency, and final decision authority. Ask prospective partners to show how they would report resolved dollars, claims worked, recurring root causes, and unresolved exceptions. Claims of performance should be supported by verified evidence, not generic promises.

Illustrative case: The backlog that looked like a staffing problem

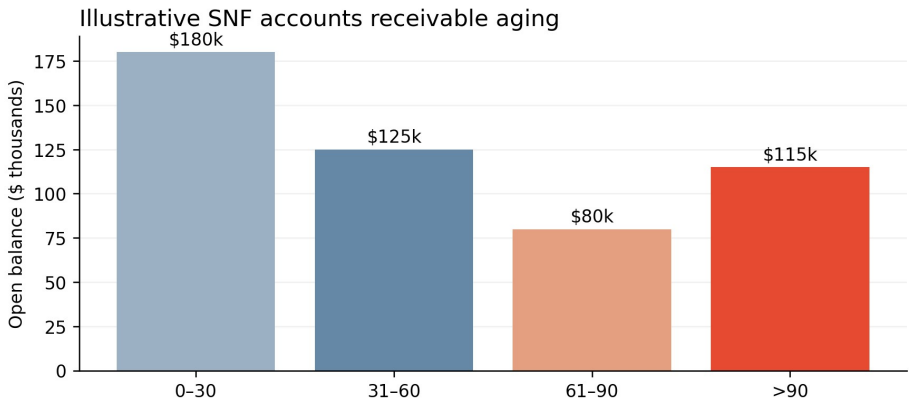
A fictional 90-bed SNF carries \$280,000 in balances older than 60 days. Staff turnover has been high, and management initially proposes adding one more biller. A focused review finds that roughly one-third of the backlog consists of claims never accepted by the clearinghouse. Another portion involves Medicare Advantage claims with missing concurrent authorization documents. A smaller group contains payments recorded in the bank but not reconciled to resident accounts. The additional employee might have helped with volume, but would not by itself have fixed these recurring handoffs.

The facility creates four distinct work queues, assigns weekly clinical and business office exception meetings, and requires every item to have a documented next action. Its first measure of progress is not whether the dollar total falls immediately; it is whether unworked claims, missed deadlines, and reconciliation exceptions stop accumulating. Any monetary improvement in such a scenario would need to be measured, not assumed.

The weekly A/R action meeting

The business office manager should arrive with the payer aging summary, the high-priority work queue, deadlines in the next two weeks, recent cash and adjustments, and a short list of issues needing decisions. The administrator should make sure representatives of admissions, nursing, MDS, therapy, or medical records are included when their information is necessary. Close the meeting by assigning an owner and a due date for each unresolved item. At the following meeting, begin with what was completed and what remains blocked.

Working checklist: Reconcile the opening and closing A/R; validate claim acceptance; separate denials from pending claims; identify deadlines; review payer and facility trends; review credits and underpayments; assign next actions; escalate clinical dependencies; verify resident liability before billing; document management decisions. The goal is not an artificially low A/R report. It is an accurate report in which each outstanding balance is understood and has a responsible next step.



Illustrative data only. This is not an industry benchmark; see the accompanying data table and analysis in Chapter 14.



ORGANIZE THE WORK

Four A/R work queues, each with an owner



Submission exceptions

Claims not yet accepted by the clearinghouse or payer



Payer processing & denials

Status reviews, corrections, documentation and appeals



Reconciliation exceptions

Credits, missing remits, offsets and underpayments



Resident & other balances

Coinsurance, permitted charges and patient liability

A REVIEW RHYTHM (PROPOSED OPERATING PRACTICE)



Every business day

Urgent deadlines



Weekly

Denial queues & A/R action meeting



Monthly

Payer aging with the administrator

A SMALL, CONSISTENT KPI SET

Days in A/R

A/R over 90 days %

Unbilled A/R

Initial rejection rate

Initial denial rate

Chapter 15 – Resident Trust Fund Management

Protecting the resident's money is a separate responsibility

A resident may ask the business office to hold money for personal expenses. Another may receive a small deposit from a family member. A third may authorize the facility to pay for a requested haircut or other permitted personal item. These transactions can appear modest beside the facility's monthly insurance collections. For the resident, however, the money is personal, and the expectation is simple: it should be safe, available, properly accounted for, and never confused with the facility's own revenue.

A Resident Trust Fund is not a collection account. It is an arrangement for safeguarding personal funds entrusted to the facility by a resident who has chosen to authorize that arrangement. Under federal resident-rights requirements, a nursing facility cannot require a resident to deposit personal funds with the facility. If the resident chooses to do so and provides written authorization, the facility must act as a fiduciary and account for those funds. The applicable federal rules are in 42 CFR § 483.10(f)(10). [R7]

Establish a clear authorization process

Before accepting or managing a resident's money, verify who is authorized to act and what the resident wants the facility to do. The record should show written authorization, the resident's name or approved identifier, the authorized representative when applicable, the start date, and the scope of the arrangement. When a representative signs, verify the representative's authority under applicable state law; a family relationship alone is not always enough.

The facility should explain, in understandable language, that residents have the right to manage their own financial affairs. Residents should know how to request money, obtain a balance, see their statements, question an entry, or withdraw authorization. Written policies should cover deposits, withdrawals, disbursements, accounting, reconciliations, account closure, staff changes, and suspected misuse. Staff should not encourage residents to place more money in the fund than they actually want the facility to hold.

Keep trust funds separate from facility operating funds

Federal rules require personal funds over \$100, or over \$50 for residents whose care is funded by Medicaid, to be deposited in an interest-bearing account separate from the facility's operating accounts. Amounts at or below the applicable limit may be maintained in an interest-bearing or non-interest-bearing account or a petty cash fund. If the facility uses a pooled account, each resident's share must be recorded separately and credited with the interest attributable to that share. Additional state requirements may apply. [R7]

These limits are not permission to mix small balances into the facility's general checking account. The facility must maintain separate, complete accounting and cannot commingle residents' money with its own. Appropriate bank arrangements, authorized signatories, secure physical cash controls, and a

separate ledger for each resident are basic safeguards. A fiduciary surety bond or other acceptable financial assurance is also required under the federal provision. [R7]

Do not move money from a resident's personal account to resolve an unpaid facility invoice simply because the invoice appears on an A/R report. Resident funds and facility accounts have different purposes and controls. Any authorized payment must comply with the resident's rights, the actual service charged, coverage rules, and applicable legal consent requirements.

What should a resident trust ledger show?

An auditable ledger lets the resident, a representative, and an authorized reviewer see where the balance came from and where it went. Each entry should capture the transaction date, description, receipt or disbursement amount, running balance, reference or receipt number, authorizing person, and the person who processed the entry. Supporting documentation can include deposit receipts, signed withdrawal requests, approved purchase receipts, interest calculations, bank records, and final disbursement acknowledgements.

A withdrawal request should identify the purpose and who requested it. Staff should be able to demonstrate the authorization rather than relying on memory. Where feasible, one employee should initiate or record transactions and another should review reconciliations. Small facilities can use compensating oversight by the administrator or an authorized finance reviewer when staffing prevents complete separation of duties.

Illustrative resident trust ledger

The figures below are fictional and shown only as an example of a transparent running balance.

Date	Transaction	Money in	Money out	Balance
October 1	Opening balance	\$150.00	–	\$150.00
October 4	Personal funds deposit	\$60.00	–	\$210.00
October 9	Resident-requested haircut	–	\$18.00	\$192.00
October 15	Resident-requested cash withdrawal	–	\$25.00	\$167.00
October 31	Ending balance	–	–	\$167.00

The ending ledger balance is $\$150 + \$60 - \$18 - \$25 = \$167$. The facility should compare this amount with its separately maintained bank and permitted cash records, investigate differences, and retain supporting receipts. An individual resident ledger alone does not prove the pooled trust bank account is reconciled.

Reconciliation must be routine, independent, and documented

A strong process reconciles every resident subledger to the pooled or individual account records and then reconciles the total to the bank and permitted cash on hand. Investigate outstanding checks, deposits in transit, interest, service charges, reversed transactions, and any unidentified difference. Reconciliation should be performed on a defined schedule, typically monthly as an internal control, and signed or electronically approved by a reviewer who did not solely create all the transactions.

When an account does not balance, do not post an unexplained adjustment just to make the difference disappear. Identify the underlying transaction, retrieve supporting records, and document the correction and approval. Repeated small differences can indicate a training gap or a more serious safeguarding problem. Access logs, custody records, and periodic unannounced reviews are reasonable controls, provided they respect resident privacy and applicable law.

The resident's individual financial record must be available through **quarterly statements and upon request**. This is a federal requirement, not just a recommended courtesy. Statements should be clear enough for the resident or representative to understand the opening balance, deposits, expenses, interest, and closing balance. Record delivery or availability in a manner consistent with the facility's procedures and privacy responsibilities. [R7]

Resident rights and allowable charges

The federal rule also limits what a nursing facility can charge to a resident's personal funds. During covered Medicare or Medicaid stays, residents generally cannot be charged separately for covered services already paid under those programs, apart from permitted cost-sharing. The regulation distinguishes required covered services from optional items specifically requested by a resident, with advance notice of the charge. Staff should check the current regulation, payer coverage, state guidance, and the resident's care plan before assessing any personal expense. [R7][R8]

A routine personal hygiene item is not automatically an optional charge. The ability to buy a special personal item does not give a facility permission to transfer the cost of required services to a resident's trust fund. Similarly, the person paying an optional expense must understand and authorize the transaction. The goal is to support residents' choices without reducing their rights or confusing them about what the facility already provides.

Monitor Medicaid resource limits without making eligibility decisions

For Medicaid recipients, the federal resident-fund rule requires notification when the account reaches \$200 less than the individual SSI resource limit, and warning that reaching the relevant resource limit may affect Medicaid or SSI eligibility. Facilities should establish an alert process and coordinate with the resident or authorized representative. Do not treat an account threshold as a complete Medicaid eligibility determination; state rules, exemptions, other resources, and individual circumstances matter. Refer eligibility questions to the appropriate state agency or qualified professional. [R7]

Discharge, transfer, and death

Trust funds should not remain open indefinitely after a resident leaves the facility. Under 42 CFR § 483.10(f)(10)(v), upon discharge, eviction, or death, the facility must convey the remaining funds and a final accounting within **30 days** to the resident or, in the event of death, to the individual or probate jurisdiction administering the estate, in accordance with state law. Confirm identity and authority before releasing funds. The accounting should show every transaction through closure and the recipient's acknowledgement where available. [R7]

When the resident dies, a family member who requests the money may not automatically be the legally authorized recipient. Staff should involve administration and follow the applicable estate procedure. Keep a documented exception list for funds that cannot be released because ownership or legal authority is unclear, and seek guidance without allowing the matter to be forgotten.

Illustrative case: A missing receipt during an annual review

During a fictional facility's monthly reconciliation, the pooled account balance agrees with the bank, but one resident subledger is \$28 lower than the balance supported by receipts. The transaction record says 'personal purchase,' with no vendor receipt or written request attached. The business office manager does not assume that \$28 is too small to investigate. Staff trace the transaction to a purchase for another resident that was mistakenly posted to the wrong account. The error is reversed, both resident ledgers are corrected, the reviewer signs the reconciliation, and the team changes its procedure so receipts must include the resident identifier before posting.

The lesson is that a balanced bank account can still hide resident-level mistakes. The right control checks the pooled total **and** the individual resident accounts. Because the case is illustrative, it does not imply an actual event at any named facility or a client of 24/7 Medical Billing Services LLC.

A practical resident fund control checklist

On enrollment: Confirm voluntary participation, written authorization, representative authority, resident rights information, and the account setup.

At each transaction: Verify authorization; identify the resident; issue or retain a receipt; post promptly; preserve the balance and supporting documentation.

Monthly: Reconcile the bank, cash, and each resident subledger; investigate variances; review the interest calculation and segregation of funds; verify sign-offs and access permissions.

Quarterly and on request: Make an individual statement available and follow up on questions or disputed items.

When Medicaid limits approach: Provide the required warning and direct benefit questions to the proper agency.

At discharge, eviction, or death: Confirm legal entitlement, prepare the final account, convey funds within the applicable time requirement, and retain proof of transfer.

Safeguarding resident funds is not the task that brings the most reimbursement into the building, but it says a great deal about how a facility operates. Residents and families should be able to trust that personal money receives the same careful attention as the facility's own accounts. For a well-run business office, that is a responsibility worth protecting every day.



RESIDENT TRUST FUNDS

A control cycle for money residents entrust to you



- 1 Enroll**
Voluntary, written authorization
- 2 Each transaction**
Verify, receipt, post
- 3 Monthly**
Reconcile bank, cash & ledgers
- 4 Quarterly**
Statements to each resident
- 5 Medicaid alert**
\$200 below SSI resource limit
- 6 Discharge or death**
Final accounting within 30 days

KEY FEDERAL SAFEGUARDS

\$100

Funds above this go in a separate interest-bearing account

\$50

Same threshold for residents whose care Medicaid funds

30 days

To convey funds and a final accounting after discharge or death



Never commingle resident money with facility funds, and never use a trust account to clear a facility invoice just because it appears on the A/R report.

State rules may add requirements. See 42 CFR § 483.10(f)(10) [R7].

Closing Summary

From admission to accountability

A successful revenue cycle does not begin with submitting a claim, and it does not end with a payer marking that claim paid. It begins with decisions about whom the facility can safely admit, which payers will cover the stay, what documentation is required, and who is responsible for each piece of information. It continues through accurate assessments, timely authorizations, appropriate charges, clean claim preparation, payment posting, reconciliation, and thoughtful follow-up on open balances.

The chapters in this book return to one lesson: when one department works in isolation, small errors can travel farther than anyone expects. A missing insurance number becomes a returned claim. An expired authorization becomes a documentation dispute. A late ancillary invoice prevents the triple-check from finding everything it should. A payment applied to the wrong account makes an A/R report less useful. These outcomes are often preventable when the facility has clear written procedures, reliable handoffs, and a routine way to identify exceptions before they turn into aging balances.

The business office cannot solve every problem alone. Admissions, nursing, MDS, medical records, therapy, the administrator, and financial leadership each contribute information that changes the final claim. Strong teams make those responsibilities visible. They agree on deadlines, record what has been completed, speak up about missing information, and review the same report rather than keeping separate versions of the truth.

Five commitments worth taking back to the facility

1. Make payer and authorization verification part of the admission decision, not an afterthought.
2. Use the month-end and triple-check process to reconcile clinical and financial information before claims are released.
3. Monitor claim acceptance, documentation requests, denials, payments, and unresolved A/R with named owners and recorded next steps.
4. Review reimbursement policies and payer rules as they change, and give staff training time rather than assuming software updates alone are enough.
5. Protect resident rights and personal funds with the same seriousness given to the facility's financial accounts.

The best time to improve an SNF's billing process is before a backlog becomes a crisis. A facility does not need to redesign every workflow at once. Choose a recurring exception, identify its cause, decide who can prevent it, and review progress at the next meeting. Over time, careful attention to those details can strengthen both financial visibility and the daily experience of people working in the building.

24/7 Medical Billing Services LLC is pleased to support the larger conversation about sound revenue cycle practices in skilled nursing and long-term care. Facilities considering additional billing

resources should evaluate the support they need, confirm the services and reporting they will receive, and retain their own accountability for clinical, regulatory, and resident-rights obligations.

For changing requirements, always return to the official sources. The websites that follow provide a starting point for Medicare coverage, SNF reimbursement, resident assessment guidance, Medicaid benefits, and resident financial protections.

TAKE IT BACK TO YOUR FACILITY**Five commitments for a stronger revenue cycle****1****Verify payers & authorizations at admission**

Make it part of the admission decision, not an afterthought.

2**Reconcile before claims are released**

Use month-end close and triple check to align clinical and financial data.

3**Give every open item an owner**

Track acceptance, ADRs, denials, payments and A/R with recorded next steps.

4**Keep pace with rule changes**

Give staff training time; software updates alone are not enough.

5**Protect resident rights & funds**

Treat personal funds with the same care as the facility's own accounts.

The best time to improve an SNF billing process is before a backlog becomes a crisis. Pick one recurring exception and start there.

Practical Working Templates

These templates are intended to be adapted to each facility’s software, staffing, policies, and payer requirements. Do not record unnecessary resident identifiers in exported spreadsheets or email.

Weekly A/R exception log

Payer / queue	Claim reference	Problem / deadline	Next action / owner
[Payer / queue]	[Reference]	[Status, age, date]	[Action, owner, due date]
[Payer / queue]	[Reference]	[Status, age, date]	[Action, owner, due date]

Resident trust fund reconciliation log

Control	Review completed	Reviewer / date
Resident ledgers to pooled bank and cash	[Yes / No, variance]	[Initials / date]
Deposits, withdrawals and receipts	[Yes / No, variance]	[Initials / date]
Statements, interest, threshold alerts	[Yes / No, variance]	[Initials / date]
Closed accounts and transfer evidence	[Yes / No, variance]	[Initials / date]

Official Resources and References

Official sources were checked for this 2026 edition. The bracketed references in the new chapters and the regulatory clarifications refer to the resources below. Always use the latest official policy, payer agreement, and state guidance when applying these practices. Access date: October 15, 2026.

[R1] CMS | FY 2027 SNF Prospective Payment System Final Rule (CMS-1843-F), and associated correction notice

<https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/list-federal-regulations/cms-1843-f>

[R2] CMS | Patient-Driven Payment Model: resources, components, and mappings

<https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/patient-driven-model>

[R3] CMS | MDS 3.0 Resident Assessment Instrument Manual, current release information

<https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual>

[R4] CMS | Skilled Nursing Facility Consolidated Billing

<https://www.cms.gov/medicare/payment/prospective-payment-systems/skilled-nursing-facility-snf/consolidated-billing>

[R5] CMS | Additional Documentation Request: timeframes and procedures

<https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medical-review-education/additional-documentation-request>

[R6] Medicare.gov | Skilled Nursing Facility Care: coverage and eligibility

<https://www.medicare.gov/coverage/skilled-nursing-facility-care>

[R7] eCFR | 42 CFR § 483.10, Resident rights, including § 483.10(f)(10) and (f)(11)

<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-B/section-483.10>

[R8] Medicaid.gov | Nursing Facilities: required services and resident charges

<https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/nursing-facilities>

[R9] CMS | First Level of Appeal: Redetermination by a Medicare Contractor

<https://www.cms.gov/medicare/appeals-grievances/fee-for-service/first-level-appeal-redetermination-medicare-contractor>

[R10] Federal Register | CY 2026 Medicare Appeals Amount-in-Controversy Thresholds (December 4, 2025)

<https://www.federalregister.gov/documents/2025/12/04/2025-21879/medicare-program-medicare-appeals-adjustment-to-the-amount-in-controversy-threshold-amounts-for>

[R11] CMS | Original Medicare Fee-for-Service Appeals

<https://www.cms.gov/medicare/appeals-grievances/fee-for-service>

[R12] CMS | Skilled Nursing Facility Billing Reference (Medicare Learning Network)

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/EnrollmentResources/provider-resources/snf/index.html>

[R13] CMS | 2026 Medicare Parts A & B Premiums and Deductibles

<https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-b-premiums-deductibles>

[R14] Medicaid.gov | Institutional Long-Term Care

<https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care>

[R15] Medicare.gov | Official Medicare beneficiary information

<https://www.medicare.gov/>

[R16] CMS | Centers for Medicare & Medicaid Services homepage

<https://www.cms.gov/>

[R17] Medicaid.gov | Official Medicaid program information

<https://www.medicaid.gov/>

[R18] 24/7 Medical Billing Services LLC | Official company website

<https://247medicalbillingservices.com/>

A note on source authority

Federal Medicare rules, federal resident-rights requirements, state Medicaid policies, Medicare Administrative Contractor instructions, and commercial payer contracts have different scopes. A statement that is correct for one payer, state, date, or contract should not be used as a universal rule. References are provided for education and must be rechecked before use in a live billing or collections process.

WHERE TO CHECK THE RULES



Official sources behind this edition



CMS

SNF PPS, PDPM,
consolidated billing,
ADRs, appeals

[R1]-[R5], [R9],
[R11]-[R13], [R16]



Medicare.gov

SNF coverage and
beneficiary
information

[R6], [R15]



Medicaid.gov

Nursing facility
services and long-term
care

[R8], [R14], [R17]



eCFR

Resident rights and
personal funds, 42 CFR
§ 483.10

[R7]



Federal Register

Appeals
amount-in-controversy
thresholds

[R10]

5 Questions to Ask Your Revenue Cycle Team

Use these as a quick self-check at your next business office or revenue cycle meeting.

1

Where is our oldest unresolved A/R?

2

What are our three most common denial or RTP causes?

3

How many authorization problems originate during the admission process?

4

Are Triple Check exceptions assigned to specific owners and followed through to resolution?

5

Which payer currently creates the greatest administrative or reimbursement challenge for our facility?

Couldn't answer all five confidently?

A fresh review of your revenue cycle may uncover opportunities.

Request a Complimentary SNF Revenue Cycle Assessment

Scan the code, or visit 247medicalbillingservices.com/snf-billing-consultation



About 24/7 Medical Billing Services



Publisher of this playbook and a revenue cycle partner for skilled nursing facilities.



WHO WE ARE

Who we are

24/7 Medical Billing Services LLC is a U.S. revenue cycle management company founded in 2015 by Hariharasudan Neelarathinam. We bring together knowledgeable people, disciplined processes, and the right technology to help healthcare organizations get paid accurately and on time.



OUR RCM CAPABILITY

Our revenue cycle capability

Eligibility verification, claim submission, denial and appeal management, accounts receivable follow-up, payment posting, and financial reporting. Our team has led more than 100 client transitions across Medicare, Medicare Advantage, Medicaid, VA/TRICARE, and commercial payers.



OUR SNF EXPERIENCE

Our SNF experience

Our long-term care work is guided by Mary-Jo Wilson, Director of Long-Term Care Services, who brings nearly 30 years in the skilled nursing community, and by Brian Reese, with more than 30 years in healthcare and revenue cycle management. This playbook reflects that experience.



HOW TO ENGAGE

How to engage with us

Most conversations start with a complimentary SNF Revenue Cycle Assessment. We review where revenue may be getting stuck, walk you through what we find, and you decide what, if anything, should happen next.

Specialized Revenue Cycle Support for Skilled Nursing Facilities

See the next page to request your complimentary assessment.

COMPLIMENTARY SNF REVENUE CYCLE ASSESSMENT

How Healthy Is Your SNF Revenue Cycle?

Our team can help identify potential opportunities across:



A/R Aging



Denials & RTPs



Authorizations



Medicare Advantage



Billing & Claim Submission



Payment Posting &
Reconciliation



Month-End & Triple Check



Collections



SCAN TO REQUEST YOUR COMPLIMENTARY ASSESSMENT

247medicalbillingservices.com/snf-billing-consultation

Prefer to talk with us?

24/7 Medical Billing Services LLC

Phone **+1 888-502-0537**

Email **info@247medicalbillingservices.com**

Website **247medicalbillingservices.com**

Brian Reese

Director of Sales

IS YOUR SNF REVENUE GETTING STUCK?

Denials • Aging A/R • Authorizations
Medicare Advantage • Billing • Collections



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