

8

dos and don'ts
to help ensure timely
reimbursements

Skilled nursing facilities manage complex reimbursement requirements across Medicare PDPM, Medicare Advantage, Medicaid, and commercial plans. With the right documentation practices, payor-specific workflows, and reimbursement support, teams can better capture resident complexity, support claim accuracy, and keep reimbursement moving.

The goal: Keep every resident moving without coverage gaps

Cleaner claims start with records that are complete, timely, and aligned with payor expectations. MatrixCare RCM Services can help skilled nursing teams strengthen MDS accuracy, support interdisciplinary workflows, manage documentation details, and identify opportunities to reduce billing disruption before it affects reimbursement.



Dos:

Tips that can move you forward

1

Strengthen interdisciplinary coordination

Insight: Fragmented workflows can lead to inconsistent coding and documentation.

Tip: Hold huddles and provide training on PDPM mappings, Section GG scoring, and payor differences.

2

Confirm eligibility and authorizations early

Insight: Eligibility errors and missing authorizations can lead to delayed or rejected claims.

Tip: Confirm coverage and authorizations at admission, especially for Medicare Advantage and commercial payors.

3

Review claims and address denials right away

Insight: Unreviewed claims and unappealed denials can lead to missed reimbursement.

Tip: Audit MDS submissions and claims regularly, submit timely appeals, and track trends.

4

Submit shadow claims for Medicare Advantage

Insight: Missing shadow claims may affect benefit-day tracking in the Common Working File.

Tip: Submit claims by the correct bill type and condition code for each skilled stay.



Don'ts:

Tips to minimize the detours

1

Submit claims without complete clinical support

Insight: Incomplete provider documentation or unsupported MDS notes may result in denials.

Tip: Ensure all entries are supported by timely, dated documentation before billing.

2

Use the same workflow for every payor

Insight: Overlooking payor-specific requirements can lead to rejections.

Tip: Follow each payor's rules, timelines, and documentation standards.

3

Under document resident needs or comorbidities

Insight: Missing NTA items or relevant diagnoses may limit reimbursement accuracy.

Tip: Capture all defensible clinical elements using current PDPM mappings.

4

Rely on outdated processes

Insight: Legacy workflows and skipped audits can increase errors and compliance risk.

Tip: Refresh processes through regular reviews and ongoing training.

Your reimbursement strategy matters

When teams stay organized, aligned, and proactive, they can help support compliance and minimize billing disruption. Start by reviewing denial trends, and shadow billing compliance. These checks can help teams identify opportunities to strengthen documentation, improve consistency, and support more efficient reimbursement workflows to noticeably enhance revenue.

The MatrixCare RCM Services team understands the challenges and opportunities that come with reimbursement workflows, and improving them doesn't have to feel overwhelming. Our experts can help providers refine their processes with practical support built around the realities of skilled nursing operations.

Want to explore what's possible together?

Contact our experts at **866-469-3766**

or visit **matrixcare.com** to learn more.