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MDS Alert

In The Spotlight: Play By The Medicare Rules And Win Big For Resident Care

Find out how this SNF increased revenues by a half mil in one year.

Implement prospective payment audits and listen to the "ka-ching" of RUG money the SNF had been leaving on the table.

Not only will that extra revenue help fill the patient-care coffers, but auditing the MDS and UB-92 before they go out helps everyone rest easy that the facility can pass a Medicare audit with flying colors.

Dr. William O. Benenson Rehabilitation Pavilion scores high points on all counts. The Flushing, NY nursing facility upped its SNF Part A revenue by $500,000 to $550,000 in one year by doing preemptive audits of the MDSs and UB-92s to fix any problems before submitting them. The facility performs at least 5,000-6,000 MDSs annually.

The facility recently underwent a random probe review of its Part A billing and had all of its claims paid. The coup de grace: The Centers for Medicare & Medicaid Services sent the facility a letter of commendation based on the audit's outcome, reports Nemcy Cavite Duran, RN, BSN, CRNAC, director of MDS for the facility.

Check These Billing Issues

Part of the facility's secret to ensuring Medicare compliance and boosting revenues includes an MDS and UB-92 audit process that accomplishes the following:

1. Confirms compliance with the assessment reference date. The MDS audit team double-checks the ARD and looks to see if the MDS captured nursing, therapy and other services within the assessment window.

2. Detects inconsistencies among MDS items. To red flag items that contradict each other, the facility uses a proprietary software program tool.

3. Bills the correct number of days at the appropriate MDS-generated RUG level.

That's important to check because sometimes the software makes mistakes in assigning the number of days covered by the type of MDS assessment, according to Duran.

4. Validates the HIPPS modifier codes used for assessment identity.

The five-digit HIPPS codes reflect the three-letter RUG and the two-digit assessment type. Getting it right in all cases requires communication between the MDS team and billing. (See "Are You Hip on HIPPS ?" in the May 2005 MDS Alert.)

5. Ensures use of ICD-9 diagnoses on the UB-92 to support medical necessity of services billed, especially therapy diagnoses required to support a rehab RUG.

Therapy example: "While we may use a treatment code as the primary SNF diagnosis, the bill should also include a medical diagnosis to support the RUG billed," says Duran.

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Wound-care example: If the facility is providing and billing wound-care supplies on the UB-92, the MDS team checks to ensure the MDS and UB-92 include the correct ICD-9-CM codes. "Venous insufficiency, arterial and decubitus ulcers have different ICD-9 codes," says Duran. "So we are specific when coding a particular type of wound in Section I3 and on the UB-92." The specific coding can also help remind fiscal and regulatory auditors about a wound's etiology.

Getting on the Same Page With Rehab

To ensure appropriate resident care and reimbursement, the MDS team works closely with the rehab therapy department. For example, the rehab team gives Duran a week's notice when a patient is coming off rehab so the staff can notify the resident and family. The notice also serves to remind the MDS staff to complete an OMRA eight to 10 days after all therapy stops if the resident still requires skilled nursing services. "If you don't communicate with the rehab department, you can miss doing an OMRA," Duran says.

By working with rehab, the MDS team also avoids losing out on an appropriate rehab RUG when the resident can't participate in prescribed therapy. "If you don't work with the rehab staff to set the ARD and move it while you still have the opportunity to do so (during the assessment window), you can miss out on a valuable rehab classification,"cautions Duran.

Example: A patient becomes ill and misses a couple days of therapy during the lookback for the 14-day MDS. Yet the facility has up to day 14 on the 14-day MDS to set the ARD - and five more grace days (up to day 19) - unless it's the OBRA-required assessment for care plan development.

"So if the resident was sick for a couple of days and didn't receive rehab therapy, you can move the ARD up to capture the appropriate treatment minutes, which will move the resident into a higher rehab classification," says Duran.

Survey and QA tip: For patients being discharged home for rehab, the facility provides and codes for training in skills required to return to the community (Section P). "That item doesn't affect payment," Duran notes. "We consider it a quality of care and survey-related activity/program."

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