MDS Alert

MEDICAID: Don't Ding Your NF's Bottom Line: Ring Up Fair Medicaid Case-Mix Payment

Put your RAI compliance and reimbursement on the high road.

Nursing facilities in states with MDS-driven Medicaid systems end up undercutting a big piece of their payment pie if they don't case manage Medicaid patients and ensure MDS accuracy.

The problem: Marc Zimmet, CPA, finds facilities "that are very sophisticated on the Medicare side but miss all kinds of opportunities under Medicaid."

Instead: Realize that even though states may use different RUG systems, there are often more similarities than differences, advises Zimmet, who spoke on the topic at the American Association of Homes & Services for the Aging's fall 2008 annual meeting. "You have to know the nuances of each system, but there are some universal strategies" to capture fair Medicaid reimbursement, says Zimmet, principal of Zimmet Healthcare Services Group Inc. in Morganville, N.J.

Focus on the Payment Drivers

Start by paying attention to what affects the Medicaid rate in your state. That usually includes restorative nursing, rehab, and ADL scores, advises **Peter Arbuthnot,** a regulatoryanalyst for a long-term care software developer in Jackson, Miss.Rehab RUGs are very important drivers under Medicaid, says Zimmet. **Important:** "With dual eligible residents, Medicare is the primary payer. So if you provide Part B rehab, you can also capture it in the rehab RUG for Medicaid, although some states have a Part B offset." But even if the state does have a Part B offset, the state is going to offset the payment whether the facility captures the rehab RUG or not, Zimmet points out.

Also make sure the facility captures diagnoses in Section I, advises Zimmet. "We have found a lot of missed diagnoses that affect RUG placement," he says. "For instance tube feeding alone is clinically complex,[whereas] tube feeding with an aphasia diagnosis is special care.[And] we often find aphasia omitted."

Undercoding mood indicators (E1) and cognitive impairment can also rob the Medicaid coffers. Zimmet sees a lot of lost Medicaid reimbursement on clinically complex RUGs due to failure to capture indicators of depression in Section E1. "We're also seeing where residents in low reduced physical function could have gone in impaired condition if staff had coded the resident's cognition correctly."

Do this: If a resident appears to have cognitive impairment and his score on the Cognitive Performance Scale falls below 3, re-check your coding at B2a (short-term memory recall), B4 (cognitive skills for daily decision-making) and C4 (making self understood). Also review "Here's How the RUG Grouper Calculates the CPS Score" in MDS Alert Vol. 4, No. 7, available in the free Online Subscription System.)

Capturing respiratory therapy can also affect RUG placement. One facility in New York, a state with a RUG-III system, captures physician-ordered respiratory therapy services provided by nurses and RTs for both Medicaid and Medicare patients,notes **Nemcy Cavite Duran, RNAC,**an MDS nurse and consultant in Flushing, N.Y.

Gear Assessment Strategies to Your Medicaid System

A facility's RAI management strategy depends on what type of system the state uses, says Arbuthnot. If the state pays an average or resident-specific rate, the facility needs to make sure to pick up on significant changes as soon as possible because that would typically increase the resident's RUG, he notes. "In some cases, the facility should do a quarterly

earlier if the resident has started new therapy or other services which would change the RUGs."

Example: Suppose a Medicaid patient gets IV fluids or rehab, says Zimmet. "In order to capture that, the facility has to move the quarterly assessment date or do a significant change in status assessment, as appropriate, to capture [those services]," he counsels. "If the facility waits until the next quarterly assessment, the IV or rehab will be over (beyond the lookback window) and the facility won't be able to capture it."

Shore Up, Support Payment

Use software with solid data collection tools to make sure the facility captures the ADLs and other services on the MDS, advises Arbuthnot. "It's also helpful to have tools to compare a recently completed MDS with the prior MDS to see what items changed that might have affected the RUGs, QIs, or RAPs etc.," he adds.

Keep in mind that states may have specific documentation requirements to support MDS coding.

For example, states can create their own documentation requirements for restorative, advises **Marilyn Mines, RN, RAC-CT, BC,** manager of clinical services for FR&R Healthcare Services in Deerfield, Ill. "Illinois, which has created its own [MDSdriven case-mix system], has 17 pointers regarding documentation for restorative alone."

Resource: Check out "Medicaid Reviewers May Be Scrutinizing Your Facility's ADL Documentation," inMDS Alert Vol. 6, No. 3, available in the Online Subscription System. If you haven't yet signed up for this free value-added service, call customer service at 1-800-508-2582.